Educational Requirements – MI LARA Pain & Symptom Management & The Newly Updated US DEA MATE Act

David Neff, DO
David Best, DO, MS, ABAM
Pam Lynch, LMSW, CAADC

Educational Requirements – MI LARA Pain Management & US DEA MATE Act

- 9:00 AM Balancing Safe and Effective Opioid Management to Treat Pain in 2023 – David Neff, DO
- 10:15 AM Medications for Opioid Use Disorder (MOUD) - An Update on the Opioid Health Home with Case Studies – David Best, DO, MS,
- 11:30 AM Harm Reduction: Continuing the Paradigm Shift – Pam Lynch, LMSW, CAADC
- 11:50 AM Q&A

Educational Requirements – MI LARA Pain Management & US DEA MATE Act

- This program meets 3.0 hours required by MI LARA for *pain & symptom management*
- It also meets 3.0 of 8.0 hours required by the US DEA to meet requirements of the Medication Access and Training Expansion (MATE) Act as of December 2022 and noted in Section 1263 of the Consolidated Appropriations Act of 2023
  - DEA license registrants are required to have completed a total of at least 8 hours of training on opioid or other substance use disorders, as well as the safe pharmacological management of pain before renewing their license

Objectives

This 3-hour presentation presentation is intended to help the health care provider put principles of opioid management into daily practice by:

1. Better understanding America's Opioid Ecosystem in 2023 in how opioids are used, misused, abused or diverted

2. How to effectively manage opioids for acute and chronic pain without abandoning the pain refugee

3. How to minimize risk for diversion, misuse and abuse

4. How to effectively identify and manage opioid and polysubstance use disorder with medications to treat opioid use disorder (MOUD)

Desired result

1. Increase provider confidence in managing pain with opioids as needed while mitigating risk for overdose, diversion, misuse or abuse but not abandoning the "pain refugee" who cannot get access to care

2. Increase willingness and ability to identify opioid use disorder (OUD) and ensure a pathway to effective therapy

3. Increase provider willingness to help reverse the ongoing opioid mortality crisis over the last 2 1/2 decades

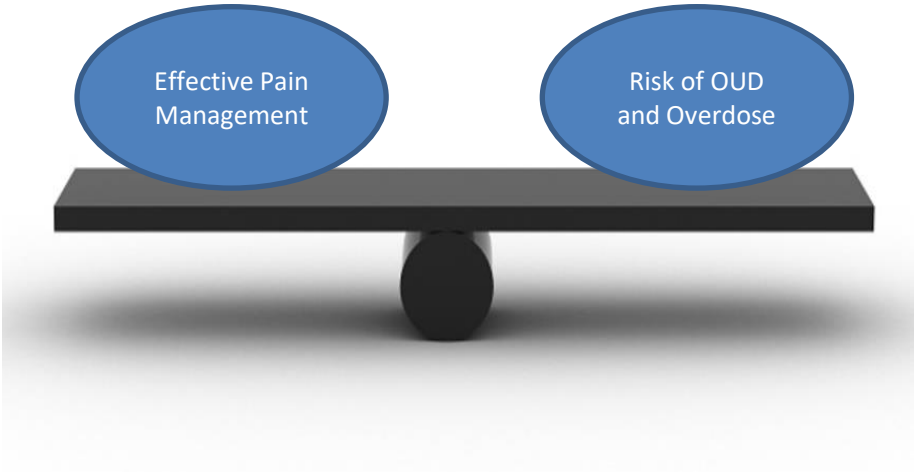
Balancing Safe and Effective Opioid Management to Treat Pain in 2023

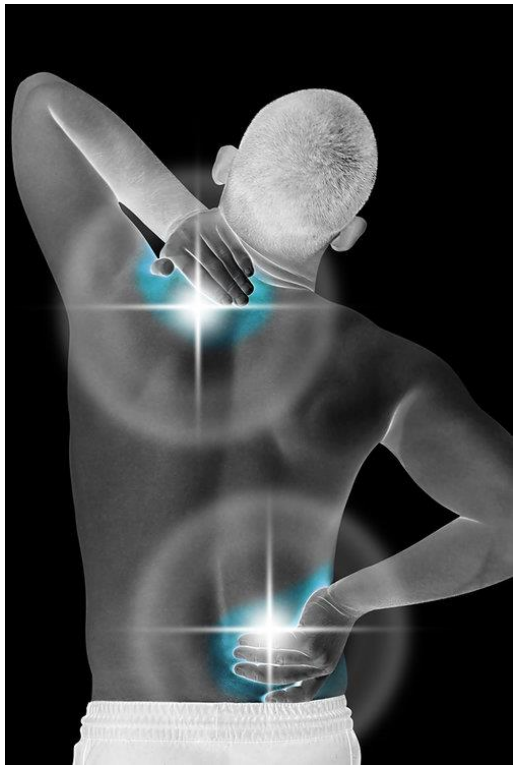
Michigan Osteopathic Association

David R. Neff, DO
Associate Clinical Professor, MSUCOM
Former Chief Medical Director, Michigan Medicaid (Retired)
Former Medical Strategy Leader, Merck Global Medical Affairs (Retired)

Founding Member, MOA Safe Opioid Task Force
Founding Member, Michigan Health Society Safe Opioid Collaborative

Primary Goal: Help the Provider to Balance Effective Pain Management When Using Opioids While Mitigating Overdose Risk, Diversion, Misuse and Abuse





Topics

Part 1 - Examining the Current Landscape in Treating Pain in the background of the Ongoing Opioid Overdose Epidemic

1. The Challenges That Impact Ability to Appropriately Manage Opioids in 2023 Go Back At Least Six Millenia
2. The Overdose Landscape in 2023
3. What's Happening with Current Prescription Trends and Rates of Patient Misuse
4. What's Being Done to Combat Trafficking of Illicit Synthetic Opioids (ie, Fentanyl)
5. What's Being Done in 2023 to Curb Addiction, Overdose and Other Harms
6. The Negative Impact to "Legacy" Pain Patients Already Taking Chronic Opioids
7. The Impact of Sedatives, Alcohol and Stimulants With and Without Opioids – Polysubstance Use Disorder

Part 2 – Determining Medical Necessity and Developing a Rational Treatment Plan When Prescribing Opioids for Pain

8. Weighing Benefit and Risk When Prescribing Opioids
9. Introducing the 2022 CDC Pain Guidelines
10. Approaches to Treat Acute and Chronic Pain in 2022
11. Approaches to Enhance Medical Documentation, Communication and Coordination of Care

Balancing Safe and Effective Opioid Management to Treat Pain in 2023

(Part 1 – Examining the Current Landscape in Treating Pain in the Background of the Opioid Overdose Epidemic)

1. The Challenges That Impact The Ability to Appropriately Manage Opioids in 2023 Go Back At Least Six Millenia

The Controversy About Opioid Use is Over 6000 Years Old

~5700 BC
- Archeological Evidence of Poppy Seeds and Opium Were in Use in Italy & Iberia (which is now Spain, Portugal, South-western France) & Italy
- Eased pain
- Created Euphoria
- Decrease anxiety
- Induced Sleep
- Eased Diarrheal Diseases

460 BC – 1700's AD
- Multiple Purpose Use in the Mediterranean & Middle East – Medicinal, Recreational, Religious & Economic
- The British East India Tea Company traded opium in China to balance deficits (1683)

1880's
- Early discoveries - Morphine (1804) & Codeine (1832) isolated from opium
- Opium Wars (1839 & 1856) – China leases Hong Kong to the UK to stop opium trading
- Laudinum (a mixture of opium, wine and spices) used to treat pain during the Civil War
- Later discoveries - Heroin (diamorphine) (1874)

Early 1900's
- Heroin addictions began to soar leading to the Harrison Narcotics Tax Act, the first opioid control legislation in the U.S
- The industrial age and world war accelerated demand for newer agents
- ~150 synthetic opioids developed to improve pain relief without causing dependance, none found
- Discoveries included oxymorphone (1913), oxycodone (1916), hydrocodone (1920), hydromorphone (1924), meperidine (1932), and methadone (1937)

Mid to Late 1900's
- More potent semi-synthetics and synthetics emerged
- These include ultrapotent fentanyl (1959), buprenorphine (1972), most potent carfentanil (1974)
- The Controlled Substances Act (CSA) of 1970 relaxed the harshness of the Harrison Act (1970)
- NEJM publishes an editorial stating that narcotics do not cause addiction in pain patients (Jan 1980)
- Oxycodone Approved by the FDA (1995)
- The Food & Drug Modernization Act (FDAMA) (1997) was passed to better cope with advancing technical, trade and public health issues

2000 - 2020
- Pain Declared as the 5th Vital Sign Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), no "upper limit" (2000)
- Overdosed Deaths Started Being Identified with Increase Prescription Rates (2001-2011)
- Opioid Prescriptions Peaked as Opioid Deaths Increased (2011)
- Heroin Deaths Increased and Illicit Fentanyl Arises as Prescription Rates Fall (2013)
- Fentanyl-related Deaths Begin to Outpace Heroin and Prescription Opioid Deaths (2015)
- CDC Chronic Pain Guidelines Emerge and Inadvertently Became the Yardstick For Regulators (2016)
- Chronic Pain Patients Begin to Lose Access to Care

2020-2023
- Opioid deaths reach an all-time high largely driven by illicit fentanyl
- Opioid Rx's drop to 2000 prescribing levels
- Over ½ of chronic pain patients cannot get access to care
- The updated 2022 CDC Guideline (to be released Fall 2022) focuses on patient centered care & restates the original purpose of how it should and should not be used
- X-waiver program retired to allow more prescribers to provide MAT (MOUD) – The MATE Act 0f 2022

The Ongoing Conundrum in 2023

- **Illicit Fentanyl-Related Deaths Reach an All-time High**
- **The Number of "Pain Refugees" Who Truly Need Relief Has Grown Due to Restrictive Access to Care**

MICHIGAN

Drug overdose deaths continue to climb in Michigan, across nation

Georgea Kovanis
Detroit Free Press

Published 7:00 a.m. ET Feb. 17, 2022 | **Updated 10:26 a.m. ET Feb. 17, 2022**

PAIN REEXAMINED

The New York Times

Good News: Opioid Prescribing Fell. The Bad? Pain Patients Suffer, Doctors Say.

Doctors and insurers are using federal guidelines as cover to turn away patients, experts tell the C.D.C. and Congress.

CDC Clarifies its Opioid Prescription Guideline

Laura Mills
Researcher

[Report]

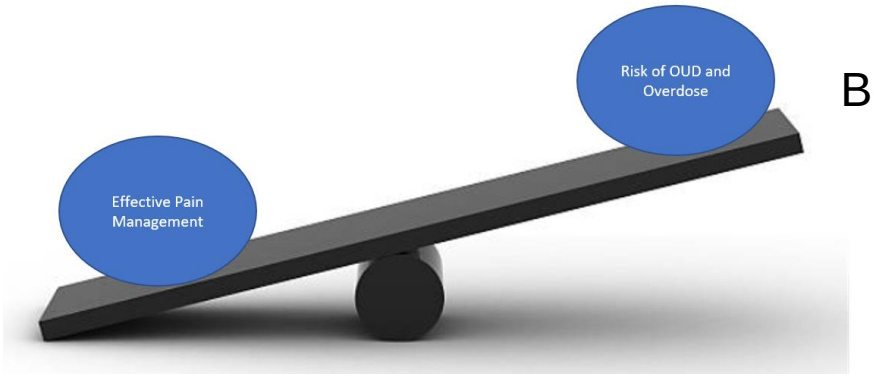
HARPER'S MAGAZINE

The Pain Refugees

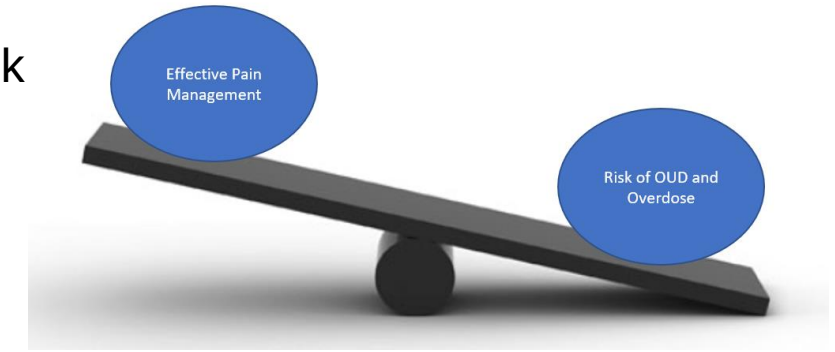
The forgotten victims of America's opioid crisis

by Brian Goldstone

The Ability to Provide Adequate Pain Relief When Using Opioids is Confounded by the Unchecked Number Deaths Related to Illicitly Manufactured Fentanyl and Stimulants



Benefit vs. Risk



Counterfeit Oxycodone Tablet Containing Fentanyl

2. The Overdose Landscape in 2023

National Center for Health Statistics

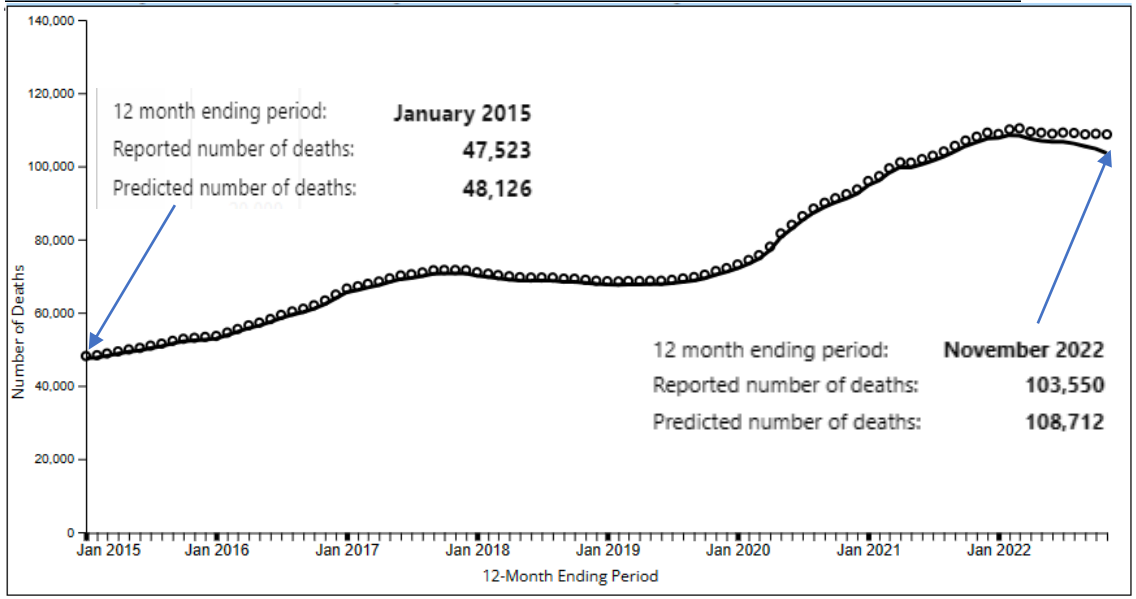
NVSS Vital Statistics Rapid Release

Provisional Drug Overdose Death Counts

The Overdose Landscape for 2023: U.S.

