Jim Shames MD
shamesjg@jacksoncounty.org

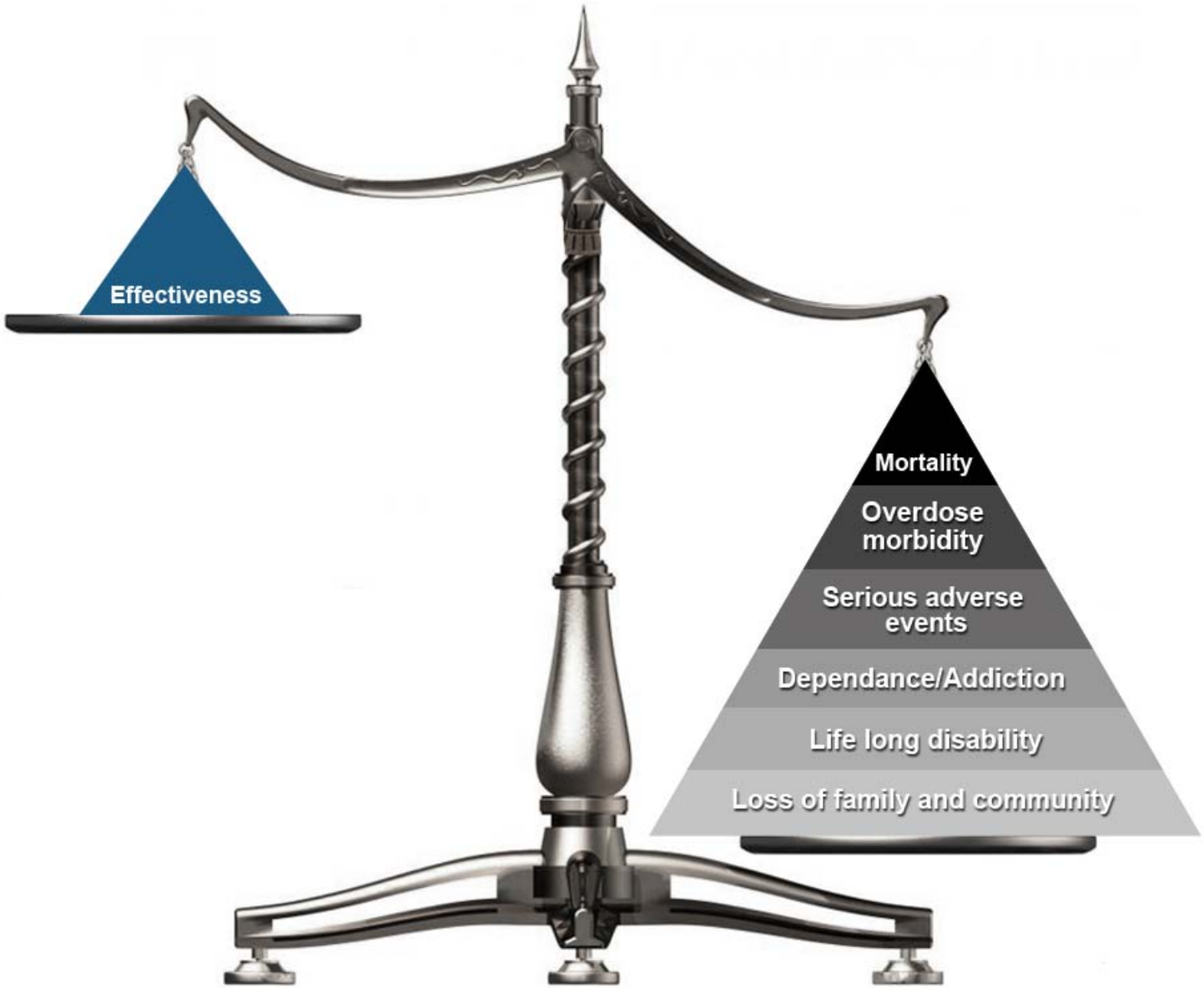
Oregon Pain Guidance group

I no longer accept gifts, lunches, or anything “free” from pharmaceutical companies.

This is an iatrogenic public health crisis

Provider Responsibility

Risk/Benefit of Opioids for Chronic Non-Cancer Pain
-Franklin; Neurology; Sept 2014-Position paper of the AAN-



If we don’t solve this problem as a community, we are only passing it on to the next provider.

That’s how you got your “legacy patients” in the first place!

Oregon Pain Guidance

(formerly Opioid Prescribers Group)

Attendees: Physicians, Mid-level providers, Nurses, Substance Abuse Counselors, CCOs, Therapists, Pharmacists, Medical specialty (Pain Medicine, ED), Dental, Community Justice Partners

Oregon Pain Guidance (OPG)

- Public Health initiative to reduce opioid morbidity and mortality
- Steering Committee
- CME and dinner provided
- Video conference with

  Josephine County
- OPG evolution:

  Brainstormed >

  Guidelines > Acceptance>

  Case reviews and discussion

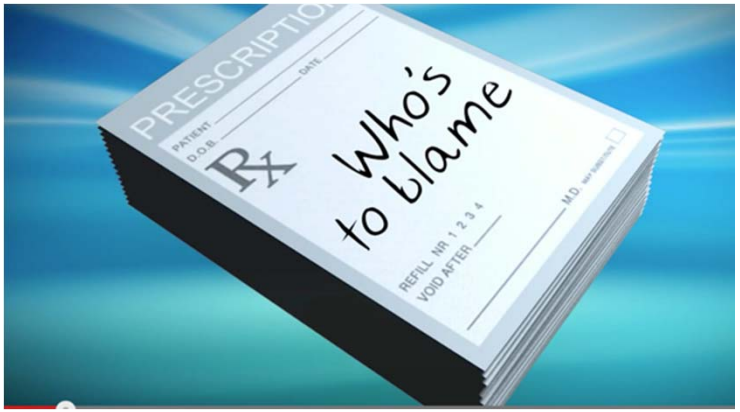
Providers

- Some providers are isolated from current “best practices.”
- Prescribers often don’t really believe the data concerning opioid management.

