Massachusetts Consultation Service

MCSTAP

for Treatment of Addiction and Pain

Call **1-833-PAIN-SUD** (1-833-724-6783)
Monday through Friday - 9 am to 5 pm
WWW.MCSTAP.COM

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What is MCSTAP?

MCSTAP

To support clinicians increase their capacity and comfort using evidence-based practices to screen, diagnose, treat, & and manage the care of patients with chronic pain &/or SUD

- Free consultations for **ALL** patients statewide, insurance amnestic
- Personalized, real-time, phone consultation and coaching to PCPs on safe prescribing & managing care for all patients with Substance Use Disorder or Chronic Pain
- Initial & FU consultation & longitudinal consultation
- Info on community resources to address patient needs
- Technical support available to enhance your practice & care of patients
- **1-833-PAIN-SUD** (1-833-724-6783) / Monday - Friday, 9 am- 5 pm
- Funding: Mass. Executive Office of Health & Human Services

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MCSTAP Physician Consultants

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MCSTAP: Live Telephone Support & Expanded Services for Clinicians

Weekday Telephone Support

MOUD & Opioid Treatment

- Complex Care **Treatment Planning & Med Changes** (when indicated)
  - Individual Case review
  - Initiation
  - Dose adjustment
  - Monitoring
  - Termination/referral/titration

Special Issues:

- Pregnancy, special populations, ethics, stigma

Expanded Services & Supports

Mentorship Sessions

- ~3 months (prescriber request)
- **Free CME**

Monthly Case Webinar

- **Free CME:**

MCSTAP Also Provides:

- Real-time coaching
- Initial & FU consults & Ongoing support
- Community resource referral

- **Residency Training & Outreach**
- **Technical support**:
  - Enhance practice capacity

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Additional MCSTAP Services

- **Mentorship**
  - Individual sessions
  - Free, 3 months, by prescriber request only
  - Up to 6 CME credits available per mentoring cycle
- **MCSTAP Monthly Case Webinar Series**
  - Highly interactive Case-Discussion & Free CME
- **Clinical Presentations**
  - Topics: Chronic pain and/or SUD
  - For local clinician groups (e.g., Noon conference).
  - All practice settings (ACO, Hospital-Based, Group Practice, & Primary Care Residency Training Programs, etc.)
- **E-consultation service**
  - IT Integration support

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Training Requirements & Credits: AMA CME (Type I), MA Risk Management, DEA Licensure

Each Monthly MCSTAP Case Webinar can be used to:

- Earn 1.0 AMA CME credits for participating in each Webinar
- Earn 1 hour toward your total 8-hour DEA License New/Renewal Certificate training requirement (every 2 years). (3/27/2023 memo)
- Earn 1 hour of Risk Management credits toward your total Massachusetts State Controlled Substances License renewal training requirement (every 2 years). (3/27/2023 memo)

MCSTAP Webinar Content aligns with these regulatory agencies' guidelines:

- SAMHSA's content recommendations required by the 2022 Medication Access & Training Expansion (MATE) Act
- Massachusetts Commonwealth of Massachusetts, Board of Registration in Medicine (BORIM), Quality and Patient Safety Division

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The MCSTAP team

- Ten (10) Physician Consultants (PCs) from different health systems across Massachusetts
- All have:
  - Expertise treating CP/SUD
  - Experience teaching & mentoring providers
  - **Deep commitment** to helping others work for better outcomes for patients with CP/SUD

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MCSTAP Physician Consultants

NB: MCSTAP has also had an active Community Advisory Board > 1 year. MCSTAP

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Learning Objectives

By the end of this session, participants will be able to:

1. **Describe what MCSTAP is and how it supports clinicians** in pain management, enabling learners to understand its structure and purpose in improving patient care. (*Comprehension*)
2. **Assess and analyze patient information FOR risk factors a/w chronic pain and opioid use**, enabling learners to identify potential challenges in clinical decision-making. (*Analysis*)
3. **Demonstrate effective communication of safety and risk concerns with patients**, fostering collaborative and informed discussions to improve treatment adherence. (*Application*)
4. **Develop individualized treatment plans based** on evaluation of the patient's pain sources, equipping learners to create tailored interventions based on comprehensive clinical assessment. (*Synthesis and Evaluation*)

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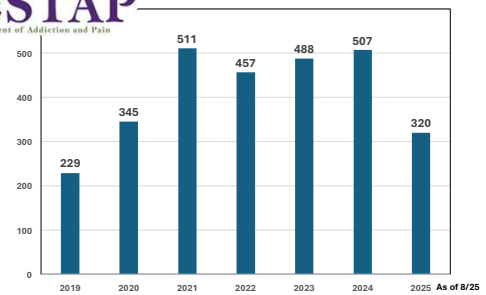
for Treatment of Addiction and Pain

Annual Consultations



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Caller Organizations

- Atrius Health
- BayMark
- Beth Israel Deaconess Medical Center
- Beth Israel Lahey Health Primary Care
- Beverly Hospital
- Boston Healthcare for the Homeless
- Boston HealthNet Comm. Health Centers
- BMC ACO
- BMC Addiction Fellows
- BMC Family Medicine Department
- BMC Family Medicine Residents
- BMC Geriatrics
- BMC/Grayken Center
- Boston University Charles River
- Bournewood Hospital
- Brockton Neighborhood Health
- C3 ACO
- Cape Cod Health Care
- Comm. Health Center Franklin County
- DOTWELL Health
- Emerson Internal Medicine
- Fitchburg Family Medicine
- Greater New England Society for Post-Acute & Long-Term Care
- Greater Roslindale Community Health Center
- Greenfield Family Medicine
- Hampshire County Reg. Med. Society
- Health Alliance Hospital: Clinton
- Health Alliance Hospital: Leominster
- Heywood Hospital
- Lawrence General Hospital
- Lowell General
- Manet Community Health Center
- Massachusetts AFP
- MGH Primary Care
- MGH Revere
- Mass Medical Society (MMS)
- MMS Comm. Mental Health & SUDs
- Mattapan Community Health Center
- Metrowest Medical Ctr IM Residents
- Mount Auburn Hospital IM Residents
- New England Community Health Svcs
- Newton Wellesley Extended Care
- Newton Wellesley Hospital
- Newton Wellesley Internal Medicine
- National Library of Medicine Webinar
- Northshore Community Health
- BMC Grayken / OBAT TTA
- Reliant Medical Group
- Riverside Community Cares
- Saint Elizabeth's Hospital
- Salem Hospital
- BU Scope of Pain
- Signature Health Care: Brockton
- UMass Mem. Med. Group, Div. GIM
- UMass Memorial Schwartz
- UMass Comm. Med. Grp Primary Care
- UMass CHAN Primary Care
- Worcester N. District Reg. Med. Soc.
- Yankee Dental Congress
- Zaheen Medical Center