Based on data available for analysis on: April 2, 2023

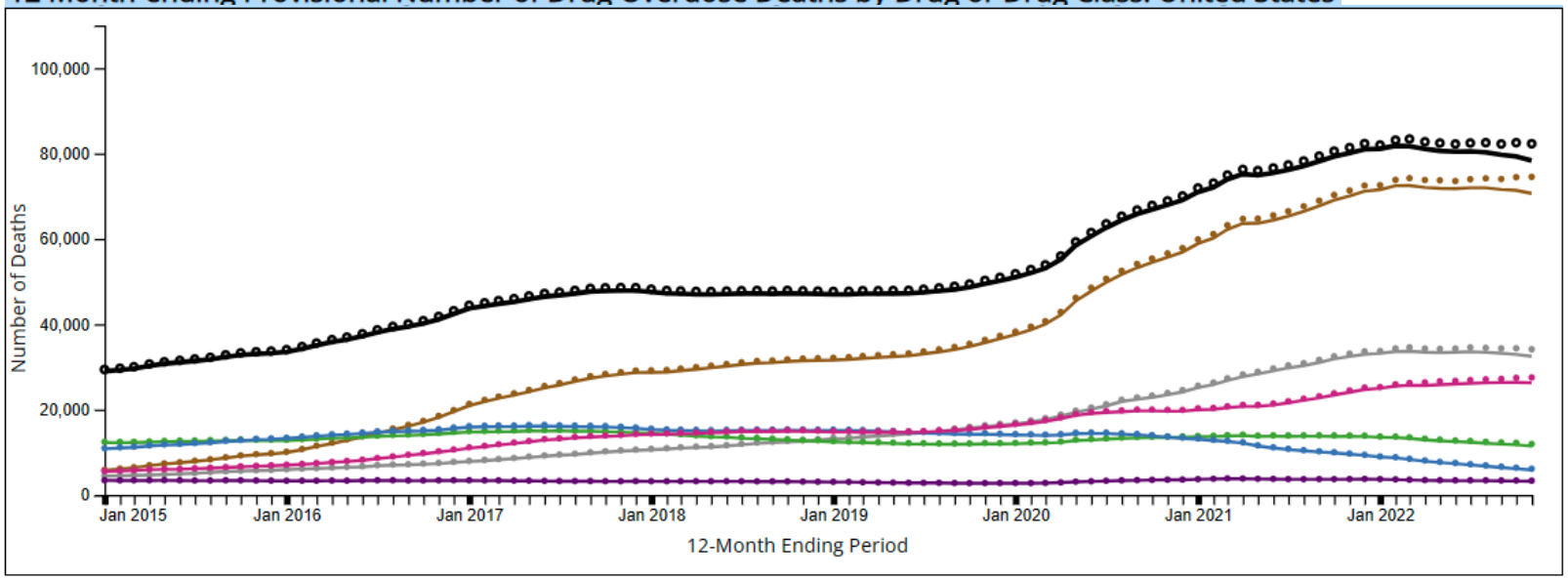
12 Month-ending Provisional Counts of Drug Overdose Deaths: United States



215% Higher Than in January 2015

-4 % Higher Than the Previous 12 months

12 Month-ending Provisional Number of Drug Overdose Deaths by Drug or Drug Class: United States



12 months-ending April 2023 (Predicted)

All opioids 82,224
Fentanyl-Related 74,507

Amphetamines 34,135
Cocaine 27,529

Prescription Opioids 11,945
Heroin 6,143
Methadone 3,346

Vital Statistics Rapid Release - Provisional Drug Overdose Data (cdc.gov) Accessed 4/22/2023

National Center for Health Statistics

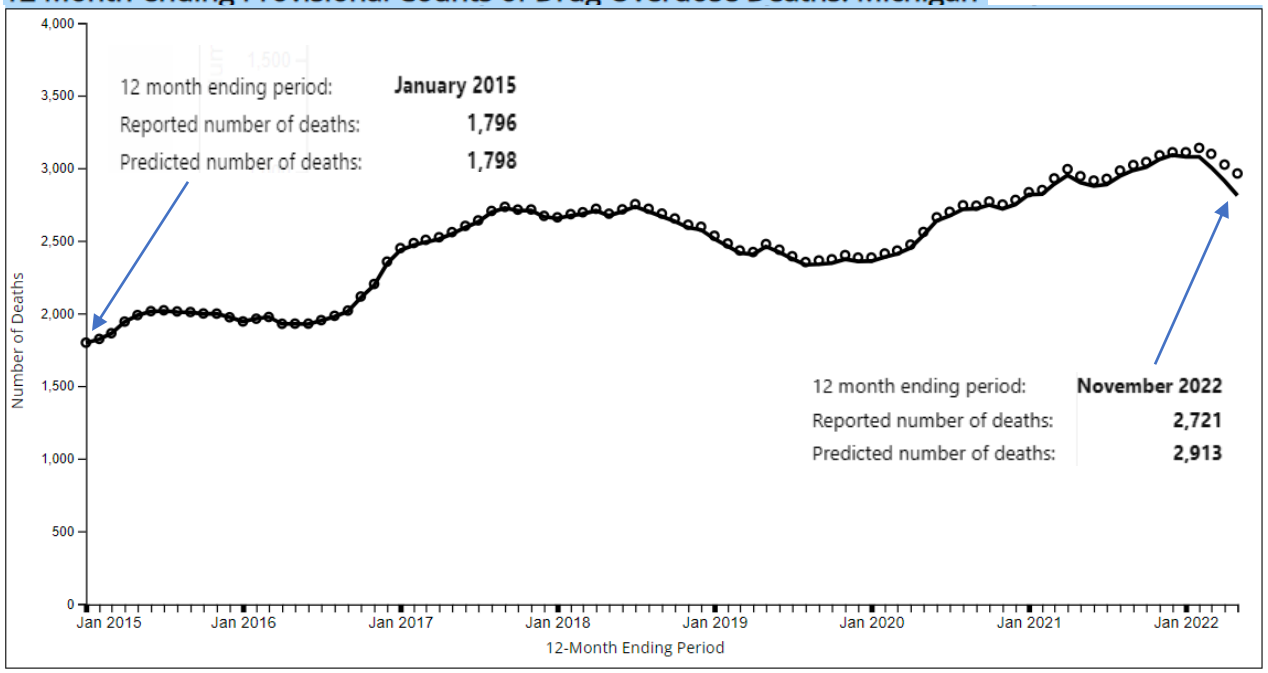
NVSS Vital Statistics Rapid Release

Provisional Drug Overdose Death Counts

The Overdose Landscape for 2023: Michigan

Based on data available for analysis on: April 2, 2023

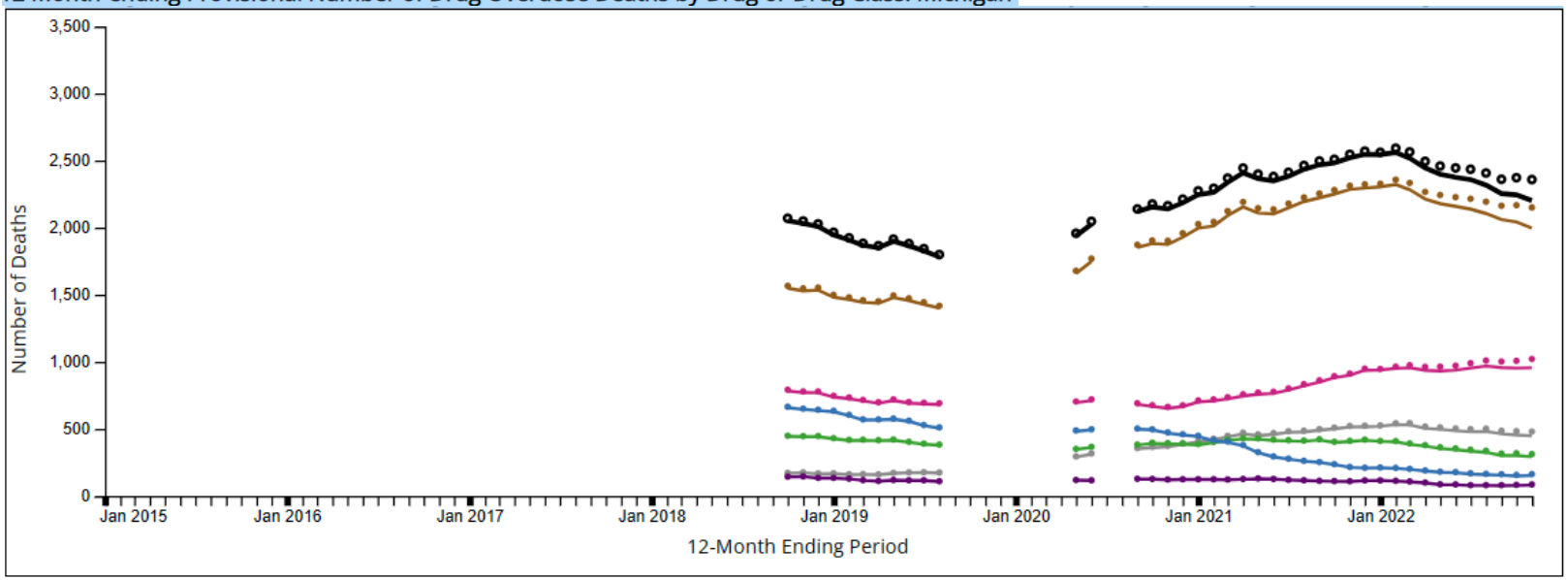
12 Month-ending Provisional Counts of Drug Overdose Deaths: Michigan



161% - Higher Than 1/1/2015

-6% - Over Last 1 Year

12 Month-ending Provisional Number of Drug Overdose Deaths by Drug or Drug Class: Michigan



12 months-ending April 2023 (Predicted)

All opioids 2,358
Fentanyl Related 2,358

Cocaine 1021

Amphetamines 480
Prescription Opioids 312
Heroin 163
Methadone 86

[Vital Statistics Rapid Release - Provisional Drug Overdose Data (cdc.gov)](#) Accessed 4/22/2023

National Center for Health Statistics

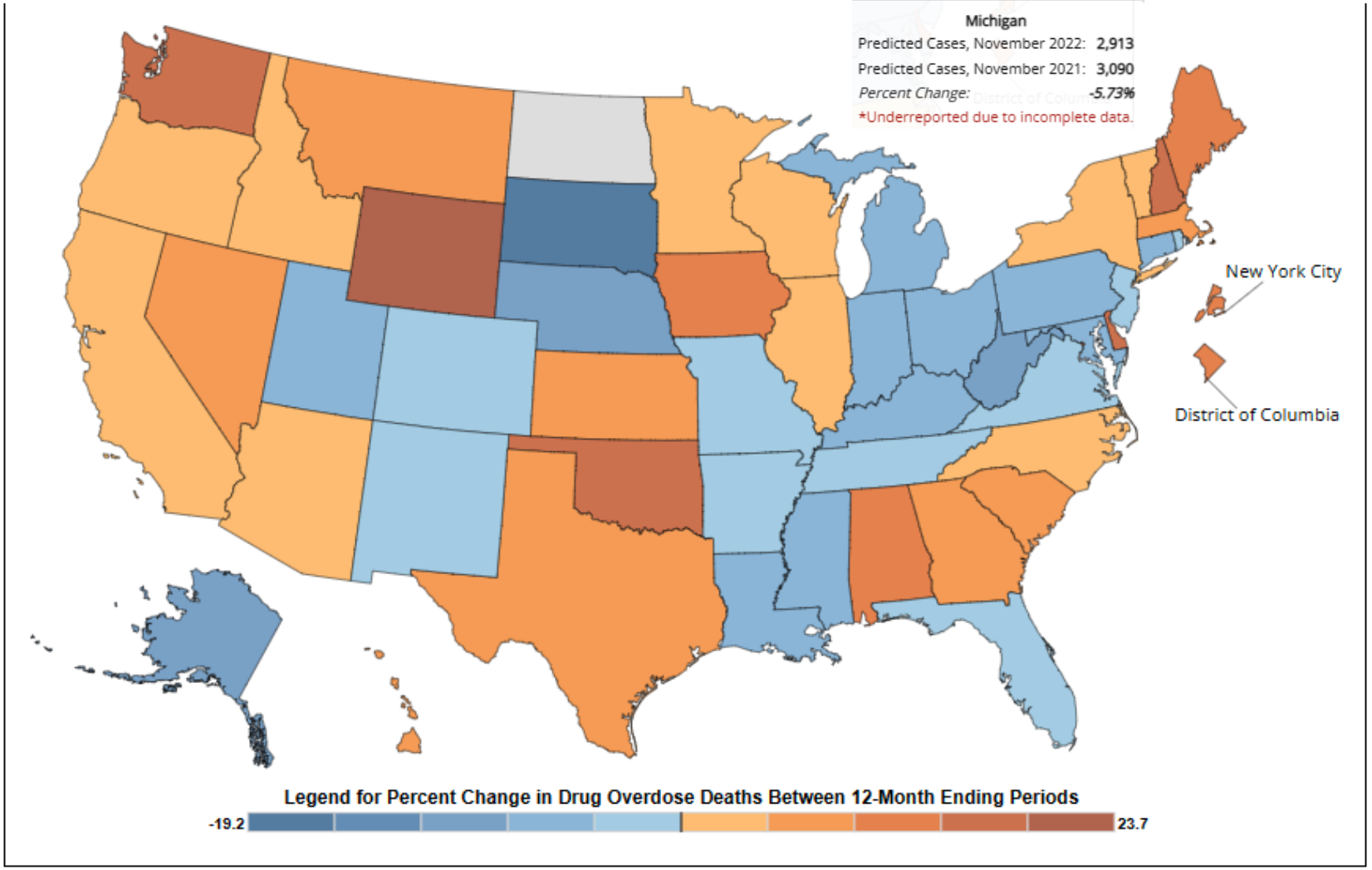
NVSS Vital Statistics Rapid Release

Provisional Drug Overdose Death Counts

The Overdose Landscape for 2023: Comparison Across States

Based on data available for analysis on: April 2, 2023

Percent Change in Predicted 12 Month-ending Count of Drug Overdose Deaths, by Jurisdiction: November 2021 to November 2022