The 3 legged stool for community engagement: The 3 Ps

- Providers
- Patients
- Public

Public Education



MOVING THROUGH CHRONIC PAIN
A COMMUNITY FORUM

WHEN

THURSDAY, MAY 19TH, 2016 4:00-8:00 PM

WHERE

RAMADA HOTEL AND CONVENTION CENTER
2250 BIDDLE ROAD, MEDFORD, OREGON 97504

WHO

ANYONE AFFECTED BY CHRONIC PAIN

FREE TO THE PUBLIC

SPEAKERS FOR THE EVENT

SAM QUINONES JOURNALIST AND AUTHOR "DREAMLAND- The True Tale of America's Opiate Epidemic"

DR. CSABA MERA MEDICAL DIRECTOR OF REGENCE BLUE CROSS

KEVIN VOWLES ASSOCIATE PROFESSOR OF CLINICAL PSYCHOLOGY, UNIVERSITY OF NEW MEXICO

RAMADA MEDFORD and Convention Center

Primary Health of Josephine County

Jackson Care Connect
Your Community Health Plan

SISKIYOU

JACKSON COUNTY
Health & Human Services

The Dissemination concept

Critical mass: If enough providers, and the public, understand the guidelines, word of mouth and peer pressure will lead to adoption.

OPG
OREGON PAIN GUIDANCE

SEARCH OUR SITE

Pain management guidance and tools for patients, families and healthcare professionals.

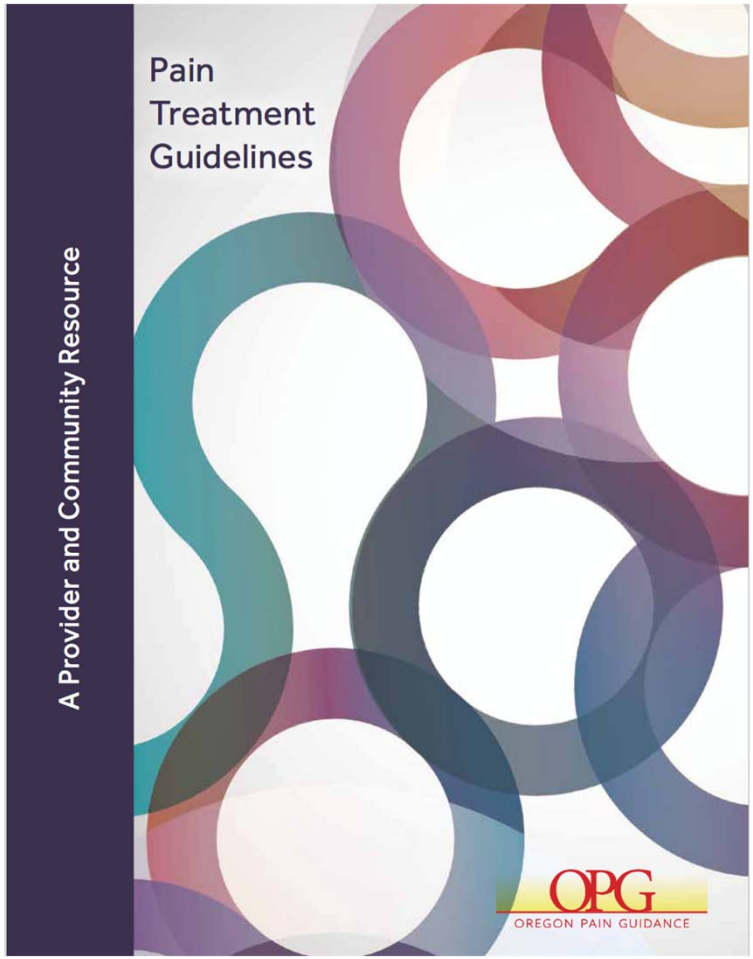
Since 2008 the number of deaths from overdoses has exceeded deaths due to motor vehicle accidents in the U.S.

Patients and Families SELECT »

Healthcare Professionals SELECT »

Oregon Pain Guidance (OPG) is a group of healthcare providers from Jackson and Josephine Counties in Southern Oregon, who are working together on standardizing community guidelines and best practices for treating patients with chronic pain. An improved quality of life for people with chronic pain can be achieved when patients and their families work closely with their healthcare providers. This website provides educational information, news, community resources and upcoming events for both the public and healthcare providers.

Revised OPG guidelines



- How is it different?
  - Operationalize the CDC guidelines
  - Focus on the practicing professional
  - All subjects updated with latest information
  - Recognition of the importance of: Acute Pain, Pain Specialty, Tapering and more

CONTENTS

TREATING ACUTE PAIN
(0–7 Days Following Trauma or Surgery)

In most cases, acute pain can be treated effectively with non-opioid or non-pharmacological options (e.g., elevation, ice). With more severe acute injury (e.g., significant trauma, fracture, crush injury, postoperative pain, extensive burns), short-term use of opioids may be appropriate. Initial opioid prescriptions should not exceed seven days for most situations, and two to three days of opioid medication will often suffice.[7,8,9,10,11] If an individual needs medication beyond three days (or beyond the average expected time for initial healing) a reevaluation of the patient should be performed prior to further opioid prescribing. Physical dependence on opioids can occur within only a few weeks of continuous use, so great caution needs to be exercised during this critical recovery period.

Assessment

- Review medical history, including records from previous providers, when available.
- Administer a physical exam to determine diagnosis and appropriate care. Document baseline function and baseline pain.
- Determine whether the injury can be treated without opioids or if the severity of the injury justifies the risks of opioid therapy.