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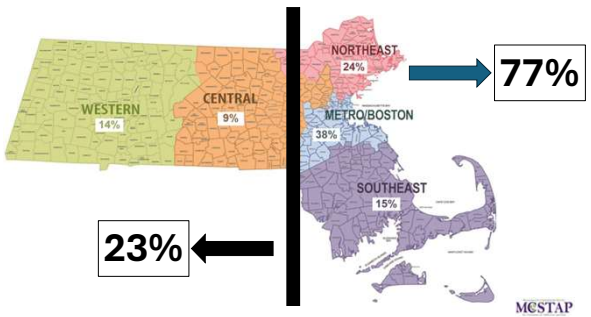
MCSTAP Consultations across Massachusetts 2024



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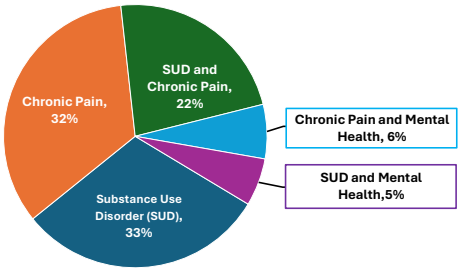
MCSTAP Consultation Type, 2019-2024



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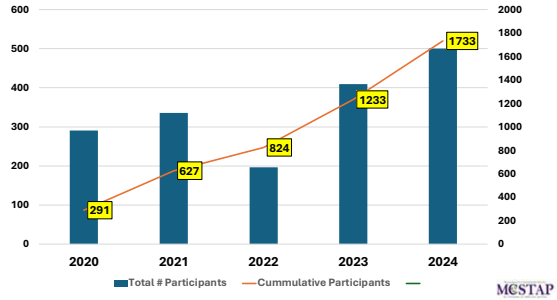
MCSTAP Case Discussion Call-in Hours



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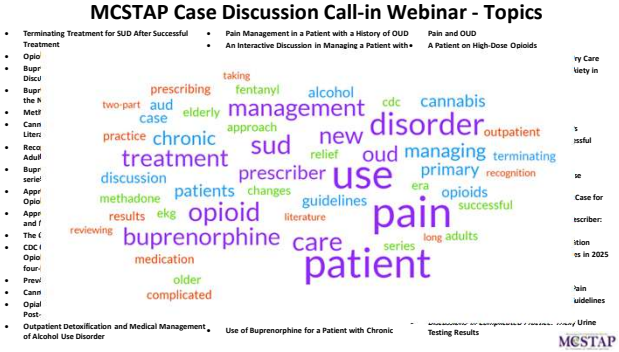
MCSTAP Case Discussion Call-in Webinar - Topics



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MCSTAP Organizational Outreach

- Bureau of Substance Addiction Services (BSAS)
- Massachusetts Medical Society
- Massachusetts League of Community Health Centers
- Massachusetts Hospital Association
- Boston Medical Center (BMC) Grayken Center for Addiction Training and Technical Assistance
- Scope of Pain
- Massachusetts Society of Addiction Medicine
- Massachusetts Chapter of American College of Physicians
- Cape Cod Healthcare
- Sturdy Health

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MCSTAP Educational Presentations 2025

BMC New GIM Clinicians: Safer Opioid Prescribing to Treat Chronic Pain Using a Risk-Benefit Framework	**MCSTAP Case Discussion Call-In Hour:** Monitoring Patients with SUD or Chronic Pain
MCSTAP Case Discussion Call-In Hour: Trans and Gender Diverse People & SUD Foundations	**MCSTAP Case Discussion Call-In Hour:** Safe Opioid Prescribing: 2025 Refresh of Guidelines and Best Practices
MCSTAP Case Discussion Call-In Hour: Bupe 101: Part 1	**BayMark Health**
MCSTAP Case Discussion Call-In Hour: Bupe 101: Part 2	**Martha's Vineyard Hospital Grand Rounds**
Grayken Together for Hope: Massachusetts Addiction Conference	**MCSTAP Case Discussion Call-In Hour:** Discussions in Complicated Practice: Tricky Urine Testing Results
MCSTAP Case Discussion Call-In Hour: Medication Management of Tobacco Cessation	**Massachusetts American Society for Addiction Medicine (MASAM)**
MCSTAP Case Discussion Call-In Hour: Pain Management 101: Common Challenges in 2025	**Boston Medical Center General Internal Medicine:** Chronic Pain Management
Mass Pain Initiative	**Boston Consortium for Higher Education**

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Cases

1. **Patient with severe, acute pain**
2. **Patient with chronic pain**
3. **Patient previously stable on MOUD & Chronic Musculoskeletal Pain fractures his leg**

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Case 1.
Severe, acute pain with an unexpected outcome

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Case 1

Severe, acute pain: Unexpected Outcome

- 42-year old ♂ scheduled for FU of a bunionectomy
- No PMHx; Tolerated Surgery without incident
- D/c'd from same-day surgery w/ Rx for #60 Oxycodone (5 mg) / Acetaminophen (325 mg)
- Pt told: "***Should be walking w/ minimal pain in 5-7 days.***"
- **Three days later patient calls you (not the surgeon)**:
  - Pain is 12/10.
  - Took more pills than Rx'd b/o inadequate pain relief.
  - Now out of pain medication.
  - Requesting oxycodone refill

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Case 1

Discussion Points

- Avoiding / Mitigating this situation
  - Clarify the goal
  - Pre-surgical risk assessment
  - Informed consent – Set clear expectations
  - Post-surgical pain management planning
- How to handle ***"Ran out meds early"***

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Case 1

What are the goals?