Select predicted or reported number of deaths

(•) Predicted

( ) Reported

Percent Change for United States

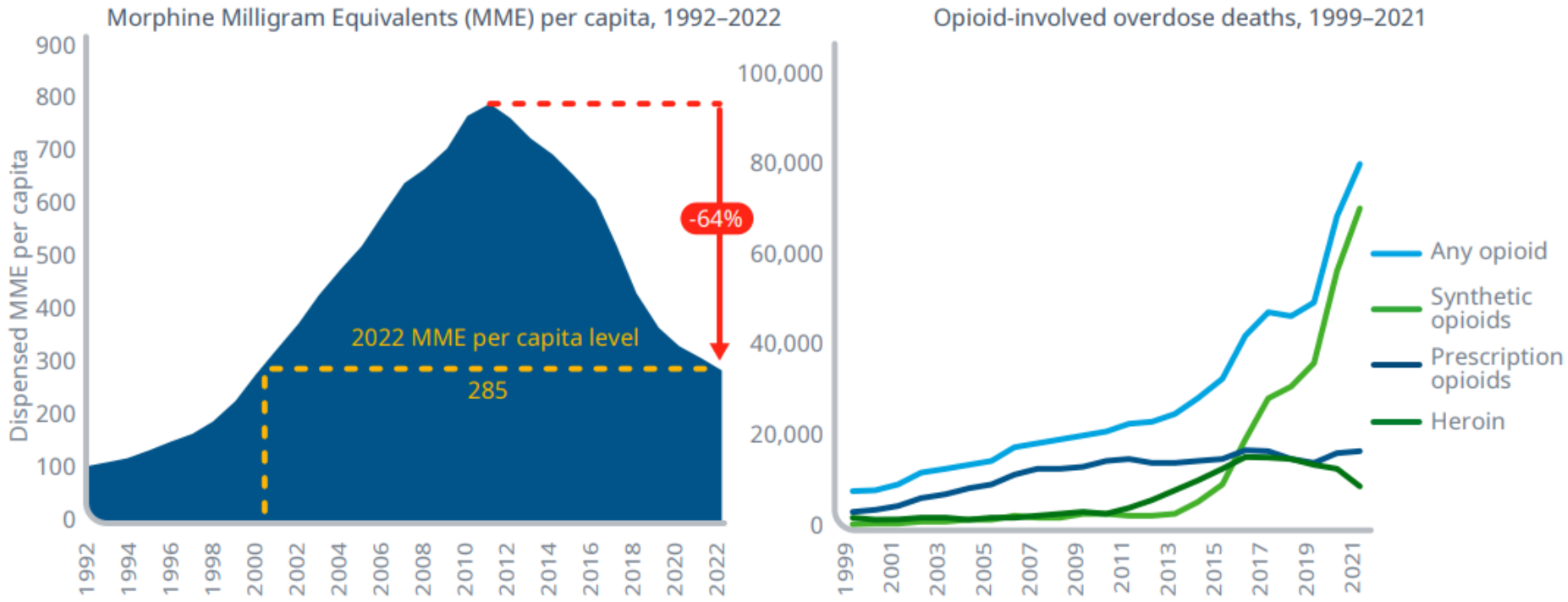
0.6

[Vital Statistics Rapid Release - Provisional Drug Overdose Data (cdc.gov)](#) Accessed 4/22/2023

3. What's Happening with Current Prescription Trends and Rates of Patient Misuse

Per capita prescription opioid use continues to decline to levels seen in 2000, however overdose deaths continue to rise

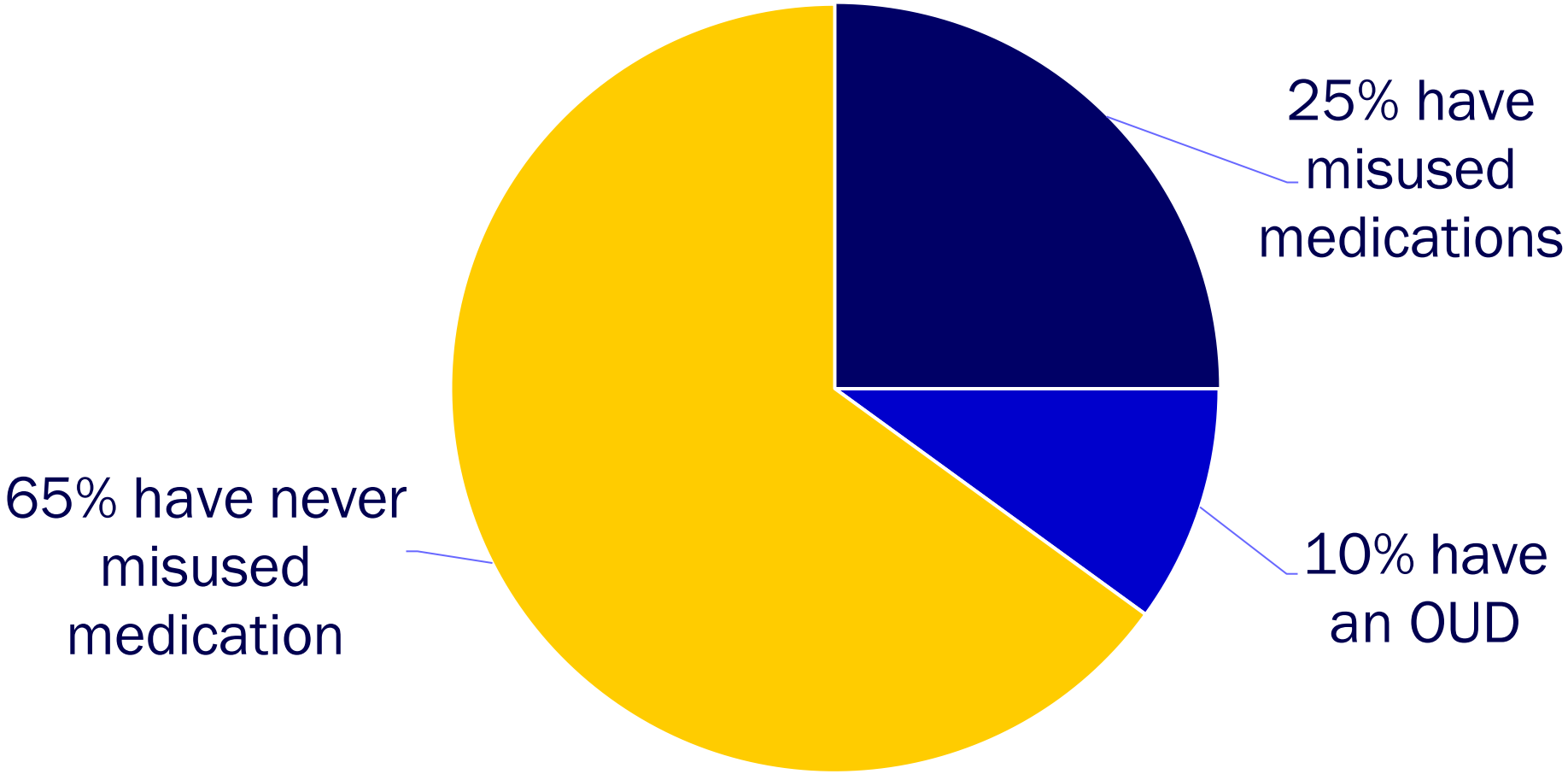
Exhibit 18: Prescription opioid use overall and opioid-involved overdose deaths



Source: IQVIA Xponent, IQVIA National Prescription Audit, Sep 2022; IQVIA Institute, Mar 2023; National Institute on Drug Abuse, Feb 2023.

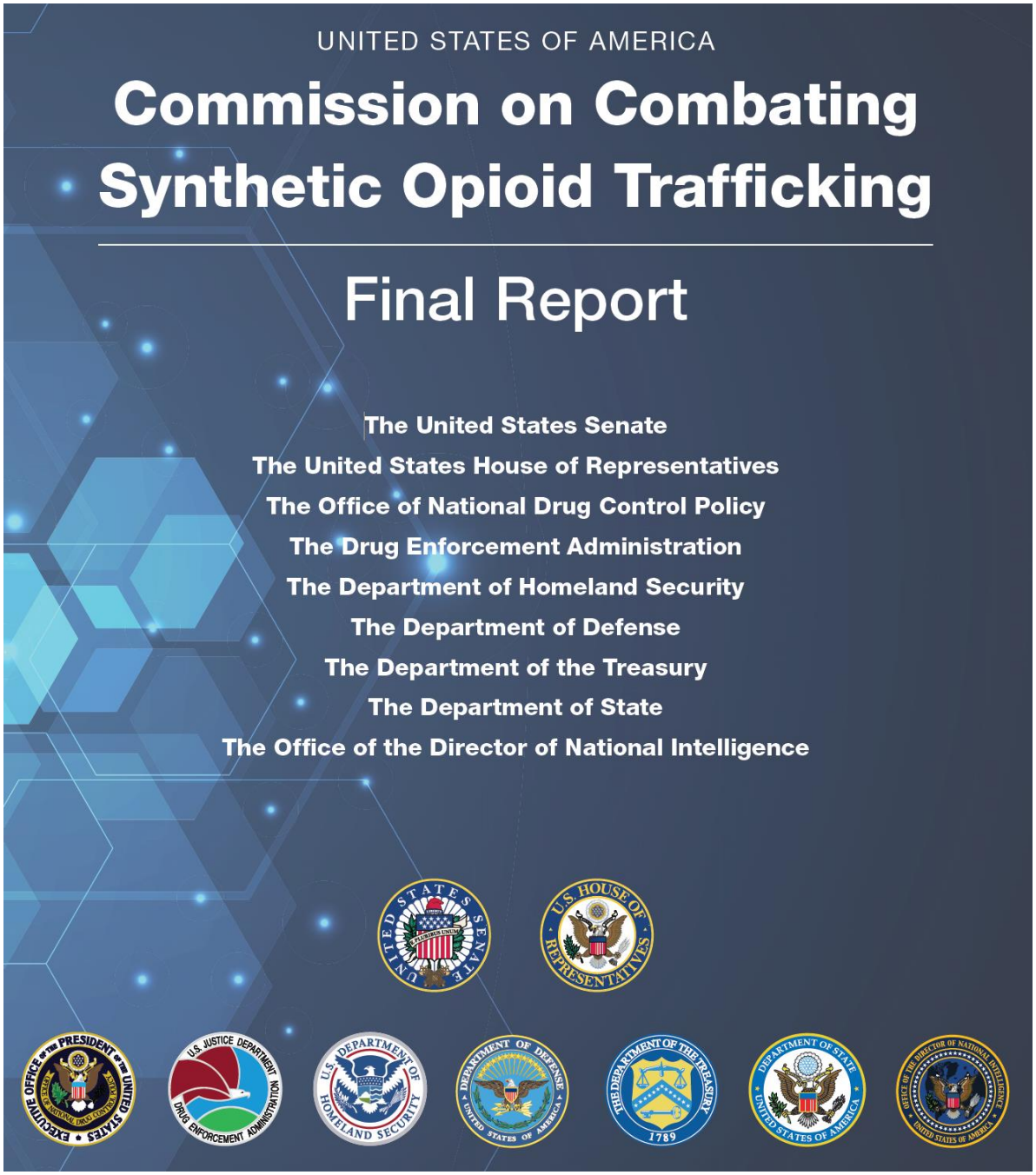
Most Chronic Pain Patients Don't Misuse Opioids

Of chronic pain patients prescribed opioids



Frank, et al. Annals of Int Med, 2017

4. What's Being Done in 2023 to Combat Trafficking of Illicit Synthetic Opioids (ie, Fentanyl)



Published February 2022 - Posted on RAND.org on February 08, 2022

URL: http://www.rand.org/hsrd/hsoac/commission-combating-synthetic-opioid-trafficking

Current Challenges In 2023

These challenges include --

1. Serious geopolitical issues significantly impede actions to disrupt supply
   - Fentanyl trafficked from Mexico with raw materials coming from China
2. Synthetic opioids are highly potent and easy to make, and small amounts can be transported for large profits
3. Social media and encryption platforms, as well as established logistics systems, make distribution difficult to disrupt
4. The pull of demand continues to drive the supply of synthetic opioids
   - The advent of synthetic opioids in pill form leverages Americans' familiarity with taking pills and does away with the social stigma of injection, snorting, and smoking.
   - It is being laced into heroin or manufactured as counterfeit tablets, including such brand names as OxyContin, Percocet, Vicodin, Adderall, and Xanax, driving overdose deaths.
5. External factors, including the coronavirus disease 2019 (COVID-19) pandemic, have driven increases in substance use
6. Overall, synthetic opioids offer economic and tactical advantages that allow criminals to vastly outpace enforcement efforts

URL: http://www.rand.org/hsrd/hsoac/commission-combating-synthetic-opioid-trafficking

New Challenges Call For a New Response

The United States must --

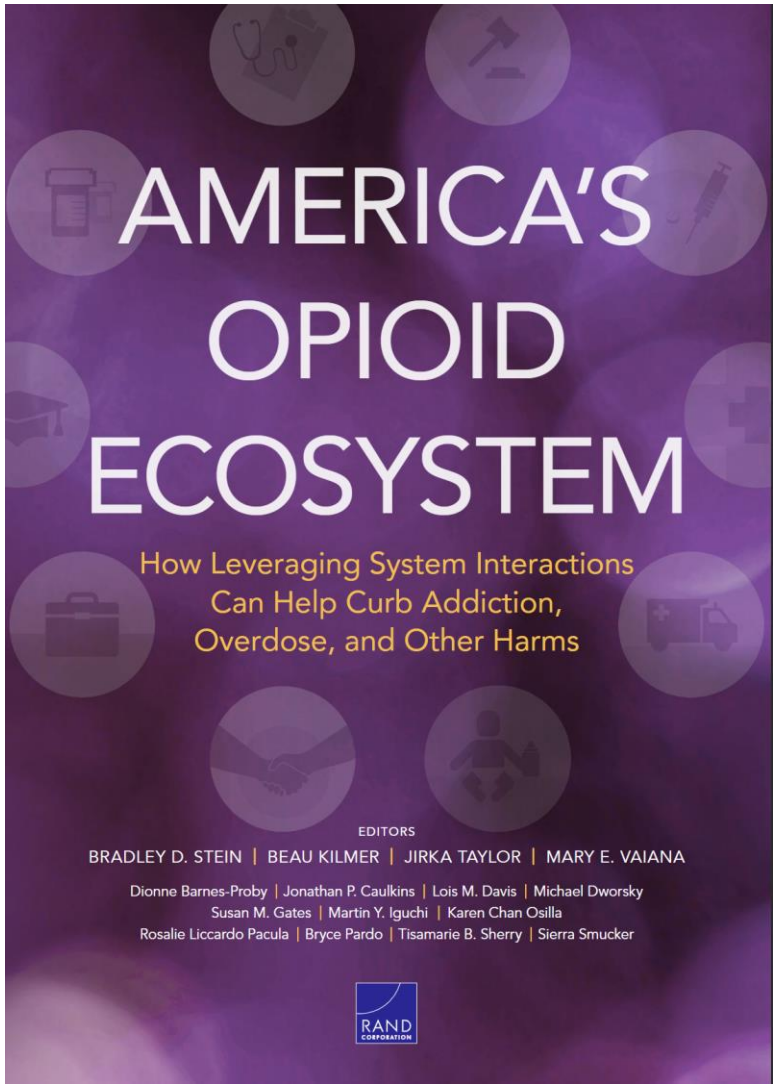
1. Develop a more unified, central body to coordinate planning, implementation, and evaluation of all U.S. drug policies
2. Disrupt drug supply through targeted oversight and enforcement
3. Make public health demand-reduction approaches central in the fight against opioid trafficking to reduce the number of potential buyers
4. Collaborate with other countries involved in the production and distribution of synthetic opioids and precursors
5. Improve surveillance and data analysis to allow for more timely and effective interventions