Non-Opioid Treatment

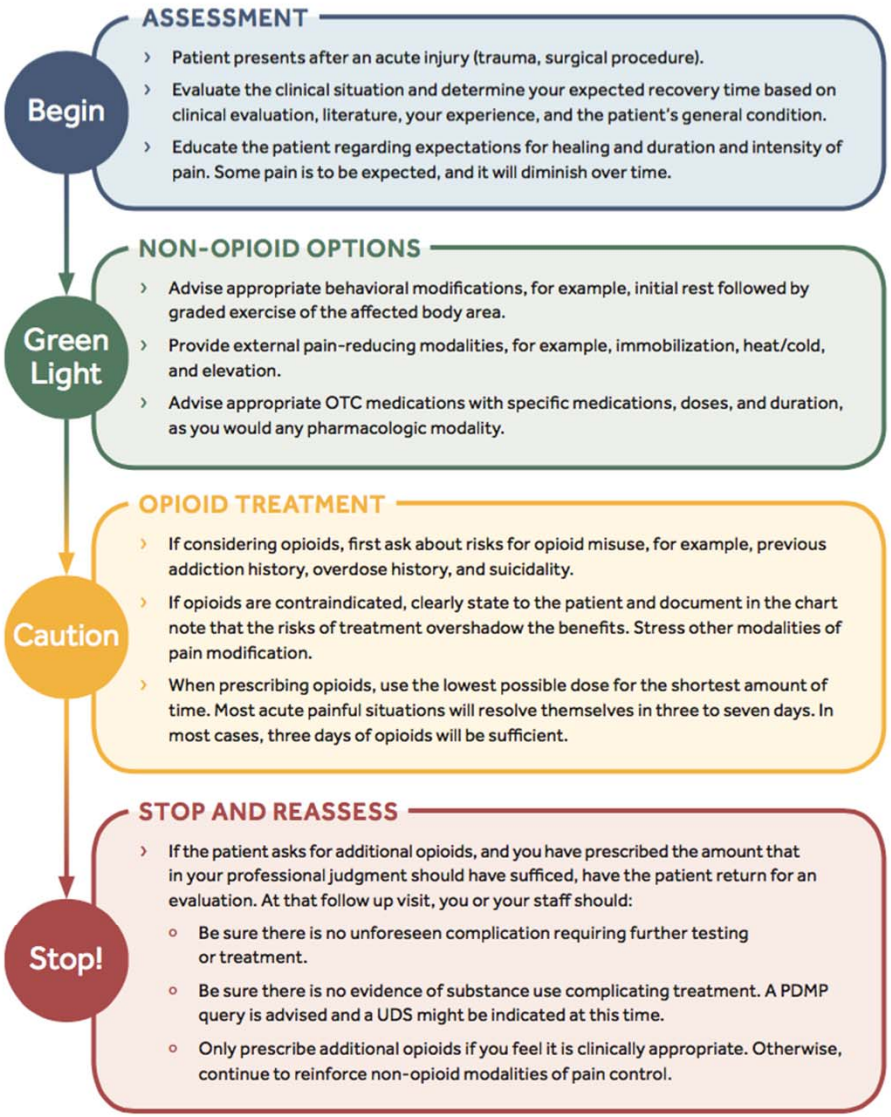
- Help patients set reasonable expectations concerning recovery from the injury. Educate them about the healing process and the benefits of appropriate activity.
- Reassure the patient that some pain is to be expected and that it will subside in time. Over-the-counter (OTC) medications will provide significant relief from pain in many situations and can be relied upon for ongoing pain relief after the acute period is over.
- Patients should improve in function and pain and resume their normal activities in a matter of days to weeks, depending upon the diagnosis. Reevaluate those who do not follow the normal course of recovery.

Opioid Treatment

- If the severity of the injury indicates that limited opioid treatment is appropriate, *before prescribing*, you:
  - Should perform a simple screen for substance abuse (e.g., ORT). Individuals in active recovery are at high risk of being "triggered" by even small amounts of opioids, and you can inadvertently put them in harm's way with your prescription. Those with a history of attempted suicide or overtaking opioids should be prescribed the least amount of medication necessary.

Acute Pain Flow Sheet

FOR THE EVALUATION AND TREATMENT OF ACUTE PAIN



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TREATING CHRONIC PAIN
(Pain Lasting More Than Three Months)

For almost 30 years, common medical wisdom held that most individuals experiencing chronic pain would benefit from daily doses of opioids. Medical knowledge has matured, and our understanding of the risk/benefit of chronic opioid use has changed, such that we now know the risks of chronic use are significant, and the benefits are often modest.[14] Most patients with chronic non-cancer pain can be managed with non-opioid modalities or occasional opioid use.

The problem we now face is the "legacy patients," those who have been on high-dose daily opioids for years, sometimes passing from provider to provider. Many primary care practitioners care for these patients, though they may not have initiated the opioid treatment regimen. These individuals deserve compassionate care and may sincerely believe that they could not cope without continuing their medication regimen. However, current best practice suggests that a slow-dosage reduction will improve the quality of life for the majority of patients.

The characteristics that contribute to dose escalation for chronic pain patients are the same as those which predispose to addiction. When appropriate screening, safe monitoring, and dose reduction are instituted, some of these individuals will be found to have the true diagnosis of substance-use disorder. Co-occurring mental health disorders related to trauma, depression, and anxiety may be revealed, as well. Management of these emerging disorders may require a shift in treatment modalities or a specialty-care referral. A strong partnership with behavioral health experts is essential to managing these patients.[15]

Involvement in daily activities and improved quality of life are the goals of chronic pain treatment. Monitoring function, rather than simply measuring the perception of pain, is the method of assessing patient improvement. Many patients do better after tapering and are grateful to "have their lives back" despite their initial fears of dose reduction.