- Focus on safety & quality of care
- Minimize risk & maximize benefit
- Set expectations
- Prepare for the unexpected

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Case 1

Pre-surgical risk assessment

- **Screen for Risk Substance Use**
  - Single Item Drug & Alcohol
- **Check MassPAT**
  - Prescription Medication Program
- **Opioid Risk Tool (ORT)**

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Case 1

Single item drug & alcohol risk screening

Drug: *"How many times in the past year have you used an illegal drug or used a prescription medication for non-medical reasons?"*

- If asked to clarify meaning of "non-medical reasons", add "**for instance because of the experience or feeling it caused**" Smith PC, et.al. 2010.
- ✚ = **Response >0** (100% sens., 74% spec. for Drug Use Disorder; 93% sens. & 94% spec. for past-year drug use

Alcohol (NIAAA): *"Do you sometimes drink beer wine or other alcoholic beverages? How many times in the past year have you had 5 (4 for women) or more drinks in a day?"*

- ✚ = **Response >0** (82% sens., 79% spec.) NIAAA. Clinicians Guide to Helping Patients Who Drink Too Much, 2007.

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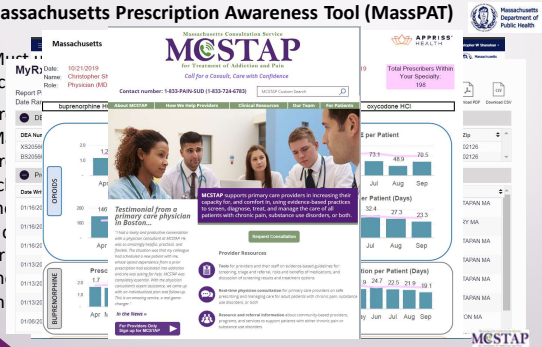
Case 1

Massachusetts Prescription Awareness Tool (MassPAT)



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Case 1

Before Prescribing: The Opioid Risk Tool-R (ORTr)

		♂	♀
Family History of Substance Abuse	Alcohol	3	1
	Illegal Drugs	3	2
	Prescription Drugs	4	4
Personal History of Substance Abuse	Alcohol	3	3
	Illegal Drugs	4	4
	Prescription Drugs	5	5
Age	(Mark box if 16 – 45)	1	1
Psychological Disease	h/o ADD, OCD, Bipolar, Schizophrenia	2	2
	Depression	1	1
	Total		

Risk Category (Total Score)
Low Risk (0 – 3)
Moderate Risk (4 – 7)
High Risk (> 8)

LR Webster, 2005

http://mytopcare.org/udt-calculator/opioid-risk-tool/

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Case 1

Informed consent – Setting expectations

Set Expectations:

"The medications may not prevent all the pain"

talk! about it.

Patient Responsibilities

- Communication if unacceptable levels of post-operative pain, Medication Disposal, No sharing

Discuss Benefits & Risks Opioids

- Focus on safety
- **Benefits:** Pain relief, Increased function, Quality of Life
- **Risks**:
  - Side effects: physical dependence; sedation
  - Misuse, abuse, addiction, overdose, death
  - Drug interactions

Paterick et al. Mayo Clinic Proc. 2008

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Case 1

Acute pain management planning

Fortune favors the prepared mind.

Non-opioid pain medications (Opioid Adjuncts)

- Acetaminophen
- NSAIDS (Naprosyn)
- Tylenol with Codeine
- Local measures (heat / cold / massage, etc.)

J Barden J, et.al. Cochrane Reviews 2004
CJ Derry et.al. Cochrane Reviews 2009,

Contingency planning for unexpected acute pain

- Develop & implement policies
- Discuss policy pre-operatively with pt when consenting
  - Instruct patient when, how, & who to contact
- Establish specific strategies for:
  - treatment escalation
  - dealing w/ aberrant medication taking behaviors

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Oral Analgesics for Postop Pain

Analgesic(s)	Dose (mg)	NNT vs Placebo ≥50% max pain relief > 4-6 hrs.
SINGLE AGENTS:		
Ibuprofen	600	**2.7**
Naproxen	500	**2.7**
Celecoxib	400	**2.6**
Acetaminophen (APAP)	1000	**3.6**
Oxycodone	15	**4.6**
Codeine	60	**12.0**
Gabapentin	250	**11.0**
COMBINATIONS:		
Ibuprofen + APAP	**400+1000**	**1.5**
Ibuprofen + oxycodone	400+5	**2.3**
APAP + oxycodone	325+5	**5.4**
APAP + codeine	300+30	**6.9**

~50K participants
- ~460 high-quality studies
- Mostly dental extractions

Moore RA, et al. *The Cochrane Library*. 2015

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Risk Factors for Transitioning from Short-term to Chronic Opioid Use

Risk factors associated with long-term opioid use

- **Male** (OR 1.34)
- **Older than 50 years old** (OR 1.74)
- **Drug use disorder** (OR 3.15)
- **Alcohol use disorder** (OR 1.83)
- **Benzodiazepine use** (OR 1.82)
- **Antidepressant use** (OR 1.65)
- **Depression** (OR 1.15)

3-5% of **Opioid-naïve patients** ***receiving an opioid,*** *became* **long-term opioid users**

Deyo RA, et al. *J Gen Intern Med*. 2017
Clarke H, et al. *BMJ*. 2014
Sun EC, et al. *JAMA Intern Med*. 2016

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Post-Op Pain Management Guideline

- Offer multimodal analgesia
  - *Strong recommendation, high-quality evidence*
- Most severe post-op pain diminishes rapidly in the first few days, but…
  - need to individualize approach for each patient
- There is **insufficient evidence** to guide post-op opioid taper
  - ~20–25% decrease every 1-2 days can be tolerated when pain is improving
- Some minor surgeries, appropriate to discharge patients with acetaminophen and/or NSAIDs, or a limited opioid supply before the transition to acetaminophen and/or NSAIDs

McDaid C, et al. *Health Technol Assess*. 2010
Kessler ER, et al. *Pharmacotherapy*. 2013
Chou R, et al. *J Pain*. 2016
Elia N, et al. *Anesthesiology*. 2005

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Case 1

"Ran out meds early" is a symptom

1. What is going on? **Make a diagnosis!!**
   - Post-surgical complication?
   - Wrong diagnosis or progression of the disease?
   - Unfounded patient expectations?
   - Inadequate pain-management?
   - Misuse? Addiction? Diversion?
2. Reset patient expectations
3. Refer to & adhere to existing office policy
4. Revisit & modify as needed