URL: http://www.rand.org/hsrd/hsoac/commission-combating-synthetic-opioid-trafficking

5. What's Being Done in 2023 to Curb Addiction, Overdose and Other Harms

America's Opioid Ecosystem

How Leveraging System Interactions Can Help Curb Addiction, Overdose, and Other Harms

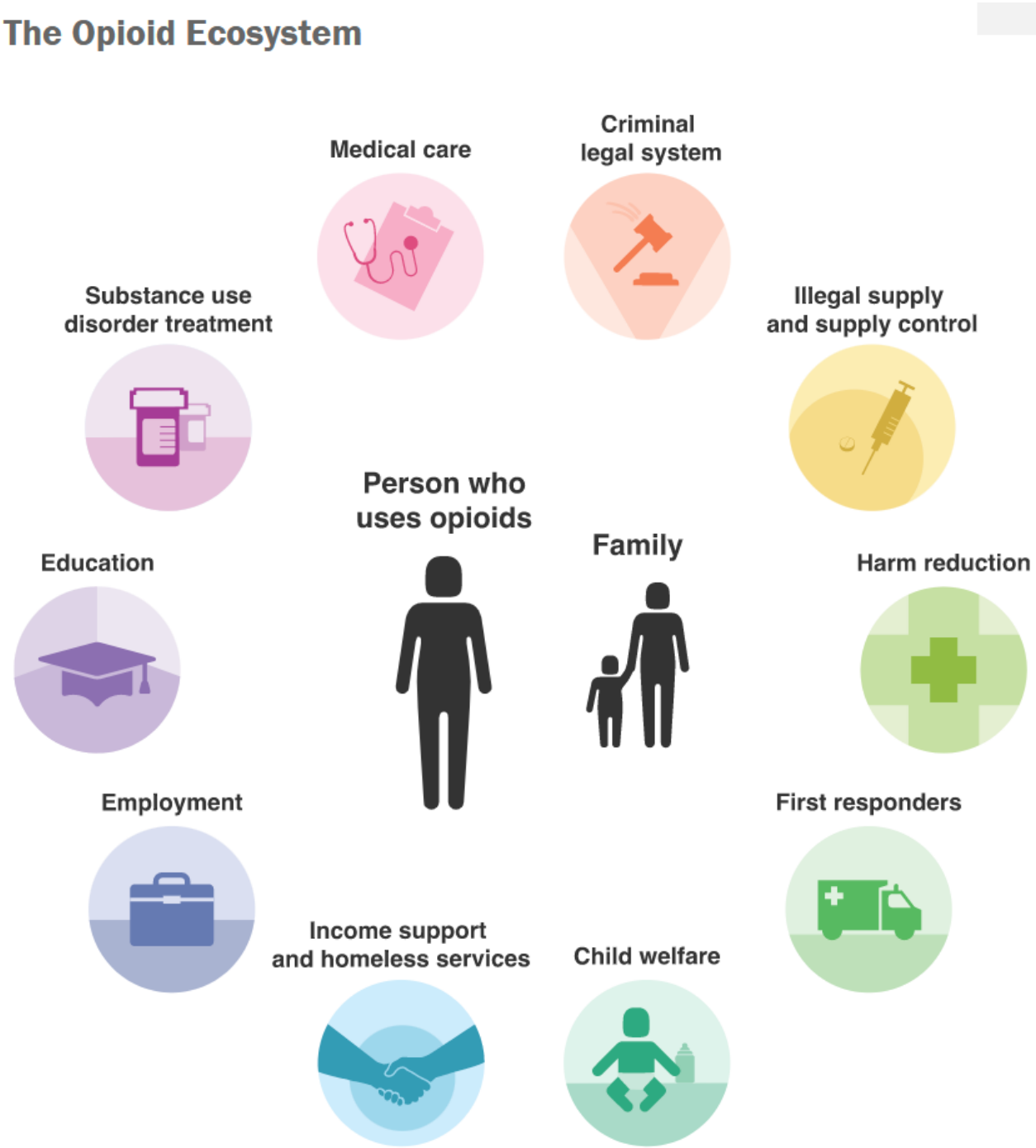


URL – [America's Opioid Ecosystem: How Leveraging System Interactions Can Help Curb Addiction, Overdose, and Other Harms | RAND] Accessed 4/22/23

Key Findings

- **U.S. issues surrounding opioids are most appropriately viewed in the context of an ecosystem**
  - Like a biological ecosystem, the opioid ecosystem is dynamic, and its components often interact.
  - Ecosystem components often focus on individuals, but families are also at the heart of the system. Each ecosystem component has its own mission, priorities, and funding; policies furthering those priorities may hamper the efforts of other system components.
- **Current responses to U.S. opioid problems are insufficient—innovation is needed**
  - Increasing access to and use of high-quality treatment for substance use disorder remains the top priority, but it will not be enough to stem the tide of overdose deaths and addiction.
  - The federal government should make it easier for states or localities to pilot and evaluate interventions intended to reduce harms associated with opioids and other drugs.
- **It is not always clear who is responsible for coordinating among ecosystem components or managing the transition from one component to another**
  - By making clear who is responsible at these junctures and providing the resources necessary to meet the commitment, some of the disconnects that hamper the provision of treatment and support could be decreased.
- **The United States is often flying blind, which makes it difficult to evaluate existing interventions, develop new ones, or improve understanding of ecosystem interactions**
  - Unlike many prior public health challenges, the onset of the overdose crisis has not motivated substantial new surveillance efforts.
  - The data infrastructure for understanding people who use drugs, drug consumption, and markets urgently needs improving.

URL – America's Opioid Ecosystem: How Leveraging System Interactions Can Help Curb Addiction, Overdose, and Other Harms | RAND Accessed 4/22/23



URL – [America's Opioid Ecosystem: How Leveraging System Interactions Can Help Curb Addiction, Overdose, and Other Harms | RAND] Accessed 4/22/23

U.S. Department of Health & Human Services

SAMHSA
Substance Abuse and Mental Health Services Administration

Improving Access to Opioid Use Disorder Treatment

- Federal and state policy over the last decade has sought to overcome the long-term effects of substance misuse impacting individuals, families, communities, and those charged with resource allocation.
  - To expand access to care, a major effort is underway to integrate therapy into primary care
  - The traditional x-waiver program has been retired
  - Most recently, Section 1263 of the 'Consolidated Appropriations Act of 2023'[2] otherwise known as the Medication Access and Training Expansion (MATE) Act as of December, 2022, requires new or renewing Drug Enforcement Administration (DEA) registrants, as of June 27, 2023, to have completed a total of at least 8 hours of training on opioid or other substance use disorders, as well as the safe pharmacological management of dental pain.
- Practitioners can meet this requirement in one of three ways:
  - **A total of 8-hours of training from a range of training entities on opioid or other substance use disorders; or**
  - Board certification in addiction medicine or addiction psychiatry from the American Board of Medical Specialties, American Board of Addiction Medicine, or the American Osteopathic Association; or
  - Graduation within 5 years and in good standing from a medical, advanced practice nursing, or physician assistant school in the United States that included successful completion of an opioid or other substance use disorder curriculum of at least 8 hours. This curriculum must have included teaching on the treatment and management of patients with opioid and other substance use disorders, including the appropriate clinical use of all drugs approved by the Food and Drug Administration for the treatment of a substance use disorder.[4]
  - The 8 required hours of training can occur through classroom situations, seminars at professional society meetings, virtual platforms, or via other accredited continuing education sources. Practitioners who previously took training to meet the requirements of the DATA-2000 waiver to prescribe buprenorphine can count this training towards the 8-hour training requirement. Additionally, the 8 hours do not have to be completed in one session and can be satisfied through cumulative CME hours, as long as the training is provided by or approved by participating organizations:

Recommendations for Curricular Elements in Substance Use Disorders Training | SAMHSA
Accessed 5/2/2022

Improving Access to Opioid Use Disorder Treatment

Please Note

All training/modules/webinars on PCSS covering topics on the treatment and management of patients with opioid or other substance use disorders will count towards the DEA's new 8 hour training requirement when applying for or renewing your DEA license.

Medications for Opioid Use Disorder (MOUD) involves a combination of a medications that targets the brain, and psychosocial interventions (e.g., counseling, skills development) aimed at improving treatment outcomes. Research shows that medications and therapy together may be more successful than either treatment method alone.

Historically, pharmacological treatment for opioid use disorder was referred to as "Medications for Addiction Treatment (MAT)," but more recently it has been determined that the more appropriate term is "Medications for Opioid Use Disorder (MOUD)." PCSS trainings, resources and website will use MOUD going forward.

Request Your Buprenorphine Certificate

If you have completed your Buprenorphine Training with PCSS, you can request your certificate here.

Request Now

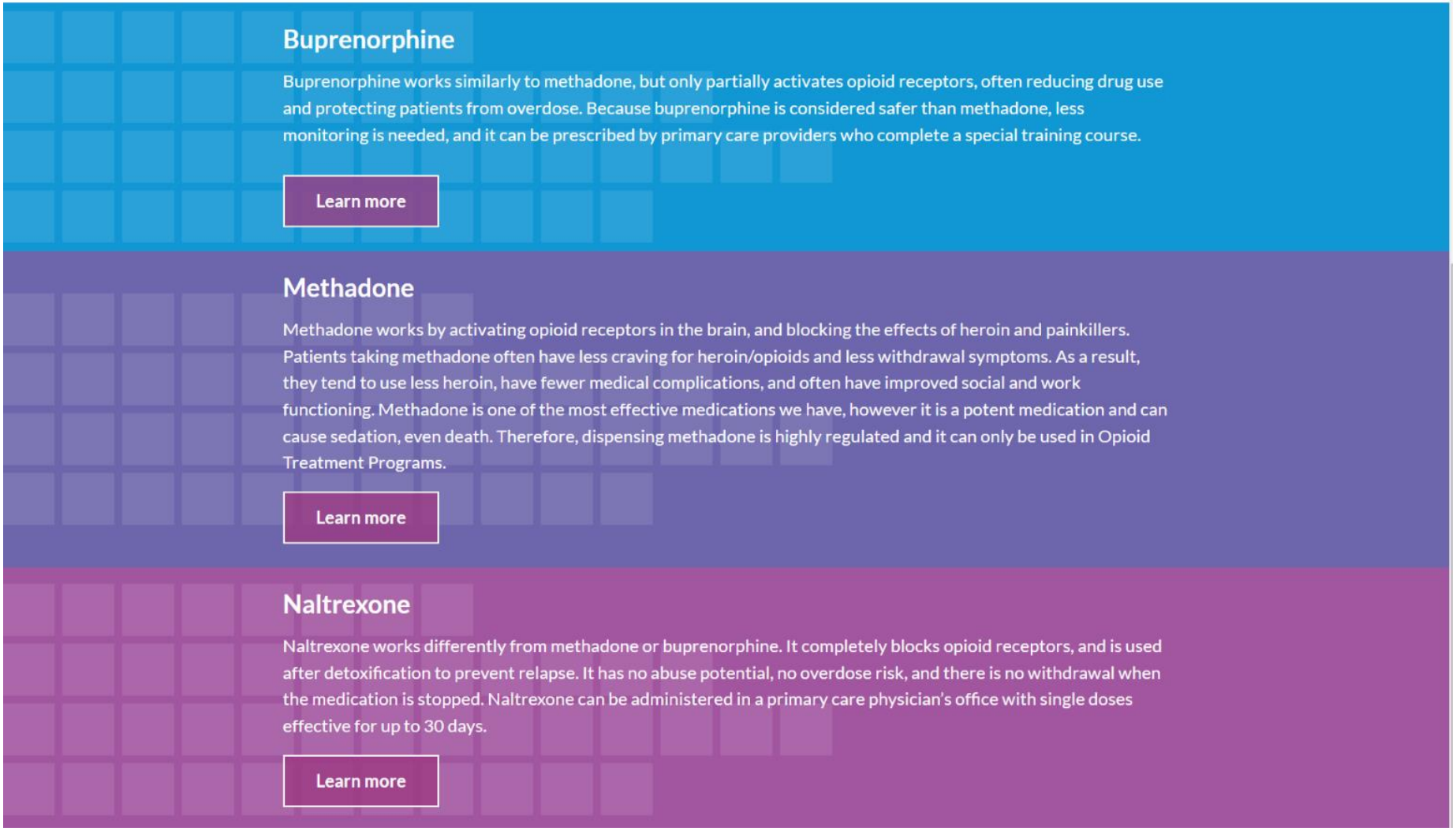
Buprenorphine Quick Start Guide

SAMHSA has developed a Buprenorphine Quick Start Guide for practitioners looking to prescribe buprenorphine.

View Guide

URL - Medications for Opioid Use Disorder (MOUD) - PCSS (pcssnow.org)) Accessed 5/6/23

Improving Access to Opioid Use Disorder Treatment

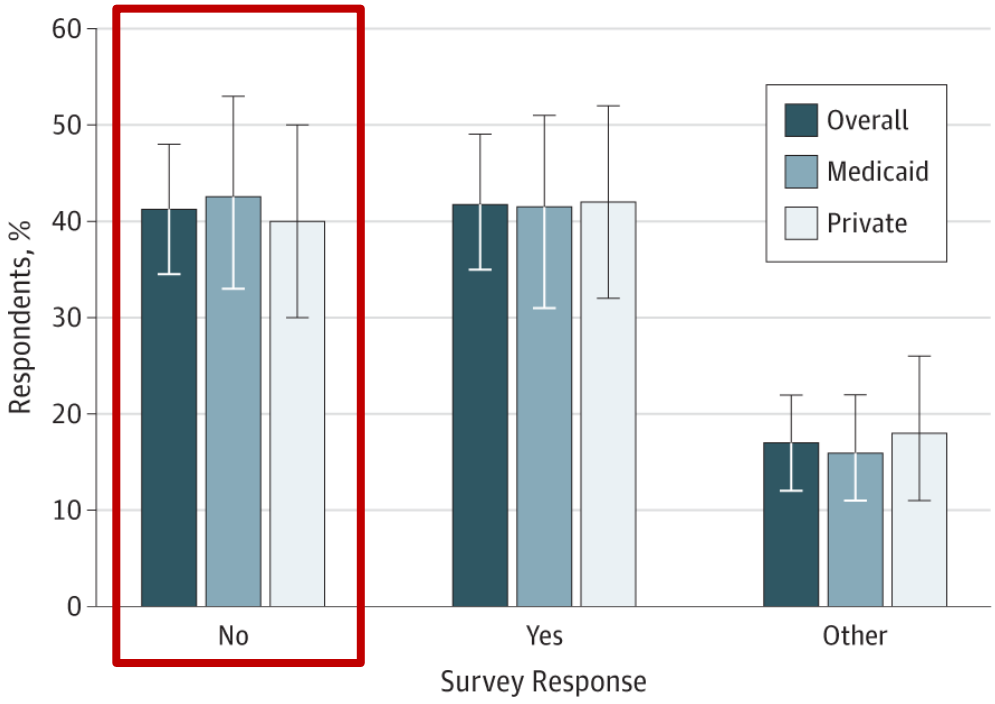


URL - [Medications for Opioid Use Disorder (MOUD) - PCSS (pcssnow.org))](Medications for Opioid Use Disorder (MOUD) - PCSS (pcssnow.org)) Accessed 5/6/23

6. The Negative Impact to “Legacy” Chronic Pain Patients Already Taking Opioids

“Legacy” Chronic Pain Patients Cannot Find Appropriate Access to Primary Care

- 41% of clinics won’t accept new pain patients on opioids
- Providers are reluctant to “inherit” the “legacy” patient due to regulatory constraints
- These patients may require long-term opioid use
- They are typically tolerant and dependent on opioids and would go into withdrawal if they were abruptly discontinued
- Most due not misuse opioids and exhibit addictive behaviors
- These patients typically have “cancer quality pain” without dying of cancer and are being treated palliatively.
- By some definitions – they have a “dual diagnosis” of “chronic pain disorder” and “opioid use disorder”
- There is potential for subsequent harm is high if abandoned.