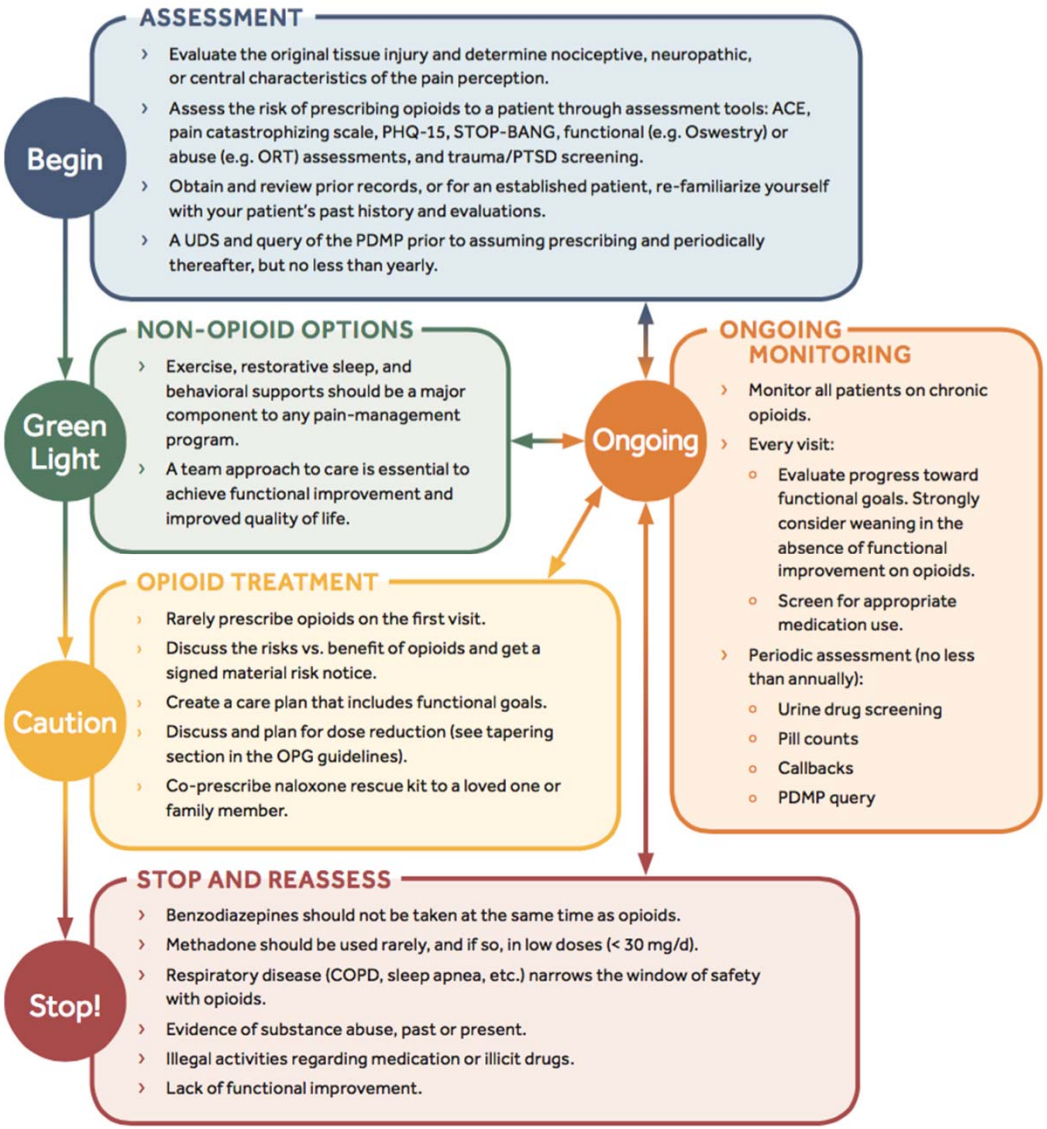
Categorization of Chronic Pain Patients

It may be helpful to think of chronic pain patients as having pain belonging to one of three broad categories: peripheral (nociceptive), neuropathic, and central (non-nociceptive).

- **Nociceptive pain:** Pain whose etiology is ongoing peripheral inflammation or damage. This pain may be responsive to medications or procedures.

Chronic Pain Flow Sheet

FOR THE EVALUATION AND TREATMENT OF CHRONIC NON-CANCER PAIN



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Opioid Tapering Flow Sheet

START HERE

Consider opioid taper for patients with opioid MED > 90 mg/d or methadone > 30 mg/d, aberrant behaviors, significant behavioral/physical risks, lack of improvement in pain and function.

1. Frame the conversation around tapering as a safety issue.
2. Determine rate of taper based on degree of risk.
3. If multiple drugs involved, taper one at a time (e.g., start with opioids, follow with BZPs).
4. Set a date to begin and set a reasonable date for completion. Provide information to the patient and establish behavioral supports prior to instituting the taper. See OPG guidelines.

OPIOID TAPER

Opioids

Basic principle: For longer-acting drugs and a more stable patient, use slower taper. For shorter-acting drugs, less stable patient, use faster taper.

1. Use an MED calculator to help plan your tapering strategy. Methadone MED calculations increase exponentially as the dose increases, so methadone tapering is generally a slower process.
2. Long-acting opioid: Decrease total daily dose by 5–10% of initial dose per week.

   Short-acting opioids: Decrease total daily dose by 5–15% per week.
3. See patient frequently during process and stress behavioral supports. Consider UDS, pill counts, and PDMP to help determine adherence.
4. After ¼ to ½ of the dose has been reached, with a cooperative patient, you can slow the process down.
5. Consider adjuvant medications: antidepressants, gabapentin, NSAIDs, clonidine, anti-nausea, anti-diarrhea agents.