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Case 2. Managing chronic pain

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Case 2

Managing Chronic pain

- 58 yo ♀ inherited from a colleague years ago
- Chronic foot pain (? Etiology) on stable dose of Percocet© 2 tabs q.i.d, (**60 MEDD**)
- Followed by PCP for DM, HTN, Anxiety
- Active but & increasingly forgetful
- Recently fell & hit head
- Monthly visit today to RF Percocet©
- Tried but unable to taper Percocet© which patient states is the **only** pain med that works

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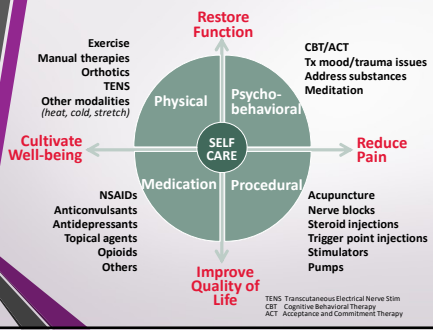
Multidimensional Care for Chronic Pain



Studies of all pharmacologic & nonpharmacologic treatments for chronic pain, the vast majority are ***≤ 12 weeks***

Tayeb BO, et al. *Pain Med.* 2016

Multimodal approaches are more cost-effective than single modality options

Flor H, et al. *Pain* 1992
Roberts AH, et al. *Clin J Pain.* 1993
Patrick LE, et al. *Spine.* 2004
Kamper SJ, et al. *Cochrane Review.* 2014

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Case 2

Key Topics

- Benefits, risks, & possible unintended consequences
- Should opioids for chronic pain be continued?
- When to refer or discontinue the opioids
- Online tools for providers

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Case 2

Risk - Benefit Framework

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Opioids & Chronic Pain in Perspective

The efficacy of long-term opioid therapy for chronic pain has been **requires further study**

- Opioid prescribing should be more judicious
- Opioid misuse can be fatal (overdose, opioid use disorder)
- Opioids for chronic pain…
  - Are indicated after alternative safer options are inadequate
  - Only part of multimodal approach to manage severe chronic pain

Chou R et al. *Ann Intern Med.* 2015
Dowell D et al. *JAMA.* 2016
Manchikanti L, et al. *Pain Physician.* 2011
Reuben DB, et al. *Ann Intern Med.* 2015
Volkow ND, McLellan T. *N Engl J Med.* 2016

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Case 2

Benefits, risks, & unintended consequences

- **Benefits**
  - Improved QOL, Function
- **Risks**
  - Side effects: physical dependence; sedation
  - Drug interactions
  - Misuse, abuse, addiction, overdose, death
- **Unintended consequences**
  - Not all meds taken → Increased risk for:
    - Diversion → Misuse, abuse, addiction, overdose, death

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Case 2

Assessing benefit

PEG (**P**ain, **E**njoyment, **G**eneral activity) Scale (0-10)

1. **What number best describes your Pain on average in the past week?**
   No pain (0) - - - - - - - - - - - - - - Pain as bad as you can imagine (10)
2. **What number best describes how, during the past week, pain has interfered with your Enjoyment of life?**
   Does not interfere (0)- - - - - - - - - - - - - - Completely interferes (10)
3. **What number best describes how, during the past week, pain has interfered with your General activity?**
   Does not interfere (0) - - - - - - - - - - - - - - Completely interferes (10)

Krebs EE, et al. J Gen Intern Med. 2009

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Case 2

Assessing Risk: Monitor Aberrant Behaviors

The **Screener & Opioid Assessment for Patients with Pain (SOAPP)®** helps determine monitoring for patients on long-term opioid therapy

	0 1 2 3 4
1. How often do you have mood swings?	
2. How often do you smoke a cigarette within an hour after you wake up?	
3. How often have any of your family members, including parents and grandparents, had a problem with alcohol or drugs?	
4. How often have any of your close friends had a problem with alcohol or drugs?	
5. How often have others suggested that you have a drug or alcohol problem?	
6. How often have you attended an AA or NA meeting?	
7. How often have you taken medication other than the way that it was prescribed?	
8. How often have you been treated for an alcohol or drug problem?	
9. How often have your medications been lost or stolen?	
10. How often have others expressed concern over your use of medication?	
11. How often have you felt a craving for medication?	
12. How often have you been asked to give a urine screen for substance abuse?	
13. How often have you used illegal drugs (for example, marijuana, cocaine, etc.) in the past five years?	
14. How often, in your lifetime, have you had legal problems or been arrested?	

0 = Never, 1 = Seldom, 2 = Sometimes, 3 = Often, 4 = Very Often
Score of ≥7 positive.

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Case 2

Aberrant medication-taking behaviors

- O Requests for increase opioid dose
- O Requests for specific opioid by name, "brand name only"
- O Non-adherence w/other recommended therapies (e.g., PT)
- O Running out early (i.e., unsanctioned dose escalation)
- O Resistance to change therapy despite AE (e.g. over-sedation)
- O Deterioration in function at home and work
- O Non-adherence w/monitoring (e.g., pill counts, UDT)
- O Multiple "lost" or "stolen" opioid prescriptions
- O Illegal activities – forging scripts, selling opioid prescription

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Case 2

Urine drug testing: Key to opioid prescribing

Why do it:
- Objective information (*Supports patient & public safety*)
- Demonstrate med adherence (*Is patient using the Rx?*)
- Detects non-prescribed substances (*What else is the patient taking?*)
- Supports recovery / may prevent misuse **if pts. know drug tests will occur**
- Urine drug testing an evolving standard of care

How to Discuss Urine Drug Testing with Patients:
- Some physicians awkward discussing urine drug testing
- Frame urine drug testing as a personal and public health issue
- Can tell which patients might be misusing
- Standard of care, no singling out

When to Perform Urine Drug Testing:
- No clear standard: Regular scheduled basis vs. Random
- Ad hoc: When concerns arise (e.g. an observed aberrant behavior)

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Case 2

When to refer

Need assistance with / Discomfort with prescribing high doses of chronic opioids
- Pain Specialist, Colleague with more experience

Misuse of possible addiction
- Addiction Specialist / Substance Abuse Treatment

Assistance w/ discontinuing high dose opioids
- Addiction Specialist / Substance Abuse Treatment

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Case 2

When to discontinue: Risks > Benefits ⚖

DO NOT have to prove diversion/addiction to stop opioid therapy.