Lagisetty, et al. *JAMA Netw Open.* 2019

Many Pain Clinics Also Have Restrictive Acceptance Policies

Roughly half (48%) of pain clinics did not accept Medicaid

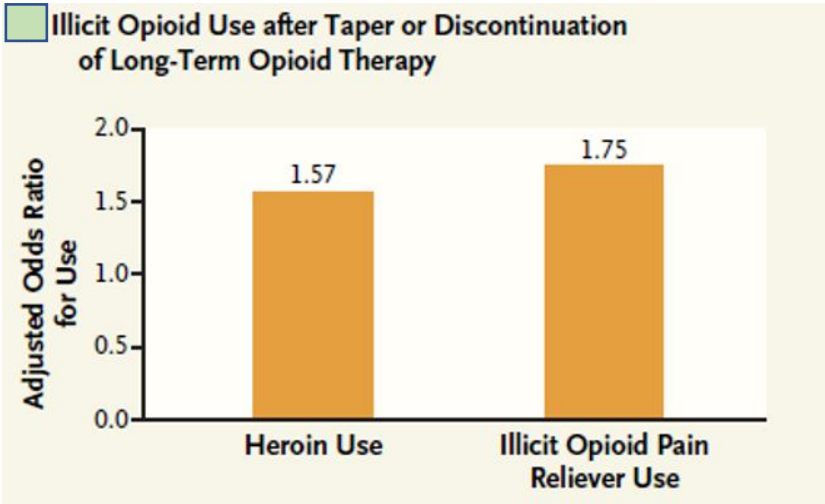
Over half (51%) required a referral before accepting new patients

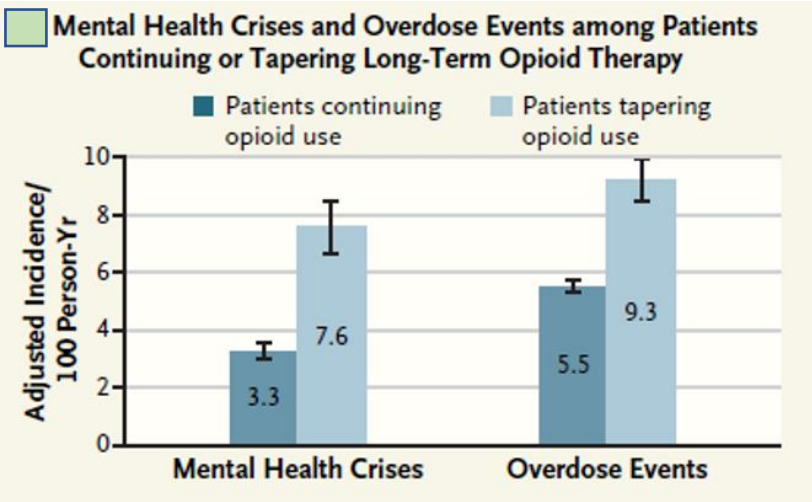
An additional 23% required a referral based on insurance type

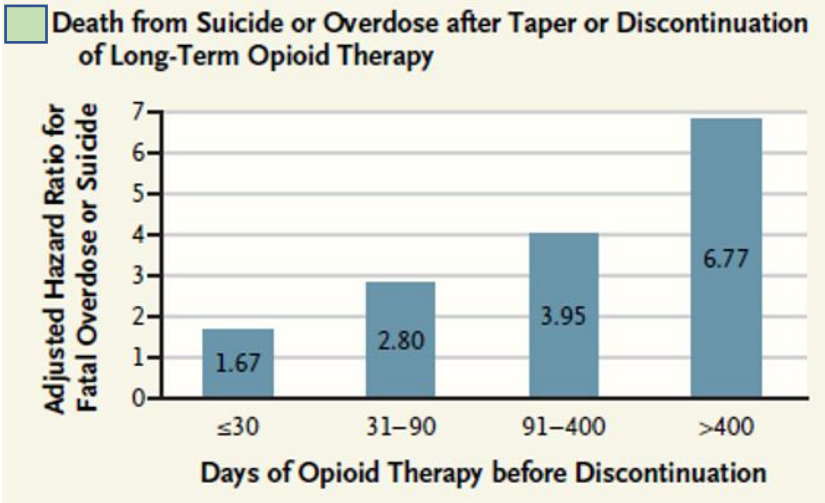
Lagisetty et al. *JGIM.* 2020.

With Loss of Access, "Legacy" Pain Patients Have Become "Pain Refugees" and Are Now Facing Harm

Phillip O. Coffin, M.D., and Antje M. Barreveld, M.D.



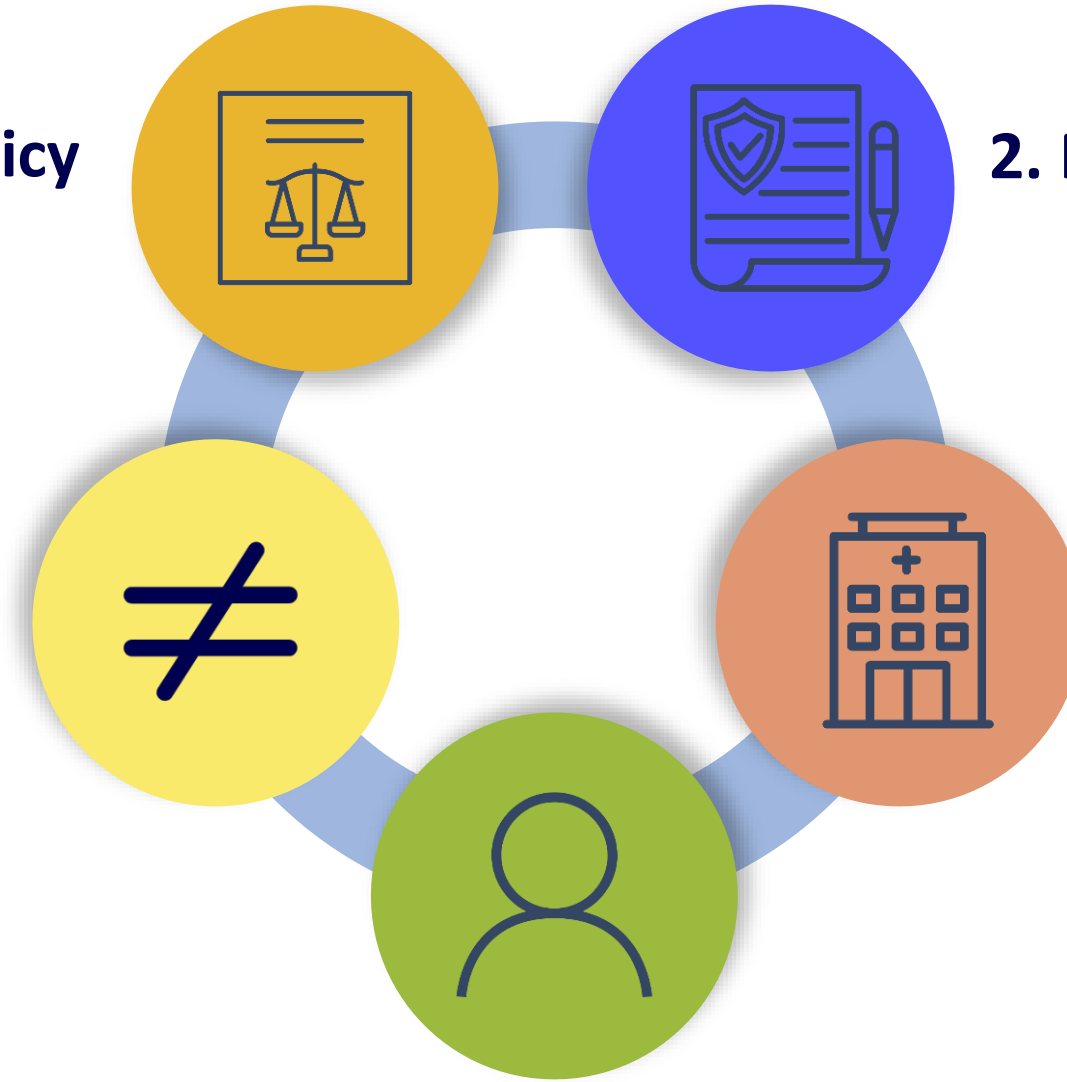




Patients whose medications were inappropriately tapered or stopped were:

- 1.75 x more likely to use illicitly obtained Rx's (including counterfeits which may be laced with fentanyl)
- 1.57 x more likely to use heroin (with or without fentanyl)
- 2.3 x more likely to experience a mental health crisis
- 1.69 x more likely to have an overdose event
- At increasingly greater risk for overdose or suicide the longer they have been on long term opioid therapy

Primary Barriers to Pain Care



Lagisetty, et al.

Policy Changes Being Made in 2022-23 About Being Compensated for Intensive Pain and OUD Services

UPDATE: 9/1/2022

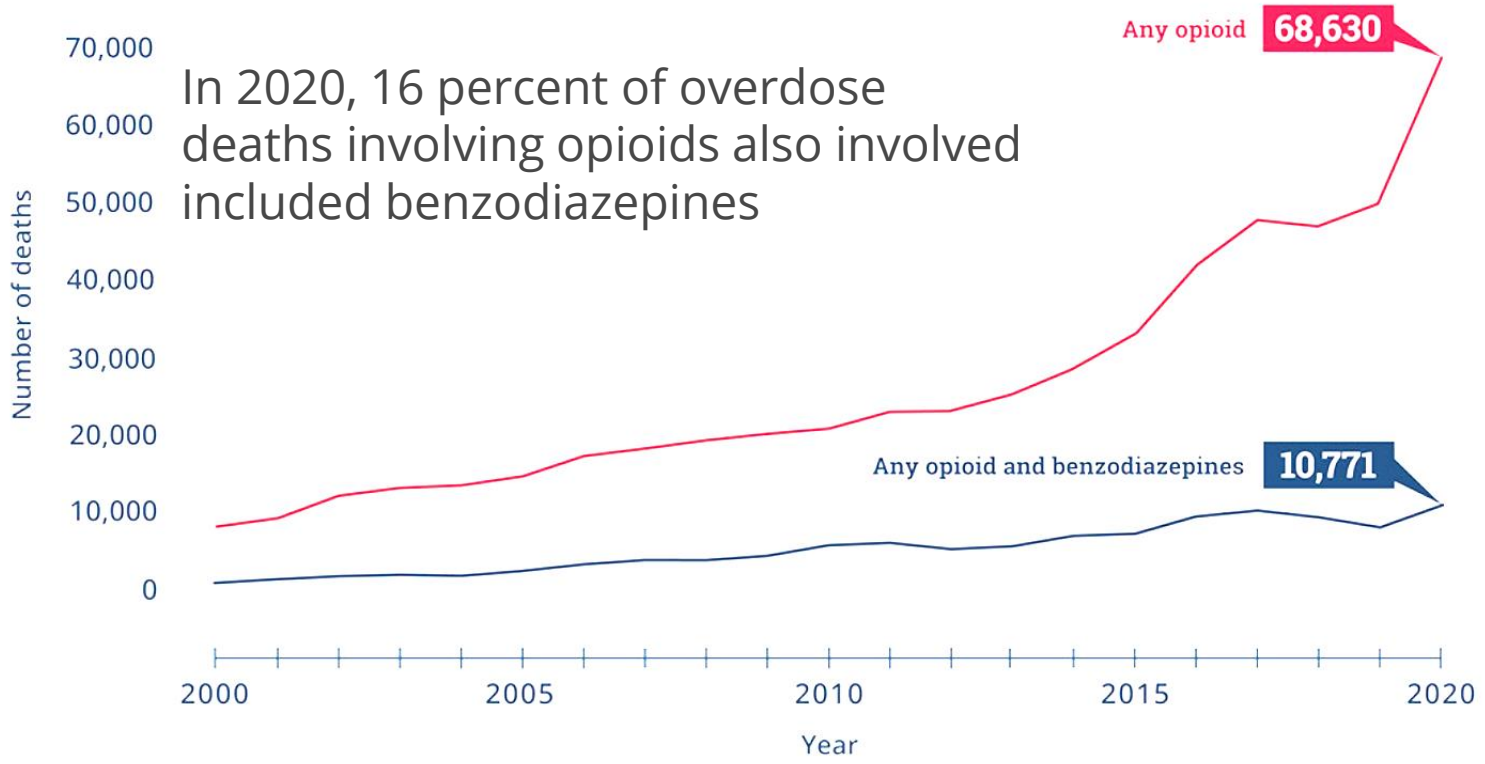
- The U.S. Centers for Medicare and Medicaid Services (CMS) Announced a Large Step Forward for Chronic Pain Management (CPM) and Opioid Use Disorder (OUD) Services Utilizing Chronic Care Management (CCM)
- The codes can be billed monthly for each beneficiary.