MED for Selected Opioids

Opioid	Approximate Equianalgesic Dose (oral and ransdermal)
Morphine (reference)	30mg
Codeine	200mg
Fentanyl transdermal	12.5mcg/hr
Hydrocodone	30mg
Hydromorphone	7.5mg
Methadone Chronic	4mg
Oxycodone	20mg
Oxymorphone	10mg
Tapentodol	75mg
Tramadol	300mg

Morphine Equivalent Dosing (MED) Calculator:
agencymeddirectors.wa.gov/mobile.html

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Benzodiazepine Tapering Flow Sheet

START HERE

Consider benzodiazepine taper for patients with aberrant behaviors, behavioral risk factors, impairment, or concurrent opioid use.

1. Frame the conversation around tapering as a safety issue.
2. Determine rate of taper based on degree of risk.
3. If multiple drugs are involved, taper one at a time (e.g., start with opioids, follow with BZPs).
4. Set a date to begin and a reasonable date for completion. Provide information to the patient and establish behavioral supports prior to instituting the taper. See OPG guidelines.

BENZODIAZEPINE TAPER

Basic principle: Expect anxiety, insomnia, and resistance. Patient education and support will be critical. Risk of seizures with abrupt withdrawal increases with higher doses. The slower the taper, the better tolerated.

SLOW TAPER

1. Calculate total daily dose. Switch from short-acting agent (alprazolam, lorazepam) to longer-acting agent (diazepam, clonazepam, chlordiazepoxide, or phenobarbital). Upon initiation of taper, reduce the calculated dose by 25–50% to adjust for possible metabolic variance.
2. Schedule first follow-up visit two to four days after initiating taper to determine if adjustment in initial calculated dose is needed.
3. Reduce the total daily dose by 5–10% per week in divided doses.
4. After ¼ to ½ of the dose is reached, you can slow the taper with cooperative patient.
5. With cooperative patients who are having difficulty with this taper regimen, you can extend the total time of reduction to as much as six months.
6. Consider adjunctive agents to help with symptoms: trazodone, hydroxyzine, neuroleptics, anti-depressants, clonidine, and alpha-blocking agents.

RAPID TAPER

1. Pre-medicate two weeks prior to taper with valproate 500mg BID or carbamazepine 200mg every AM and 400mg every HS. Continue this medication for four weeks post-benzodiazepines. Follow the usual safeguards (lab testing and blood levels) when prescribing these medications.
2. Utilize concomitant behavioral supports.
3. Discontinue current benzodiazepine treatment and switch to diazepam 2mg BID for two days, followed by 2mg every day for two days, then stop. For high doses, begin with 5mg BID for two days and then continue as described.
4. Use adjuvant medications as mentioned above for rebound anxiety and other symptoms.

Benzodiazepine Equivalency Chart

Drug	Half-life (hrs)	Dose Equivalent
Chlordiazepoxide (Librium)	5–30 h	25mg
Diazepam (Valium)	20–50 h	10mg
Alprazolam (Xanax)	6–20 h	0.5mg
Clonazepam (Klonopin)	18–39 h	0.5mg
Lorazepam (Ativan)	10–20 h	1mg
Oxazepam (Serax)	3–21 h	15mg
Triazolam (Halcion)	1.6–5.5 h	0.5mg
Phenobarbital (barbituate)	53 – 118 h	30 mg

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SPECIALTY CARE FOR TREATING CHRONIC PAIN

Pain, in all its manifestations, is an aspect of most illnesses, as well as a normal part of the aging process. As such, its treatment is an essential component of primary care. The treatment of pain, especially acute pain, may at times require the use of opioids, which have significant risks in addition to their benefits. After years of misguided provider education, millions of patients in our healthcare system are on opioids for inappropriate diagnoses and at inappropriate doses (legacy patients or the lost generation). Even the most skilled providers may at times need specialty care to assist in the management of these complex patients. This guideline will address the following questions:

What kinds of patients are most appropriate for specialty care?

What is the screening and evaluation expected for these high-risk patients?

What kind of oversight should exist to assure consistent and safe management of these patients?

Who is a pain specialist?

What kind of services should constitute a specialty-care clinic?

What are the expectations and long-term goals for such patients?

Patient Selection for Pain Specialty Care

- Patients on high doses (>90 mg MED) or unsafe drug combinations (e.g., benzodiazepines + opioids) who either refuse dosage reduction, exhibit substance-use disorder behaviors, or have significant behavioral conditions beyond the scope of the provider, may require referral to a pain specialty program or substance abuse program for evaluation or ongoing care.
- Any chronic pain patient beyond the expertise of the primary care provider.
- The Oregon Medical Board (or similar state boards), UW "Tele-Pain" (or similar regional peer education), can be excellent resources for helping manage difficult patients in lieu of specialty referral.

Screening and Evaluation

All patients being prescribed chronic opioids need screening for behavioral, respiratory, and other psychosocial risks because, by definition, the specialty-referral clients are at higher risk. A more thorough evaluation of such patients is to be expected:

- Ongoing functional evaluation: PEG, Oswestry or similar, monitored over time.
- Respiratory: S T O P B A N G or similar, with appropriate referral or further evaluation as necessary.

TRAUMA-INFORMED CARE
(Childhood Trauma, PTSD & Chronic Pain)

It is increasingly recognized that childhood trauma and PTSD affect not only the quality of life of many individuals but also their physical health. Research has increasingly demonstrated that trauma can lead to neurobiological dysregulation, altering the functioning of catecholamine, hypothalamic-pituitary-adrenocorticoid, endogenous opioid, thyroid, immune, and neurotransmitter systems. It is not surprising, therefore, that exposure to traumatic stress is associated with increased health complaints, health-services utilization, morbidity, and mortality.

Trauma and Chronic Pain

The prevalence of trauma is substantially elevated in patients with chronic pain. A current PTSD prevalence of 35% was seen in a sample of chronic pain patients,[29] compared to 3.5% in the general population.[30] In a study of patients with chronic low back pain, 51% of the patients evidenced significant PTSD symptoms.[31] Daniel Claw and others have found a strong association between trauma, childhood sexual abuse in particular, and central sensitization (CS) syndromes.[31] Emotional pain can amplify physical pain perception, and pain itself can actually serve as a reminder of the traumatic event, and thus put the patient at risk for dose escalation.