Definitive Indications for Stopping Opioid Therapy
- No benefit identified
- Illegal activity / medication diversion / Cannot keep meds safe
- Harms from treatment
- Active addiction (unstable)
- Violent / abusive behaviors → practice staff/clinicians
- Unable / unwilling to comply w/ required monitoring

Relative Indication for stopping opioid therapy
- Clinical judgment required (excl. absolute indication for stopping)
- Risks of opioid treatment outweigh potential benefits

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Case 3.
A patient on buprenorphine with chronic pain

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Case 3

26 y.o. man w/OUD & chronic MSK pain here to establish primary care

- Social history
  - Lives in a sober house now, previously homeless
  - Not working, previously in construction for ~ 8 years
  - Single, never married, no children
- Addiction history
  - Heroin inj. 3 x daily x 6 years, d/c 2 wks. ago
  - Transitioned from "Oxys" on the street
  - Misuse after Sports injury (R ACL tear) ~10 yrs. ago
  - 1 ppd cigarettes x 11 yrs.
  - No other SUDs

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Case 3

Pain history

- Chronic pain: Knees b/l, Lt. ankle, wrists b/l, & neck
- Rt ACL tear 10 years ago
- Fell from ladder → Fx. Lt. ankle → surgical repair 5 yrs. ago
- Psychiatric history
  - Dx: w/ PTSD & Anxiety by Psych in past
- Medications (All started 2 wks. ago at detox)
  - Buprenorphine/naloxone 8/4 2 tabs SL q.d.
  - Gabapentin 300 mg po t.i.d.
  - Citalopram 20 mg po q.d.

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Case 3

Epidemiology

- Pain has a major role in initiating & continuing illicit opioid use
- Chronic non-malignant pain ("chronic pain") is pain that persists ≥ 12 weeks & is not caused by cancer
- In a study (2017) assessing EHR records of 5,307 adult patients with **OUD** in a large healthcare system, it was found that
  - Most OUD patients (64%) had chronic pain conditions
  - Among them, 62% had chronic pain before their first OUD diagnosis
  - In Pts w/ h/o prolonged opioid maintenance:
    - **Pain sensitivity:** Long-term pain sensitivity differences do not resolve if opioid maintenance is discontinued
    - **Pain tolerance:** Improves after opioid maintenance cessation.

Wachholtz A et.al. Drug Alcohol Depend 2014
Hser et. al, *Journal Of Substance Abuse Treatment* 2017

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Case 3

The Experience of Pain in Patients with OUD

Cold-pressor test (hand submerged in ice water → measure variables related to pain)

- In small experimental studies using the cold-pressor test :
- Patients with h/o OUD have ↓ pain tolerance compared to peers without addiction history
- Patients taking methadone or buprenorphine for OUD have ↓ pain tolerance compared to matched controls

Martin J & Inglis J, *British J Clin Psychology* 1965
Compton P, *Drug & Alcohol Dependence* 2001

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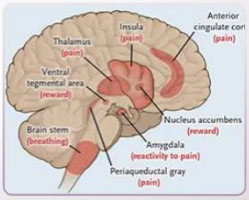
Case 3

Neurobiology of Pain & OUD

- Mu-opioid receptors found in regions of the brain that regulate **BOTH:**
  - Perception of **PAIN** (periaqueductal gray, thalamus, cingulate cortex, insula, amygdala)

  -- & --

  Perception of **PLEASURE** (ventral tegmental area & nucleus accumbens), e.g., The "***Reward Pathway***"
- Opioids **BOTH** → Analgesia & Euphoria
- This overlap appears to partially explain the connection between chronic pain & OUD



Volkow N & McLellan T, *NEJM*, 2016

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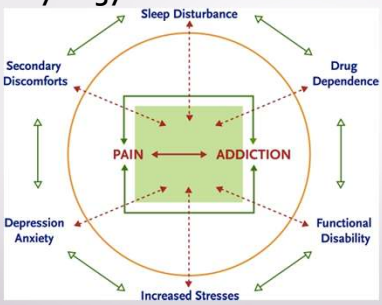
Case 3

Synergy of Pain & Addiction



Savage et. al, *Addiction Science & Clinical Practice* 2008

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Case 3

Management of Chronic Pain in PTs taking Medication for OUD

Reports of Pain are Subjective

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Case 3

Chronic Pain & MOUD: General Principles

- When selecting buprenorphine vs. methadone vs. naltrexone for OUD, consider each medication's impact on the overall management of the patient's chronic pain
- Evaluate & treat chronic pain in patients with OUD using the identical approach used for those patients without OUD.
- Goal of treatment: Manage, not eliminate, pain
- Opioid medications (other than buprenorphine, methadone) are generally not recommended (with some exceptions)
- Perform careful physical exam & appropriate workup/evaluation / referrals as needed

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Case 3

Chronic Pain & MOUD - 5 Treatment Pillars:

1. Psychosocial engagement
   - CBT, mindfulness-based therapies, group therapy
2. Physical mobility & function
   - Physical therapy, yoga, exercise
3. Medication for OUD (MOUD)
   - Buprenorphine, Methadone, or Naltrexone
4. Employ non-opioid pharmacotherapy first
5. Obesity
   - If present, help the patient lose weight

Liebschutz J, et. al, *Current Treatment Options in Psychiatry* 2014

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Case 3

Chronic Pain & MOUD: Non-opioid Pharmacologic Options

Step 1: NSAIDs, acetaminophen

- topicals (lidocaine patch, voltaren gel)

Step 2: Gabapentin*

- cyclobenzaprine
- duloxetine, venlafaxine
- tricyclic antidepressants

*** Avoid or have a low threshold for urine testing if concern for diversion**

Lasser, et al. *Journal of Substance Abuse Treatment* 2016 (mytopcare.org)

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Case 3

Chronic Pain & MOUD

- **Office-based buprenorphine treatment**
  - Prospective study
  - Compared treatment retention & illicit opioid use between participants **with** & **without** chronic pain (N=82)
  - No association between pain & buprenorphine treatment outcomes
- **Conclusion:**