Regulations.Gov - https://www.regulations.gov/document/CMS-2022-0113-1871
(Accessed 9/1/2022

7. The Impact of Sedatives, Alcohol and Stimulants With and Without Opioids – Polysubstance Use Disorders

National Overdose Deaths Involving Any Opioid, by Benzodiazepine* Involvement,

All Ages, 2000 – 2020

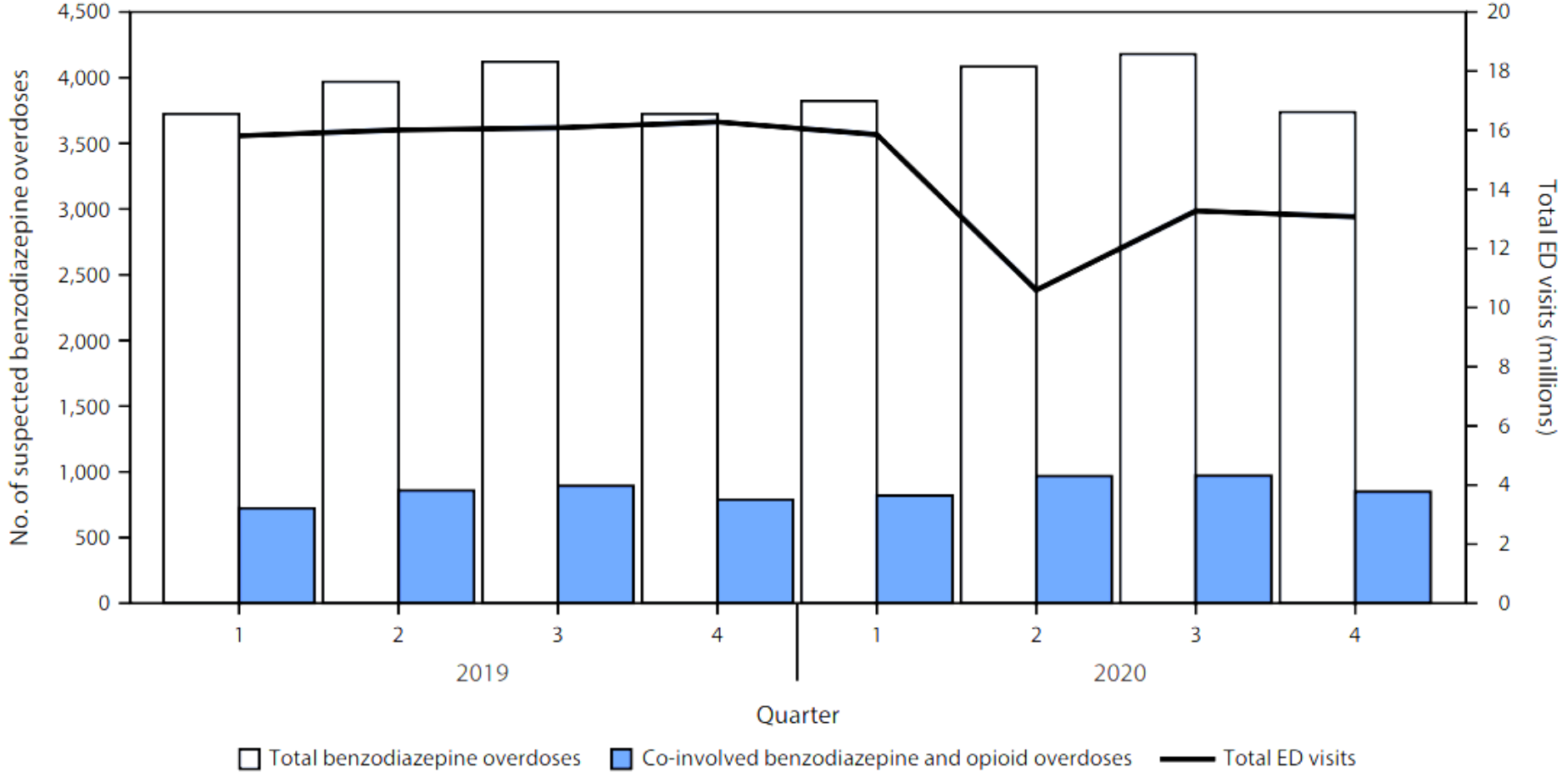


*Among deaths with drug overdose as the underlying cause, the benzodiazepine category was determined by the T402.4 ICD-10 multiple cause of death code; the any opioid category was determined by the T40.0-T40.4, T40.6 ICD-10 codes.

Source: Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death 2000–2020 on CDC WONDER Online Database, released 12/2021.

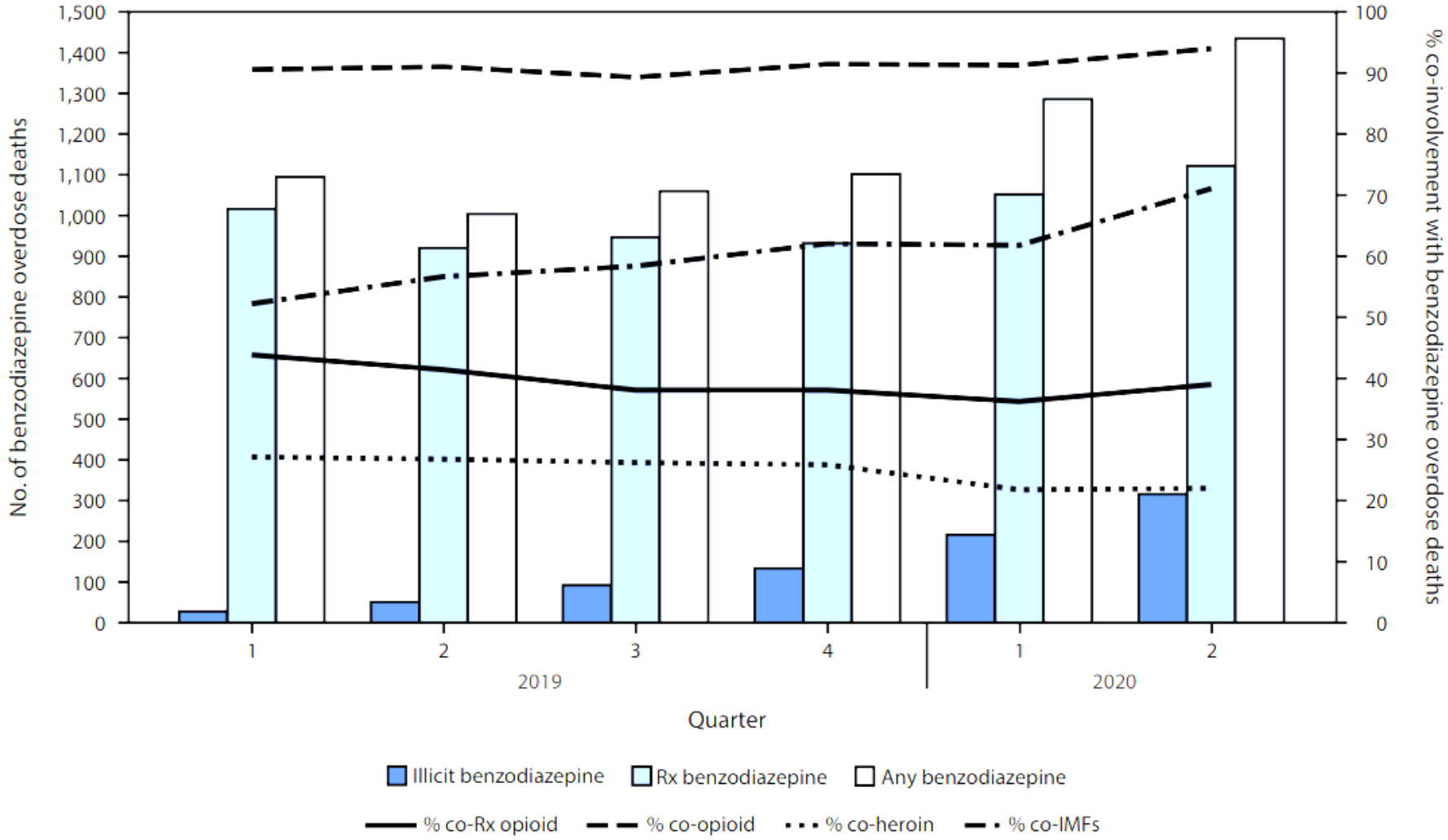
Benzodiazepine Overdoses With and Without Opioid Co-involvement 2019-2020

FIGURE 1. Number of benzodiazepine overdose and co-involved opioid overdose emergency department visits, by quarter — Drug Overdose Surveillance and Epidemiology, 32 States* and the District of Columbia, 2019–2020†, §, ¶



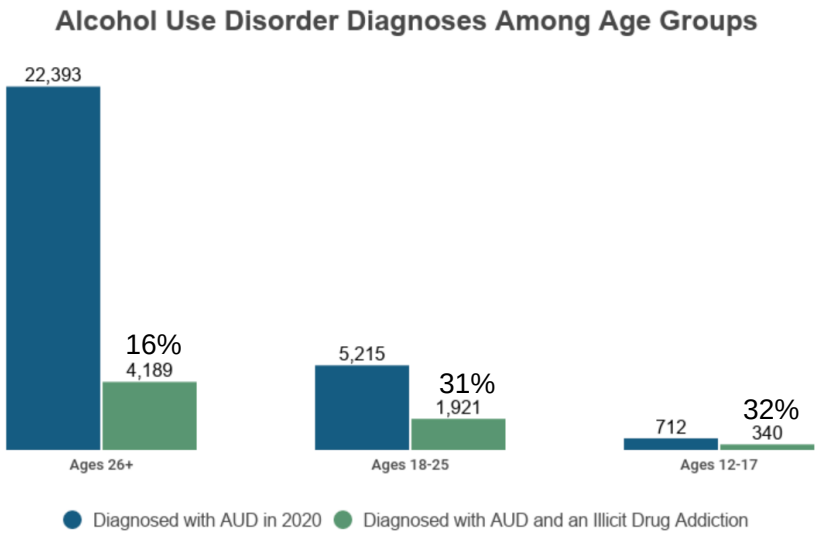
Benzodiazepine Deaths With Opioid Co-involvement (2019 - June 2020)

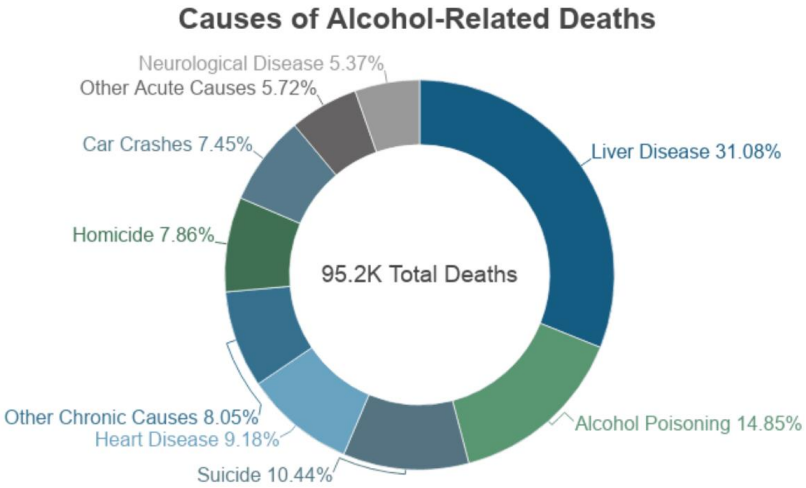
FIGURE 2. Benzodiazepine overdose deaths with opioid co-involvement — State Unintentional Drug Overdose Reporting System, 23 states,* January 2019–June 2020†

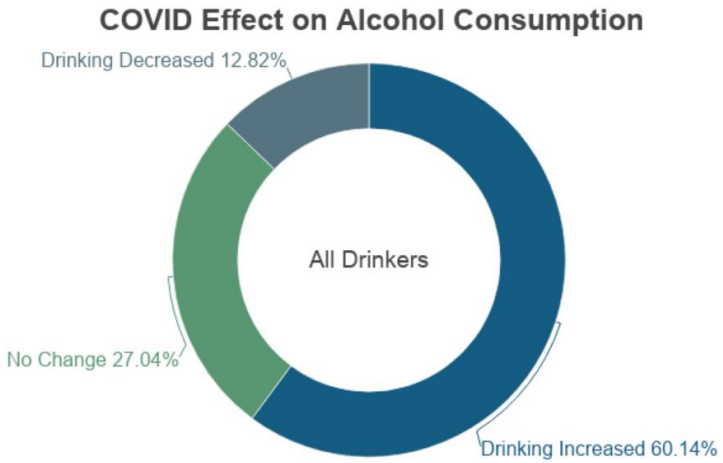


Abbreviations: co- = co-involved; IMFs = illicitly manufactured fentanyls; Rx = prescription.

The Role of Alcohol Use Disorder (AUD) With or Without Coexisting Illicit Drug Addiction