Screening and Referral Overview

- PTSD symptom screening is an important addition to routine preventive health screening in primary healthcare settings because:
  - Patients are unlikely to report trauma history or symptoms unless directly asked.
  - Trauma exposure is associated with many problems—emotional and physical—that affect health.
  - In patients with long-lasting PTSD, significant improvements in symptoms are unlikely to occur without treatment.
- Gather a thorough bio-psycho-social history and assess the individual for medical and psychiatric problems. Do a risk assessment for suicidal and homicidal ideation. Also ask about substance abuse.
- Assess for PTSD symptoms. There are a number of screening tests that have been designed for use in primary care and other medical settings. See PTSD Screening and Referral: For Health Care Providers for more information.
- Make appropriate referrals for PTSD, depression, other psychiatric disorders, or significant spiritual issues. Likewise, help build up or stabilize the patient's social support network, as this will act as a buffer against the stress they are experiencing.

MANAGING PATIENTS IN THE EMERGENCY DEPARTMENT

The Oregon Chapter of the American College of Emergency Physicians has created a set of guidelines regarding the use of opioids in a hospital emergency department (ED). The following is a modified summary of those guidelines. Emergency medical providers (EMPs) should be supported and should not be subject to adverse consequences by any regulating bodies when respectfully adhering to these guidelines.

1. Only one medical professional should provide all opioids to treat a patient's chronic pain, to the extent possible.
2. The administration of intravenous and intramuscular opioids in the ED for the relief of acute exacerbations of chronic pain is discouraged.
3. EMPs should not provide replacement prescriptions for controlled substances that were lost, destroyed, or stolen.
4. EMPs should not provide replacement doses of methadone for patients in a methadone treatment program.
5. Long-acting or controlled-release opioids (e.g., oxycodone, fentanyl patches, and methadone) should not be prescribed by EMPs.
6. EMPs are encouraged to access EDIE (emergency department information exchange) and/or the state PDMP.
7. EMPs should exercise caution when considering prescribing opioids for patients who present to the ED without a government-issued photo ID.
8. Primary care and pain-management physicians should make patient pain agreements accessible to local EDs and work to include a plan for pain treatment in the ED.
9. EDs should coordinate the care of patients who frequently visit the ED, using an ED care coordination program, to the extent possible.
10. The administration of meperidine in the ED is discouraged.
11. ED prescriptions for opioid pain medication for acute injuries should be no more than 10 pills. For more serious injuries (fractured bones), the amount prescribed should be an amount that will last until the patient is reasonably able to receive follow-up care for the injury. In most cases, this should not exceed 20 tablets.
12. EMPs are encouraged to ask patients about past or current substance abuse prior to the EMP prescribing opioid medication for acute pain. Prescribe opiates with great caution in the context of substance abuse.
13. EMPs are required by law to evaluate an ED patient who reports pain to determine whether an emergency medical condition is present. If an emergency medical condition is present, the EMP is required to stabilize the patient's condition. The law allows the EMP to use his or her clinical judgment when treating pain and does not require the use of opioids.

Concomitant Marijuana and Opioid Use

Medical and recreational marijuana is legal in Oregon and many other states. It is still illegal, however, under federal law. Marijuana is clearly a mind-altering drug, and though it may provide mild to moderate pain relief, it does have associated risks and side effects, such as altered response times, perceptual changes, and mood changes. In some circumstances, marijuana use may be associated with other illicit or risky drug use.

Some providers do not prescribe chronic opioids when marijuana is used (the patient has to choose which treatment modality to use). Others decide not to include THC in their UDS so as not to create a conflict with their patients. Others believe that marijuana may provide appropriate additional pain relief, particularly CBD (cannabidiol) enhanced varieties.

Disposal

The overprescribing of opioids can lead to the accumulation of unused pills in the medicine cabinet. This is true, especially for acute pain situations, when 30 pills may be prescribed for a time-limited situation and only five pills are taken. Those unneeded medications can pose a risk to children or can inadvertently provide a source of illicit opioids through theft or sharing. The ability to safely dispose of unused medication is an important strategy in the fight to reduce unnecessary opioids in circulation.

Drug take-back programs: The Drug Enforcement Administration promotes national drug-take back day on May 8. Many law enforcement agencies have drug drop boxes in their communities. Some pharmacies may also take unused medications as the laws have been relaxed allowing for medication return in some states. The FDA and DEA have useful hints on their websites for disposal, including how to dispose of unwanted medication safely.

Medication-Assisted Treatment (MAT)

Medication-assisted treatment refers to the use of pharmaceutical agents to treat opioid-use disorder. Generally methadone, buprenorphine, and naltrexone sustained release are used for this purpose. Methadone and buprenorphine have the highest rates of success for opioid-use disorder, an important consideration when weighing the significant risks associated with abuse versus the greater relapse rate associated with non-medication treatment regimens. Remember, those with opioid addiction are living with a potentially fatal chronic disease and deserve prompt and effective treatment.

- Methadone can only be prescribed for addiction treatment in a federally monitored treatment facility. Methadone treatment for chronic pain should be used cautiously, if at all, and only at low doses. Significantly higher daily doses (80–100 mg average) are used when treating opioid-use disorder because the MAT clinic can institute tight medication oversight such as daily nurse monitoring, counseling, UDS, and PDMP query. The use of high-dose methadone in such circumstances does not carry the same degree of risk as it would in a primary-care setting.
- Any physician in an office setting can prescribe buprenorphine, after taking a brief educational course and getting an "X" waiver added to their DEA number.[44] Buprenorphine is safer than methadone and generally more convenient to the patient. It is recommended that if you prescribe opioids for chronic pain, you should either become a buprenorphine prescriber or have ready access to that service.
- Medication-assisted treatment should be accompanied by ongoing behavioral supports, and it is strongly recommended that providers of care utilize such expertise as a part of their treatment plan.
- Recognizing opioid-use disorder in your patient should trigger an immediate referral to an effective treatment program or, if you are X waivered, a switch to buprenorphine treatment.
- Naltrexone-injectable Vivitrol can be another useful tool for the patient motivated enough to begin treatment after total opioid abstinence. It also can be provided in a practitioner's office.