  *The presence of chronic pain in patients with OUD is **not a barrier** to successful treatment with MOUD*

Fox A, et. al, *Substance Abuse* 2012

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Case 3

Chronic Pain & MOUD: Buprenorphine

- A systematic review (10 trials; 1,190 patients)
- Study demonstrated some effectiveness using buprenorphine to treat pain, but evidence was insufficient (studies were low quality)
- Buprenorphine is dosed q 8 hrs. when treating pain in patients with OUD

Cote J & Montgomery L, *Pain Medicine* 2014

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Case 3

Chronic Pain & MOUD: Methadone

- Methadone blocks euphoric effects of opioid analgesics when dosed by opiate treatment programs (OTPs)
- Methadone: Excellent analgesia when dosed q8 hrs.
- OTPs typically dose methadone once daily
  - Exception: "Split doses" for "Rapid metabolizers"
- Patients with chronic pain who receive methadone once daily from their OTP report **pain reduction**

Alford, Managing Acute & Chronic Pain with Opioid Analgesics in Patients on Medication Assisted Treatment (PCSS-MAT slides) 2015. MCSTAP

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Case 3

Regulations Governing Use of Methadone for Pain

- Practitioners (non-OTP) can prescribe methadone only to treat pain (Controlled Substances Act, 1970)
- Schedule II controlled med requiring active DEA #
- Med documentation must reflect use for pain management (*Best practice: every note*)
- **Illegal:** Clinicians outside OTPs are prohibited from prescribing methadone for the treatment of **addiction**

Olsen & Stoller: PCSS-MAT Slides 7.2015 Methadone: Its Role in Opioid Addiction Treatment vs. Pain Management MCSTAP

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Case 3

Chronic Pain & MOUD: Naltrexone

- Consider the impact of each medication on the overall management of chronic pain when selecting buprenorphine vs. methadone vs. naltrexone for OUD
- Patients taking naltrexone: **Opioids Contraindicated**
- Patients with chronic pain who are being prescribed naltrexone should be treated with multi-modal, **non-opioid therapy.**

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Case 3

Manage the Chronic Pain

- Perform a careful H&P
- Order appropriate testing (EMGs of wrists, plain films of knees)
- Consider referrals to Orthopedics / Neurosurgery based on workup
- Refer to Physical therapy
- Refer to Cognitive Behavioral Therapy (CBT) / Mindfulness group

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Case 3

Patient **NOW** taking Tx'd based on Evaluation :

- **For Pain:**
  NSAIDS, APAP, Diclofenac (Voltaren®) gel
- **For MOUD & Pain:**
  Split dose Buprenorphine/naloxone 8/4 mg 2 tabs SL total q.d. (4/1 mg 4 x daily) recommended
- **Management** :
  Consider TCA rather than gabapentin if aberrant behaviors develop and there is concern for diversion.
- **If no improvement in the pain** in 6-8 weeks:
  Consider increasing SSRI

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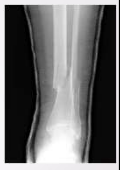
Case 3

Patient 6 months later



- Patient doing well, still at sober house
- Returned to work in construction
- Attending CBT group regularly UNTIL....
  - Pt fell off a ladder at work >> Fx R Tib/Fib, Req. surgery
  - Urgent appt with you after being seen in ER & by ortho (pre-op for urgent ORIF surgery)
  - How should his bupe/naloxone be managed pre- & post-op?
  - What will you prescribe for pain?

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Case 3

Management of Acute & Peri-Operative Pain in patients taking medication for OUD

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Case 3

Acute/Post-op Pain in Pts with OUD

- When selecting buprenorphine vs. methadone vs. naltrexone for OUD it is necessary to consider the impact of each on the management of acute or peri-operative pain
- Patients who are physically dependent on opioids (methadone or buprenorphine) must be maintained on their daily dose before ANY additional opioids can have an analgesic effect for acute pain
- Opioid analgesic requirements are often ↑ due to
  - increased pain sensitivity
  - opioid cross tolerance

Alford, Managing Acute & Chronic Pain with Opioid Analgesics in Patients on Medication Assisted Treatment (PCSS-MAT slides) 2015.

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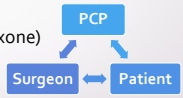
Case 3

Acute/Post-op Pain in Pts with OUD: Key Issues

- Establish and maintain bi-directional communication
- Set clear and reasonable expectations
- Discuss Pain control
  - Timing related to baseline med
    - Methadone / Buprenorphine / Naltrexone)
  - Additional opioids for pain
    - For "Breakthrough"
- Discuss relapse prevention **explicitly**
  - Main goal: **Safety**
  - Plan for administration + storage of opioids
  - Close follow-up with MOUD prescriber



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Case 3

Acute/Post-op Pain in Patients w/ OUD: Buprenorphine

Option 1: Stop buprenorphine/naloxone

- Hold buprenorphine 24 hours prior to surgery
- Rx long-acting opioid analgesic (e.g. oxycodone ER) AM of surgery & then Rx opioids analgesics as needed through peri- & post-op period
- Re-induce buprenorphine in outpatient setting (incl: holding opioid analgesics 12-24 hrs. before re-induction) after operative/acute pain subsided
- **Pro:** Avoids theoretical concern that buprenorphine (partial mu agonist) could block effects of subsequently administered opioids
- **Con:** High risk of relapse, concern for undertreated pain while analgesics are being held & buprenorphine is being re-induced

Stern, Elizabeth E., "Buprenorphine And The Anesthetic Considerations: A Literature Review" (2015). *Nurse Anesthesia Capstones.*

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Case 3

Acute/Post-op Pain in Pts with OUD: Buprenorphine

Option 2: Continue buprenorphine/naloxone (Preferred)

- Continue buprenorphine at usual dose through peri-op period
- Consider splitting the dose TID
- Prescribe opioid analgesics on top of the buprenorphine
- Close FU with prescriber

- **Pro:** Re-induction of buprenorphine **not** needed, ↓ relapse risk
- **Con:** Concern buprenorphine (partial mu agonist) could block effects of subsequently administered opioids?
  - Buprenorphine has its own intrinsic analgesic properties
  - Blockade of mu opioid receptor is incomplete & "defeat-able" with a high-enough full agonist opioid for analgesia