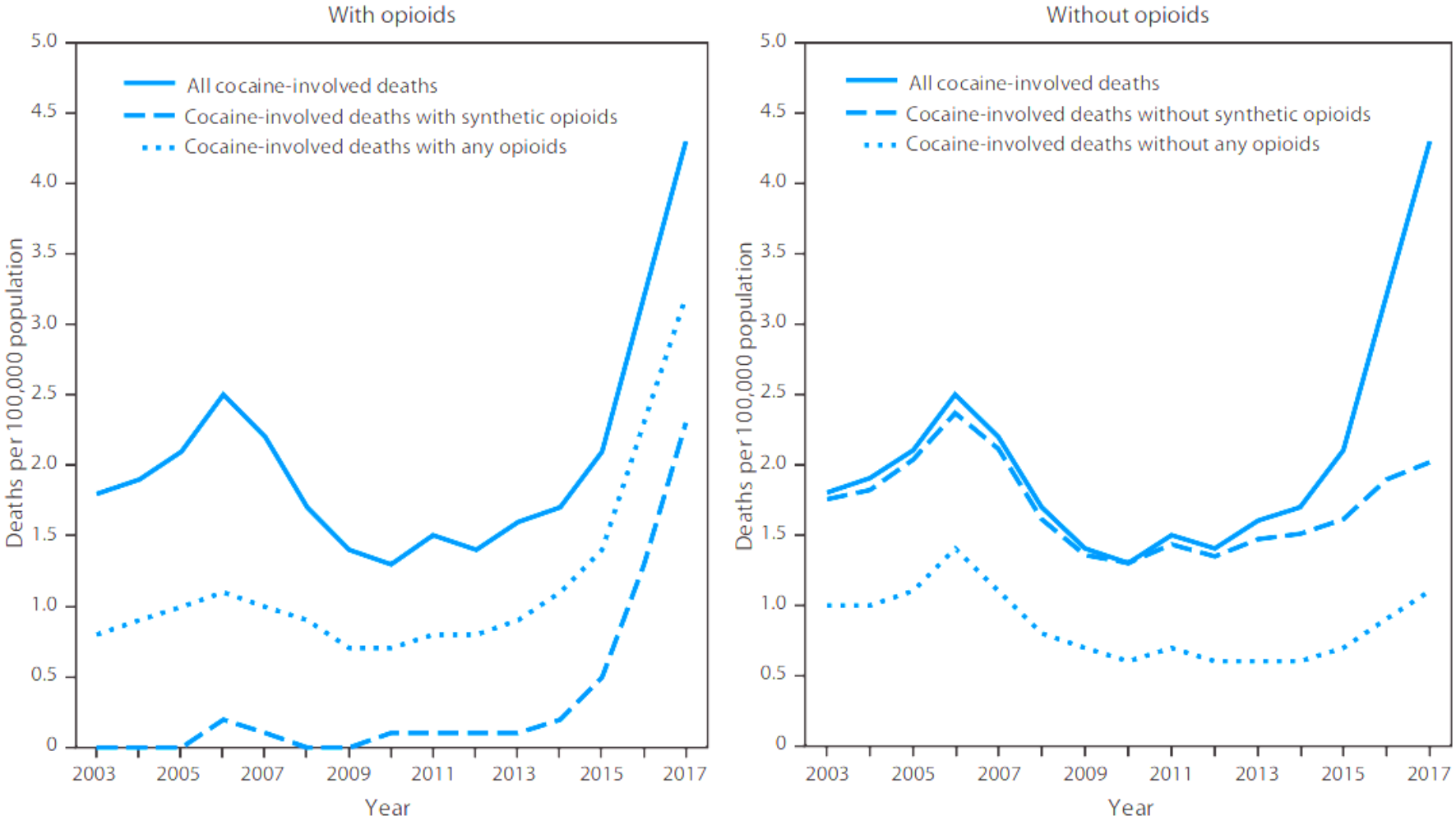




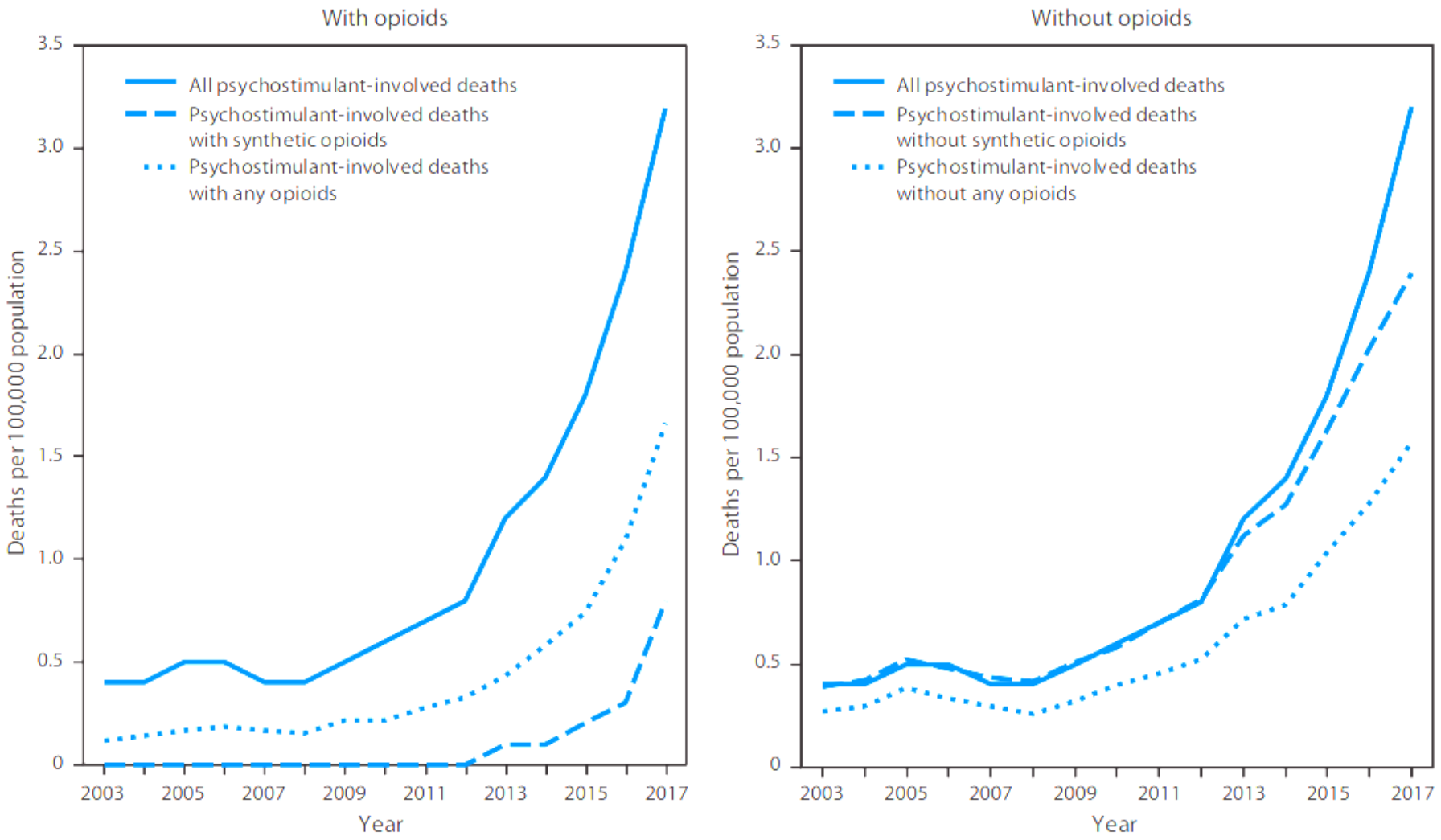
Alcohol Abuse Statistics [2022]: National + State Data - NCDAS (drugabusestatistics.org) Accessed 9/5/2022

Age-adjusted Rates of Drug Overdose Deaths Involving Cocaine With and Without Synthetic Opioids (Other Than methadone) and Any Opioids United States, 2003–2017

FIGURE 1. Age-adjusted rates* of drug overdose deaths† involving cocaine§ with and without synthetic opioids other than methadone (synthetic opioids) and any opioids¶ — United States, 2003–2017**,††



Age-adjusted rates of drug overdose deaths involving psychostimulants with abuse potential§ (psychostimulants) with and without synthetic opioids (other than methadone) and any opioids
United States, 2003–2017



Summary – Part 1

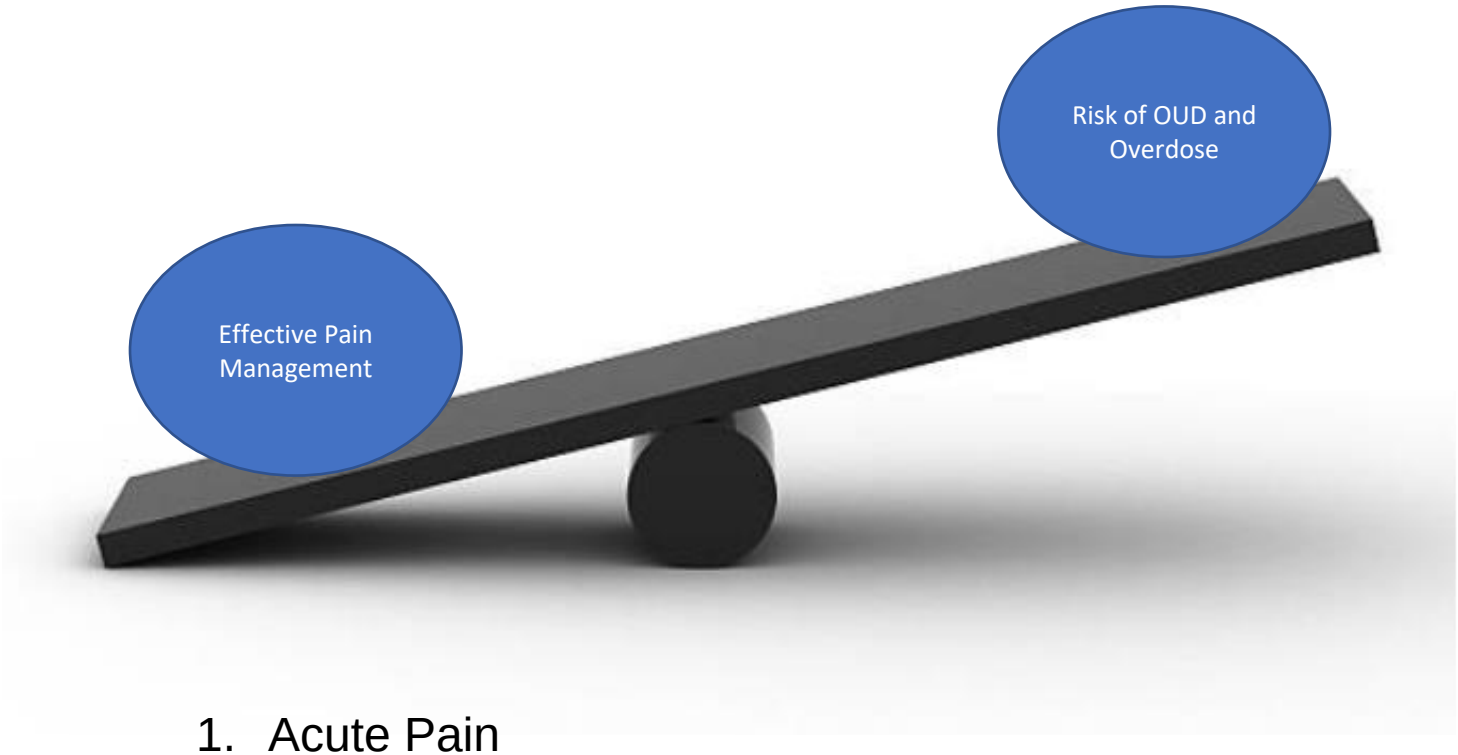
1. We must continue to effectively treat pain but still mitigate overdose risk
2. We cannot abandon the “pain refugee” because many will go to the street
3. We must help diminish supply and demand for illicit opioids and stimulants through community-based initiatives
4. We must increase access to care for both Substance Use Disorders and Pain Management Services
5. CMS is paving the way to compensate for extended services through Chronic Care Management (CCM)
6. We as Health Care Professionals are well positioned to help lead the way

Balancing Safe and Effective Opioid Management in 2023

(Part 2 – Determining Medical Necessity and Developing a Rational Treatment Plan When Prescribing Opioids for Pain)

8. Weighing Benefit and Risk When Prescribing Opioids

When The Need for Effective Pain Management Using an Opioid May Outweigh Risk In 4 Pain Types



1. Acute Pain
2. Chronic Pain
3. High Impact Chronic Pain
4. Intractable Pain That Is Otherwise Untreatable

Acute Pain

- Acute pain is defined as self-limited discomfort that typically lasts from a few moments to several weeks but less than 3 to 6 months.
- It can relate to soft tissue or skeletal damage, and may be categorized as spontaneous or post-traumatic, with the trauma planned (surgical) or unplanned (accidental).
- As the injured tissues heal, acute pain gradually resolves.

- Pain can vary in severity from mild to severe.
- Some therapies, such as opioids, are reserved for more severe pain.
- However, even if pain is severe, it is important to recognize that not all acute pain requires opioid therapy.

Severity	Examples
Spontaneous/trauma	
Mild	Sinus headache, soreness after yard work, superficial laceration
Moderate	Sprain, strain, simple bone fracture, deep laceration
Severe	Motor vehicle accident, burn, traumatic amputation

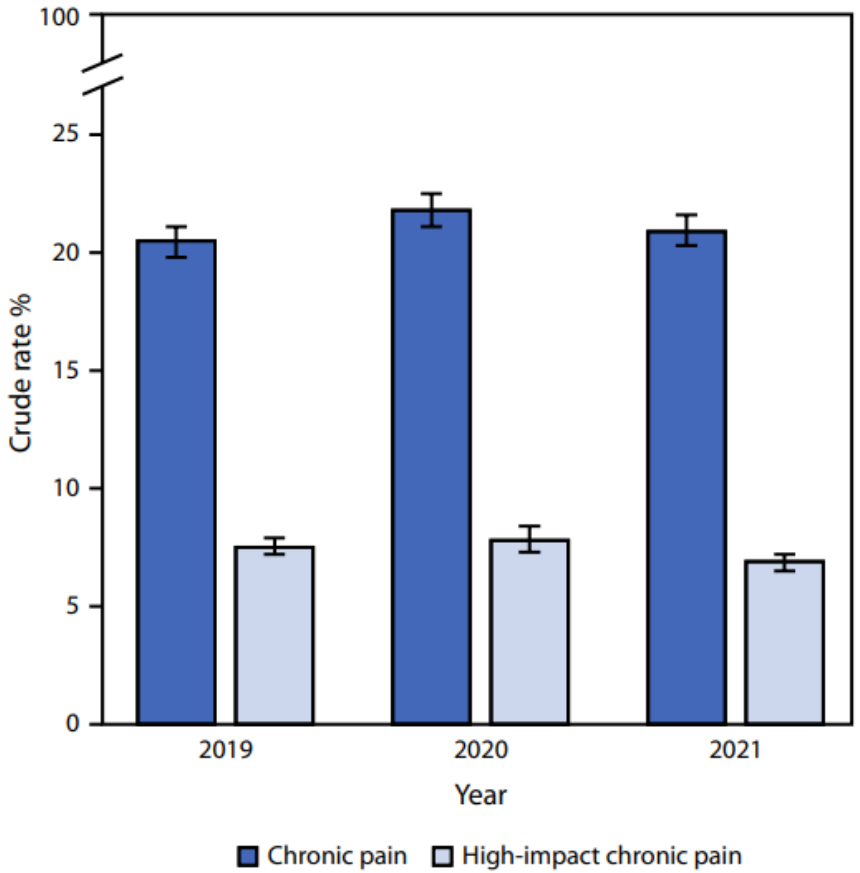
Planned/elective	
Mild	Immunization, catheter placement, phlebotomy, superficial biopsy, simple dental extractions
Moderate	Same-day surgery (arthroscopy, multiple dental extractions/ wisdom teeth, laparoscopy, podiatric procedures)
Severe	Arthroplasty, spinal, colorectal, open abdominal surgery requiring hospital stay

Medical Management of Acute Pain (practicalpainmanagement.com) – Accessed 4/30/22

Chronic and High Impact Pain

1. Chronic pain is based on responses of “most days” or “every day” to the survey question
2. High-impact chronic pain is based on responses of “frequently limits life or work activities”

FIGURE. Prevalence of chronic pain* and high-impact chronic pain† among adults — United States, 2019-2021§,¶



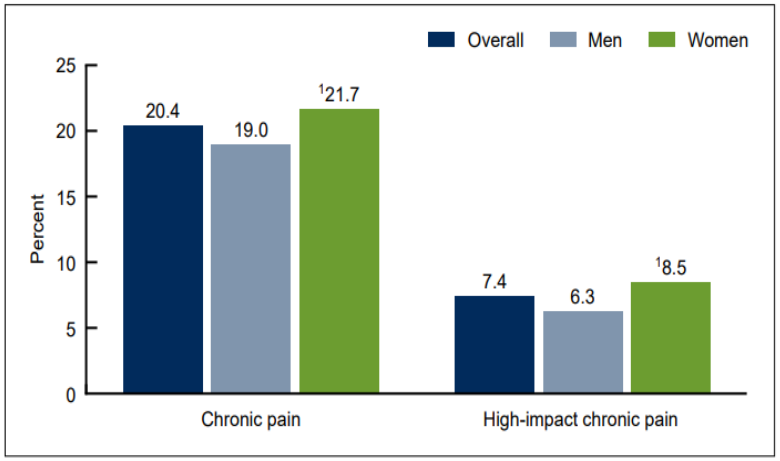
* Pain reported on most days or every day during the previous 3 months.
† Chronic pain that limited life or work activities on most days or every day during the previous 3 months.