Heroin

There has been a rise in heroin use, heroin overdoses, and heroin treatment admissions in the U.S. over the past decade.[45] Opioid dependency does not differentiate between mu agonists, so individuals who develop a substance-use disorder with prescription opioids will find symptomatic relief with any opioid, including

Carisoprodol

Carisoprodol is a muscle relaxant with properties and risks similar to benzodiazepines, with similar habit forming properties. This medication should be used cautiously, *if at all*, especially in combination with opioids. It has been removed from the market in a number of countries worldwide, and the EU recommends it not be used for the treatment of low back pain. In patients experiencing severe pain from spasticity, consider alternatives such as tizanidine or baclofen.

Meperidine

Meperidine is a narcotic analgesic with sedative properties and is not recommended for outpatient treatment of acute or chronic pain. Additionally, meperidine is included in the 2015 AGS Beers Criteria as a potentially inappropriate medication to be avoided in patients 65 years and older because of potentially higher risk for delirium (neurotoxic metabolite), and lack of analgesia when taken orally. Furthermore, the American Pain Society does not recommend its use as an analgesic.

Long-Acting Opioids

Long-acting opiates consist of ER/LA formulations such as oxycodone, morphine ER, fentanyl patches, and methadone, among others.

Long-acting opiates carry the same risks as short-acting formulations. However, the risks of addiction, abuse, misuse, overdose and death are much greater, especially in opiate-naïve patients. For this reason, the use of long-acting opiates should be reserved for the management of pain severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative modalities (both pharmacologic and non-pharmacologic) have been maximally tried and subsequently failed.

Methadone

Methadone has unique metabolic properties making it particularly dangerous to prescribe outside of a closely managed methadone clinic. Overdoses are greatly increased with methadone compared to other opioids. Most guidelines recommend dosing at fewer than 30 mg/day or not at all.

You will notice in the table below, as the dose of methadone increases, the potency of the drug in relation to other opioids increases in an exponential fashion. This will assist in making safe medication switches from methadone to other opioids and vice versa.

Morphine Equivalents	Methadone Factor
100 mg	4:1
100 – 300 mg	8:1
300 – 500 mg	12:1
500 – 1000 mg	15:1
1000 – 2000 mg	20:1
> 2000 mg	30:1

Gabapentin

Gabapentin and pregabalin have a role in the treatment of neuropathic pain, but also have potential for

Naloxone

Naloxone is a pure mu antagonist, and as such, it is an antidote to the effects of opioid intoxication. It reverses respiratory depression that is the cause of death in an opioid overdose. Naloxone has essentially no adverse effects and is remarkably successful in reversing the life-threatening effect of opioids. The incidence of opioid overdose is dose related, but anyone taking opioids is potentially at risk. Therefore, we recommend co-prescribing naloxone for the families and loved ones of all patients prescribed opioids for chronic use.

Naloxone displaces other opioids off the mu receptor sites, but is has a short half-life, having an effect for 30 to 90 minutes. After the drug wears off, the agonists may again reattach to the receptors. Anyone requiring naloxone treatment should be transported to an emergency department for further evaluation since return to the overdose state is possible with the passage of time after the initial naloxone treatment.

Naloxone can be administered parenterally (IV or IM), but it is also effective as a nasal spray. The drug has a very rapid onset of effect when given IV. Its onset of action is more gradual, but still lifesaving, when given via intra-nasal spray. Lay persons can easily be trained to use the intranasal product.

Naloxone is a drug administered by another person to rescue an individual who is overdosing on an opioid. Friends or relatives are often the ones who are present at the time of an overdose and are therefore the individuals who need to receive naloxone training.

Naloxone co-prescribing

Everyone taking opioids on a daily basis should have their friends or loved ones trained in naloxone use. It should be a part of a routine prescribing protocol for prescribers. It communicates your concerns about safety to your patient.

Many states allow lay-person use of naloxone, many insurance companies will pay for the drug, and in Oregon, a simple online training course will suffice to allow dispensing of the drug.

In 2014, 52 people died every day in the United States from prescription-opioid-related overdoses. Cities and states with naloxone distribution programs have seen 37–90% reductions in overdose deaths. Co-prescribing naloxone with medications is an important component of opioid therapy. Patients and their providers commonly underestimate the chance of experiencing an overdose. "Risky drugs, not risky people" is a useful phrase to use when explaining the necessity of naloxone co-prescribing to patients.

Overdose risk factors

As was stated earlier, all individuals taking opioids are at some risk of an overdose. Certain factors will increase that risk:

- Individuals taking sedative-hypnotics (alcohol, benzodiazepines) in addition to opioids are at increased risk. Such individuals may have a partial response to naloxone, since the drug only acts to reverse the opioid component of the overdose.
- Individuals whose opioid tolerance has decreased are at risk. This includes people who leave residential addiction-treatment programs or are released from incarceration.
- Individuals whose dose of opioids is suddenly increased are at risk. A sudden increase in opioid dosing, or a new source of heroin, stronger than what the user was expecting, for example.
- Someone who has previously overdosed is at risk of overdosing again.

THE ART OF DIFFICULT CONVERSATIONS

It is common for the provider/healthcare team to experience challenging conversations with patients as safety guidelines in the area of chronic pain and prescription opioids are implemented. Some topics that may elicit fear in patients and therefore potential discord may include:

- Discussing controlled substance client/clinic agreements.
- Discussing community, state, and national guidelines for safe-prescribing practices.
- Informing new patients that opioids or other controlled substances will not be prescribed and/or increased.
- Informing patients that opioids will be discontinued and/or tapered.
- Discussing the dangers and side effects of the medication.