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Case 3

Acute/Post-op Pain in Pts with OUD: Buprenorphine

Concern: Does buprenorphine block the effects of subsequently administered opioids? (partial mu agonist)

- One Study (Experimental mouse & rat pain model)
  - Combination of **Buprenorphine + Full mu-receptor opioid agonist** (morphine, oxycodone, hydromorphone, fentanyl, etc.) → synergistic effects on analgesia
  - Occupancy of mu-receptor by buprenorphine **does not seem to block additional access to the receptor & activation of additional analgesia**
- Systematic Review (2019) of 18 studies that included:
  - 1 Randomized Controlled Trial (RCT); 4 Observational studies
  - **Findings:** "…no evidence against continuing buprenorphine peri-operatively,"
  - **Caveat:** the quality of the evidence was low

Kogel B et. al, *European J of Pain* 2005
Englberger W et. al *European J of Pharm* 2006
Goel et. al, *Canadian Journal Anaesthesiology* 2019

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Case 3

Acute/Post-op Pain in Pts with OUD: Methadone

- Obtain informed consent
- Set clear expectations for pain management
- Reinforce maintenance of sobriety through the peri-operative period
- Call OTP; Verify methadone dose, & call methadone program again time of d/c from hospital
- Continue methadone for "basal" needs through surgery or acute pain
- Treat pain aggressively with conventional analgesics, including opioids at higher doses & shorter intervals
- Additional opioid analgesics will not cause excessive CNS or respiratory depression due to cross-tolerance
- Risk of relapse to active drug use may be higher with inadequate pain management than with the use of opioid analgesics

Alford DP, Compton P, Samet JH. *Ann Intern Med* 2006 MCSTAP

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Case 3

Acute/Post-op Pain in Pts with OUD: Naltrexone

Naltrexone blocks analgesic effects of any co-administered opioid

- **Oral naltrexone (PO)**
  - T1/2 = 14 hours
  - d/c for >72 hours pre-operatively
  - 50% of the blockade effect is gone after 72 hrs.
- **Intramuscular (IM) depot naltrexone**
  - peak plasma within 2-3 days
  - decline begins in 14 days
  - if possible, delay elective surgery 1 month after the last dose

Kampman et. al, *Journal of Addiction Medicine* 2015 MCSTAP

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Case 3

Acute/Post-op Pain in Pts with OUD: Naltrexone

In EMERGENT situations:

- Discontinue naltrexone (all formulations)
- Experimental data show that naltrexone blockade can be overcome with opioid analgesics dosed 6-20x higher than usual dose without affecting respiration
- Consult Anesthesia
- Advanced life support options (including airway/ventilation) nearby
- Consider non-opioids & regional anesthesia

Dean RL et. al *Pharmacol Behav Biol* 2008

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Case 3

Manage Pain through Surgery

- Discuss the patient, the planned surgery, & bupe/nalox with the patient's orthopedic surgeon before surgery
- Rx: Bupe/nalox (8:2):
  - Two (2) tabs q.d. (split dose) continued pre-op & post-op
- Pt Rx'd oxycodone (p.o.) post-op
  - Rx: A prescription for a 3-day supply provided to the patient at d/c
- PCP asks patient:
  - ***"Have you thought about how you are going to prevent a possible relapse after the surgery?"***
- Plan
  - Pt moved temporarily back home w/ his parents for post-op recovery
  - A home supply of oxycodone to be kept in a locked box
  - Oxycodone to be administered by his mother

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Case 3

Take-home points

- Chronic pain & OUD are complex & intertwined problems
- When selecting buprenorphine vs. methadone vs. naltrexone for OUD it is necessary to consider the impact of each on the management of chronic pain & acute/peri-op pain
- Do NOT prescribe methadone for OUD outside OTPS (even in patients who have pain & OUD - ILLEGAL)
- When creating an acute/peri-op pain plan for patients with OUD consider both pain management & relapse prevention
- Get to know your local surgeons & anesthesiologists
- Communication is critical to clinical success

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Case 3

Guardrails for Prescribing Opioids for Pain 1

1. **What is the source of the Pain?**
   Determine the source & type of pain.
   Carefully determine indications for treating the patient's acute pain.
   Determine initial treatment approach. (Non-opioids vs. Opioids, "Stepwise approach,"
   Assess if & What opioid doses are needed & appropriate?
   Set expectations, Provide Informed consent.
2. **Optimize Non-Opioid and Non-pharmacological Treatment**
   Risks v. Benefits, Goals, Treatment progression, Discontinuation, Prognosis, etc.
3. **Use Short-acting Opioids first when initiating pain treatment**
4. **Consider all dosing decisions also accounting for other key factors**
   Start low, Go slow,
5. **Actively Manage Treatment Risks**
   Maintain a Low threshold for monitoring aberrancy & making a diagnosis
   Provide higher levels of monitoring & closer follow-up when initiating treatment.

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Guardrails for Prescribing Opioids for Pain 2

6. **Always re-review the Risks vs. Benefits at all clinical interactions.**
7. **Develop & incorporate individualized Risk Mitigation strategies into treatment planning collaboratively with the Patient**

   Prescribe naloxone, Safe Med disposal, Problem-solving, PrEP, etc.
6. **Validate Pt's History, Behavior w/ & w/o Treatment:**

   MassPAT & other resources to
7. **Monitor patients regularly for adherence & non-prescribed substances:**

   Toxicology, Pill counts, "Day in the life" review: Understand Daily pattern of Pts Med taking & Pain
8. **Maintain high vigilance for Pts Co-prescribed a benzodiazepine/sedatives:**

   Continually use caution (monitor for aberrant behaviors, reassess risks & benefits of treatment regularly)
9. **If addiction develops during pain treatment with opioids, remember to address and decrease risk, often this requires Medication changes**

   NB: The Patient is still in pain; remember to discuss the treatment plan / next steps; Ensure that the patient understands and agrees with the program.

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Treatment: Medication for OUD (MOUD)

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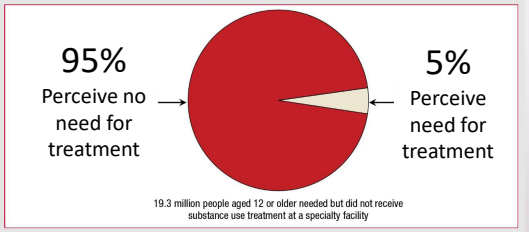
America's Need for & Receipt of Substance Use Treatment in 2015

SAMHSA Substance Abuse and Mental Health Services Administration



Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health (NSDUH), 2015.

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Stigma of Addiction

NIDA National Institute on Drug Abuse

- A core obstacle in all efforts to understand & treat
- Because of stigma:
  - Some people don't get treatment
  - Some doctors won't treat addicts
  - Some pharmaceutical companies won't work toward developing new treatments for addicts

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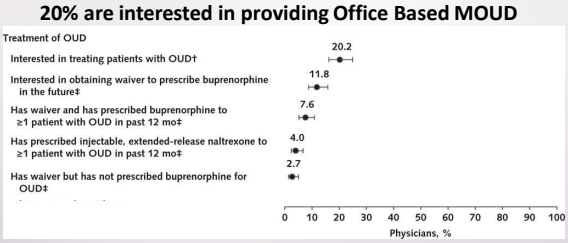
33% PCPs think Medication for OUD is not effective, Only 20% are interested in providing Office Based MOUD



McGinty EE, Stone EM, Kennedy-Hendricks A, et al. **Medication for Opioid Use Disorder: A National Survey of Primary Care Physicians**. Ann Intern Med. 2020

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Online tools

myTOPCARE.org

- Before Starting Opioids
- Starting Opioids
- Continuing Opioids
- Stopping Opioids

Scopeofpain.com

- Live Conferences
- Online Training (FREE) / Videos
- Patient Ed Resources
- Practice posters
- ER/LA Opioid Analgesics Info
- Assessment & Monitoring Tools
- Patient Prescriber Agreements
- Provider Resources / Guidelines
- Bibliography

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Massachusetts Consultation Service

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for Treatment of Addiction and Pain

For a MCSTAP consultation

1-833-PAIN-SUD (1-833-724-6783)

Monday through Friday, 9 am-5 pm

mcstap@beaconhealthoptions.com / www.mcstap.com
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John.Straus@beaconhealthoptions.com

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Defining Addiction & Diagnosis of Substance Use Disorder

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Defining Addiction

ASAM

- A primary, chronic disease of brain reward, motivation, memory & related circuitry
- This circuit dysfunction leads to characteristic biological, psychological, social & spiritual manifestations
- Reflected in pathological pursuit of reward &/or relief by substance use & other behaviors
- Inability to consistently abstain
- Impairment in behavioral control
- Craving/Increased "hunger" for drugs/rewarding experiences

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Defining Addiction (cont.)

ASAM

- Diminished recognition of significant problems with one's behaviors & interpersonal relationships
- Dysfunctional emotional response.
- Cycles of relapse & remission common (Similar to chronic diseases).
- Addiction is progressive & can result in disability or premature death w/o treatment or engagement in recovery activities.

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The Addiction Syndrome

Traditional Addiction Models

- Addictions are understood as distinct disorders despite sharing highly comorbid behaviors & associated mental health & medical problems.
- Individuals are typically referred to disorder-specific clinical services.

The Syndrome Model of Addiction

- Addiction, as substance use (chemical) (e.g. alcohol) or behavioral (e.g. gambling) **is a syndrome sharing common etiological roots**. (Shaffer H. 2004, '12, '16).
- All addiction outcomes share common biopsychosocial vulnerabilities that distinguish patients from those without addiction.
- Various expressions of addiction share overlapping biopsychosocial consequences as a result of addictive behaviors.
- Emphasizes the disordered relationship between a person & focus of addiction.
- Any object or activity - substance or behavior - can become the target of addiction.

Shaffer HJ, et.al. Using the Syndrome Model of Addiction: a Preliminary Consideration of Psychological States & Traits, Int J Ment Health Addiction (2018) 16:1373–1393

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Elephant in the Room: The Stigma of Addiction

- A core obstacle in all efforts to understand and treat Addiction
- Because of Stigma:
  - Some people don't get treatment.
  - Some doctors won't treat individuals with addiction
  - Some pharmaceutical companies won't work toward developing new treatments for addicts.

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Diagnosis

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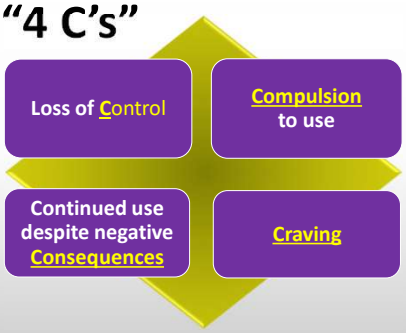
The "4 C's"



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DSM-5 defines a substance use disorder (SUD) as:

Presence of 1 or more of 11 criteria (Clustered in 4 groups)

A. Impaired control:
1. taking more or for longer than intended,
2. unsuccessful efforts to stop or cut down use,
3. spending a great deal of time obtaining, using, or recovering from use,
4. craving for the substance.

B. Social impairment:
5. failure to fulfill major obligations due to use,
6. continued use despite problems caused or exacerbated by use,
7. important activities given up or reduced because of substance use.

C. Risky use:
8. recurrent use in hazardous situations,
9. continued use despite physical or psychological problems that are caused or exacerbated by substance use.

D. Pharmacologic dependence:
10. tolerance to effects of the substance,
11. withdrawal symptoms when not using or using less.

American Psychiatric Association DSM-5 Development

APA. *Diagnostic & Statistical Manual of Mental Disorders: DSM-5*. 2013.

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New to DSM-5 (2013): Severity, Substances, Uniformity

American Psychiatric Association DSM-5 Development

APA. *Diagnostic & Statistical Manual of Mental Disorders: DSM-5*. 2013.

- **New categories**
  - cannabis & caffeine withdrawal
  - criteria for tobacco use disorder are now the same as all other SUDs.
- **Defining SUDs on a single continuum**
  - Logical (Long-term)
  - May create confusion (short-term)
- **Uses # of criteria met as general severity measure:**
  - *Mild* (2–3 criteria)
  - *Moderate* (4–5 criteria)
  - *Severe* (6 or more criteria).
- Guidance criteria cannot determine the need for formal treatment.

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