It is understandable and predictable for patients to express strong feelings when they are presented with information such as the need to reduce or eliminate opioids. Pain medications can become a patient's primary coping strategy for dealing with physical, emotional, psychological and post-traumatic pain. Delivering a message about reducing or stopping such medications can be triggering and even terrifying for a patient and the patient's family. In such situations, patient's emotions are commonly first expressed in the form of anger directed toward the prescribing provider and healthcare team. When facing a highly emotional patient, it is helpful to consider what may be underlying the strong emotional expression. Often underneath the heightened emotional response such as anger, there is fear, grief, panic, sadness, and/or a belief that living without prescription opioids is impossible. Being curious and understanding about what may be beneath a highly emotional expression does not mean one should not take action in the service of safety; however, treading lightly and following the recommendations below will make for a more positive outcome.

Value Identification

Prior to engaging in potentially challenging conversations, it is advisable to spend time reflecting on the core values and principles that you are upholding in the difficult conversation. For example, it may be in the service of practicing safe medicine, being in alignment with your colleagues, the medical board and/or community, state, and national safe opioid prescribing guidelines. When you are in alignment with your values and the healthcare team believes that the change is in the patient's best interest, the difficult conversations are often more manageable and rewarding.

APPENDICES

PRIMARY CARE PTSD SCREEN

In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, **in the past month**, that you*		
1. Have had nightmares about it or thought about it when you did not want to?	☐ YES	☐ NO
2. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?	☐ YES	☐ NO
3. Were constantly on guard, watchful, or easily startled?	☐ YES	☐ NO
4. Felt numb or detached from others, activities, or your surroundings?	☐ YES	☐ NO

Current research suggests that the results of the PC-PTSD should be considered "positive" if a patient answers "yes" to any three items.

A positive response to the screen does not necessarily indicate that a patient has Posttraumatic Stress Disorder. However, a positive response does indicate that a patient may have PTSD or trauma-related problems and further investigation of trauma symptoms by a mental-health professional may be warranted.

If the PC-PTSD screening instrument is utilized, clarify responses to determine:

a. Whether the patient has had a traumatic experience

"I notice from your answers to our questionnaire that you experience some symptoms of stress. At some point in their lives, many people have experienced extremely distressing events such as combat, physical or sexual assault, or a bad accident, and sometimes those events lead to the kinds of symptoms you have. Have you ever had any experiences like that?"

b. Whether endorsed screen items are really trauma-related symptoms

"I see that you have said you have nightmares about or have thought about an upsetting experience when you did not want to. Can you give me an example of a nightmare or thinking about an upsetting experience when you didn't want to?"

If a patient gives an example of a symptom that does not appear to be in response to a traumatic event (e.g., a response to a divorce rather than to a traumatic event), it may be that he or she is ruminating about a negative life event rather experiencing intrusive thoughts about a traumatic stressor.

c. Whether endorsed screen items are disruptive to the patient's life

"How have these thoughts, memories, or feelings affected your life? Have they interfered with your relationships? Your work? How about with recreation or your enjoyment of activities?"

Positive responses to these questions in addition to endorsement of trauma symptom items on the PCPTSD Screen indicate an increased likelihood that the patient has PTSD and needs further evaluation.

APPENDIX S

PATIENT AND COMMUNITY RESOURCES

	Inpatient care, residential	Populations served	Chronic pain services	Sliding scale	Payment options
Adapt Josephine County-Recovery Services					
418 NW 6th St., Grants Pass, OR 97526 541-474-1033 Fax: 541-474-0770 www.adaptoregon.org		Adults and adolescents	✓	✓	OHP, commercial insurance
The Addictions Recovery Center					
111 Genesee St., Medford, OR 97504 541-779-1282 Fax: 541-779-2081 www.addictionsrecovery.org	✓	Adults		✓	OHP, commercial insurance
Allied Health-Recovery Services					
777 Murphy Road, Medford, OR 97504 541-772-2763 Fax: 541-734-3164		Adults	✓ (for those with addiction only – Methadone and Suboxone)	✓	OHP, commercial insurance
Choices Josephine County-Recovery Services					
109 Manzanita Ave., Grants Pass, OR 97526 541-479-8847 Fax: 541-471-2679		Adults and adolescents	✓ (for those with addiction only)		OHP, commercial insurance
Jackson County Mental Health					
1005 E Main St., Medford, OR 97503 541-774-8201 www.co.jackson.or.us	✓	Adults and families	✓ (for those with addiction only)	✓	OHP
Kolpia-Recovery Services *(offices in Medford and Talent)*					
607 Siskiyou Blvd., Ashland, OR 97520 541-482-1718 Fax: 541-482-0964 www.kolpiacounseling.com		Adults and adolescents		✓	OHP, commercial insurance
On Track-Recovery Services *(offices in Medford, Grants Pass, White City, and Ashland)*					
221 W Main St., Medford, OR 97501 541-772-1777 Fax: 541-734-2410 www.ontrackrecovery.org	✓	Adults and children	✓	✓	OHP, commercial insurance
Options for Southern Oregon, Inc.					
1215 SW G St., Grants Pass, OR 97526 541-476-2373 Fax 541-476-1526 www.optionsonline.org	✓	Adults and families		✓	OHP
Phoenix Counseling Center-Recovery Services					
153 S Main St., Phoenix, OR 97520 541-535-4133 Fax: 541-535-5458 www.phoenixcounseling.org		Adults and adolescents	✓	✓	OHP, commercial insurance

Source: http://www.ncptsd.va.gov

What comes next?

Go home and evaluate your practice

- Do you know how many pain patients are in your practice?
- Are you aligned with the CDC guidelines?
- Do you have a unified standard of care?

The paradigm shift

Thank You

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