Chronic and High Impact Pain

1. Chronic pain is based on responses of “most days” or “every day” to the survey question
2. High-impact chronic pain is based on responses of “frequently limits life or work activities”

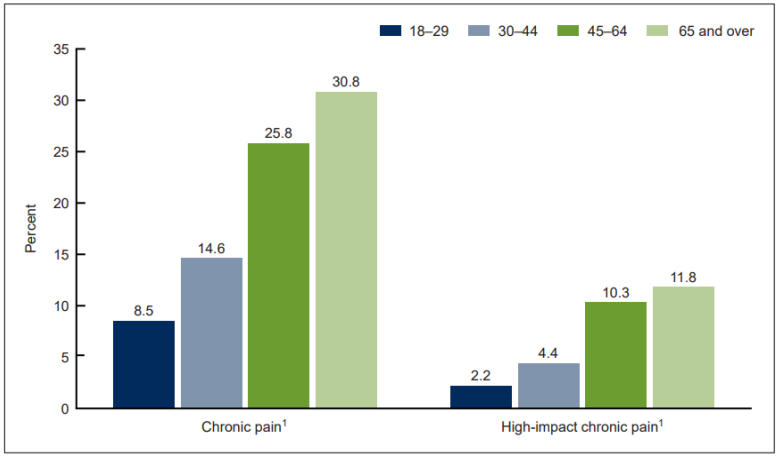
Overall and By Gender

Figure 1. Percentage of adults aged 18 and over with chronic pain and high-impact chronic pain in the past 3 months, overall and by sex: United States, 2019



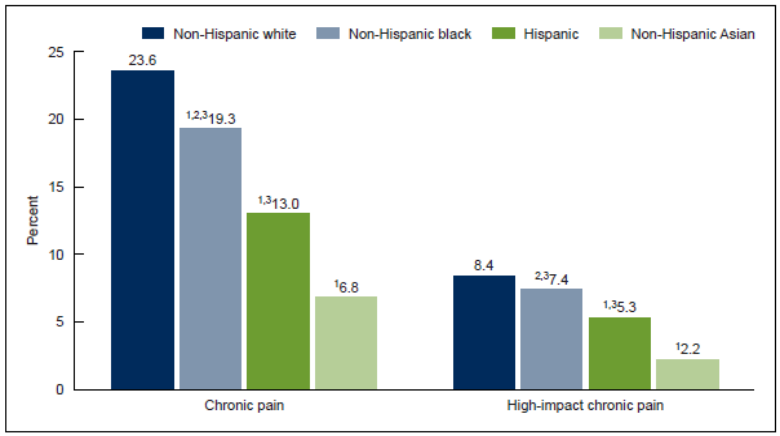
Age

Figure 2. Percentage of adults aged 18 and over with chronic pain and high-impact chronic pain in the past 3 months, by age group: United States, 2019



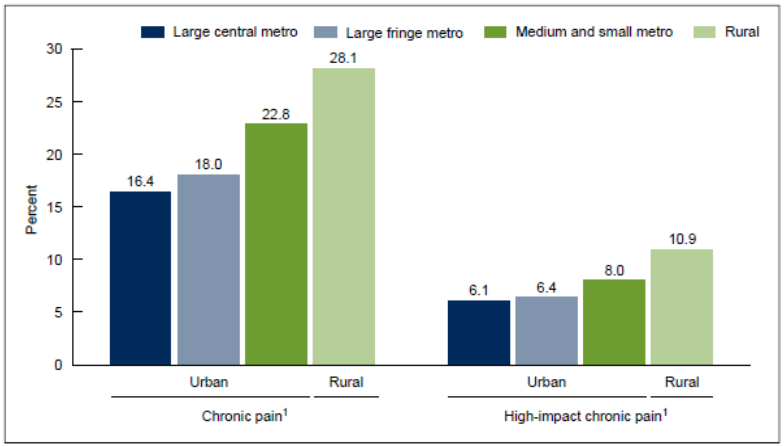
Ethnicity

Figure 3. Percentage of adults aged 18 and over with chronic pain and high-impact chronic pain in the past 3 months, by race and Hispanic origin: United States, 2019



Locale

Figure 4. Percentage of adults aged 18 and over with chronic pain and high-impact chronic pain in the past 3 months, by urbanization level: United States, 2019



Intractable Pain (IP)

- IP is defined as “pain that is excruciating, constant, incurable, and of such severity that it dominates virtually every conscious moment, produces mental and physical debilitation and may produce a desire to commit suicide for the sole purpose of stopping the pain”

Common Characteristics of Intractable Pain

Pain reduces sleep and food intake
Bed-, chair-, or house-bound in the absence of opioid treatment
Depression, attention deficit, confusion, and suicide tendencies
Underlying cause is incurable, non-removable, and fails to respond to customary pain therapies
Elevated blood pressure and pulse rate
Serum adrenal hormone and immune abnormalities

Palliative Care is Commonly Required

- It is often characterized as one having “cancer quality” pain but “not dying of cancer”
- IP patients often systematically fail the usual treatments for acute and chronic pain including anti-inflammatory, mild opioid and non-opioid analgesics, antidepressants, muscle relaxants, and anti-seizure medications.
- They also don’t respond well to corticosteroid injections in and around the spinal column or peripheral nerves.
- Physical therapy, exercise, and psychological interventions have usually been of little or no avail because the pain is so profoundly uncontrolled that participation in these therapies is not possible.
- Chronic Opioid Therapy (COT) may be required
- This treatment should be regarded as end-stage or last resort due to its expense and inherent complications.

Common Causes of Intractable Pain

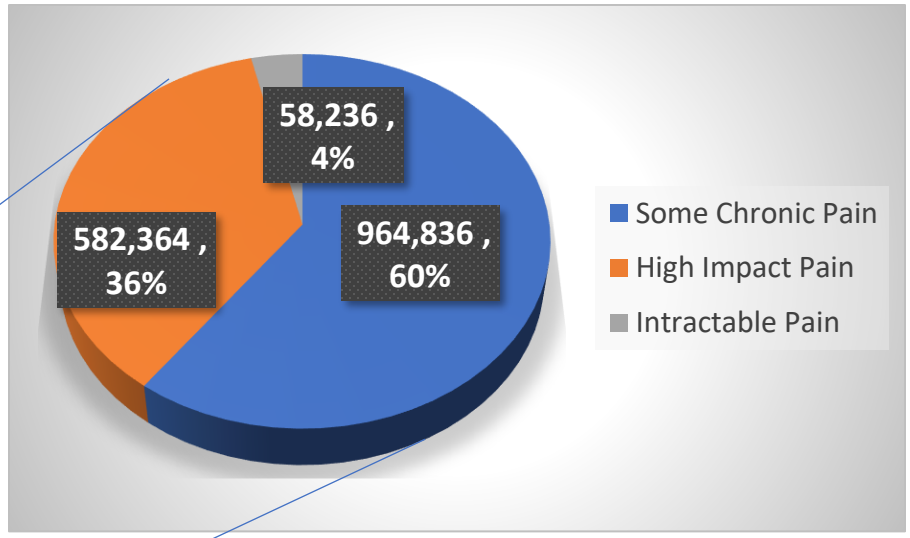
Admitted to Treatment	% Patients
Degenerative spinal disease post-surgery	32%
Degenerative spinal disease non-operable	22%
Fibromyalgia	15%
Migraine-vascular headache	8%
Neuropathies	6%
Congenital skeletal disease	5%
Headache-post trauma	3%
Reflex sympathetic dystrophy	3%
Osteoporosis	2%
Systemic lupus erythematosus	2%
Abdominal adhesions	1%
Interstitial cystitis	1%
Total	100%

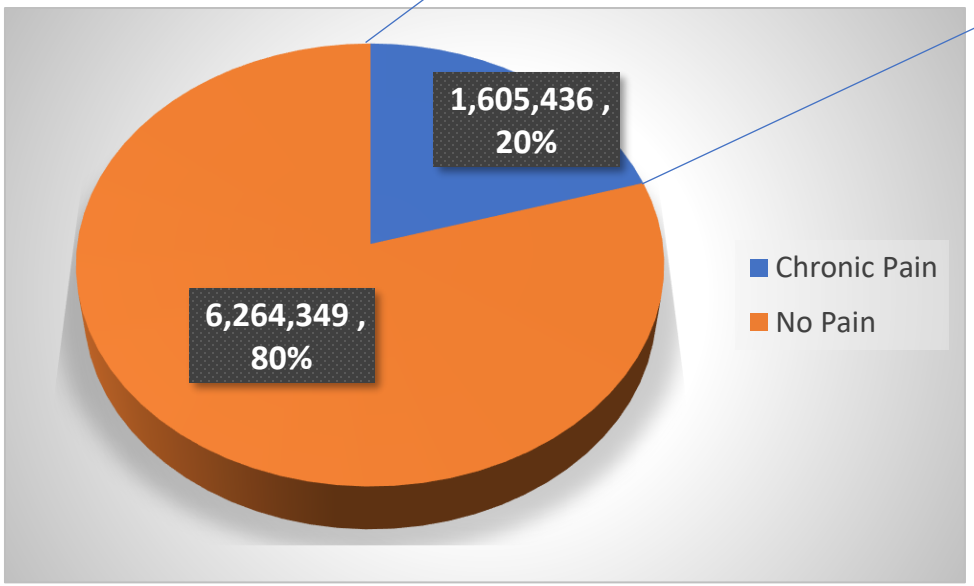
What is Intractable Pain and How Does it Differ From Chronic Pain (practicalpainmanagement.com) – Accessed 4/30/22

The Magnitude of Chronic Pain in Michigan Adult Residents Aged ≥18

(Best Estimate of NCHS 2020 Data Brief Extrapolated to the 2020 US Census Estimates for MI Residents)

- About 20% of all Michigan adults have chronic pain
- Chronic pain can occur with severe acquired illness
  - Cancer
  - Infection
  - Chronic Autoimmune and inflammatory disorders
- Long-term permanent injury
  - Auto
  - Work
  - Military Service
  - Sports Injuries
  - Slips and Falls
- Certain genetic disorders

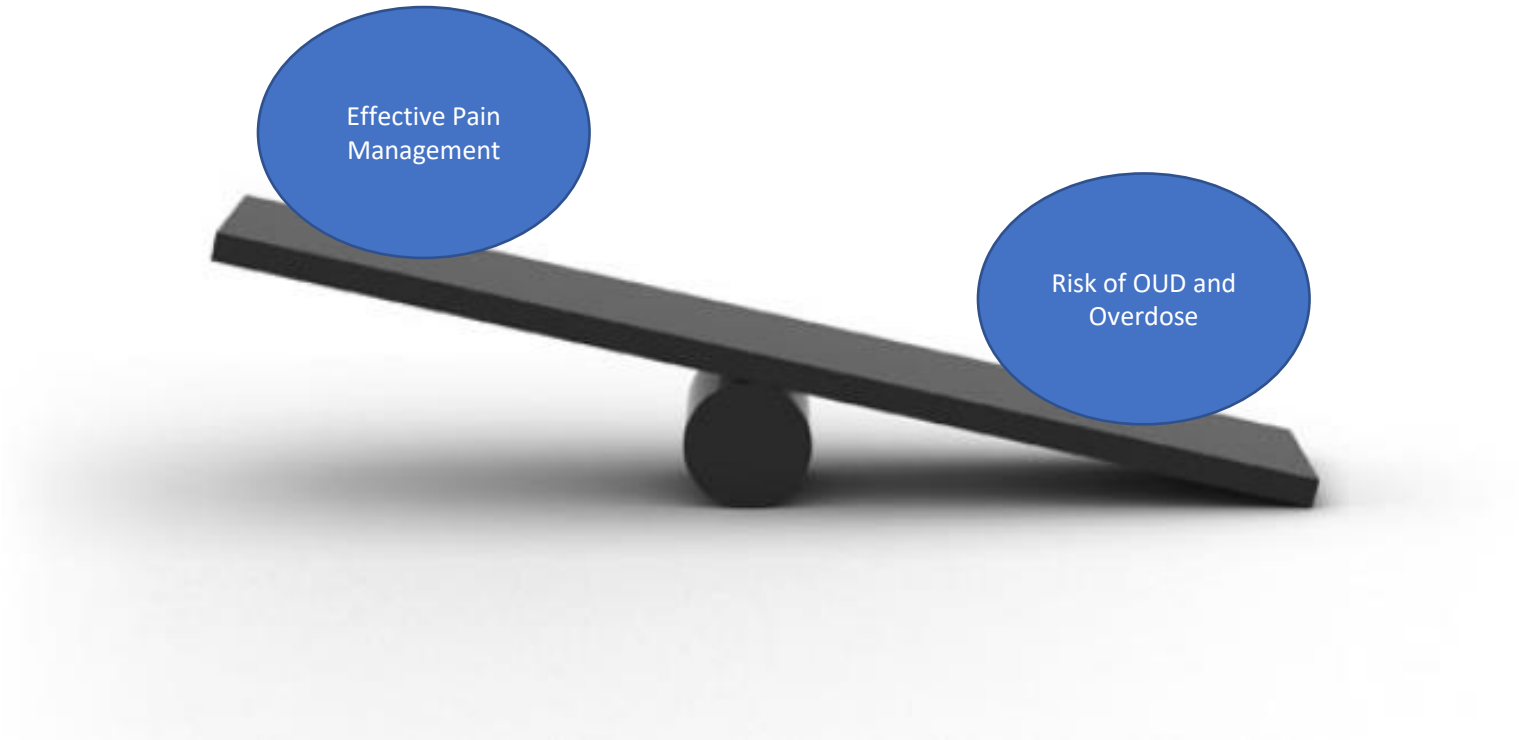




- Up to 60,000 (~4%) of the adult MI population has **Intractable Pain (IP)** which is a moderate to severe, constant pain that is typically relentless and debilitating, not curable by any known means, causes suffering, and leads to a house-bound or bed-bound state and possibly to premature death
- Intractable Pain patients cannot get access to care
- Abandoning the intractable pain patient challenges medical ethics, professional duty, the public health code and perhaps more

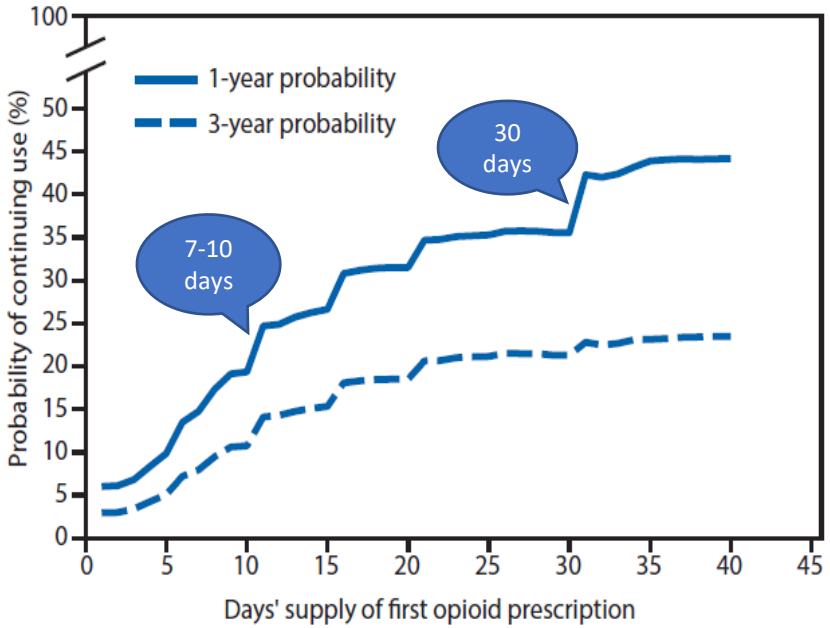
Data on File

When Risk Begins to Outweigh Benefit



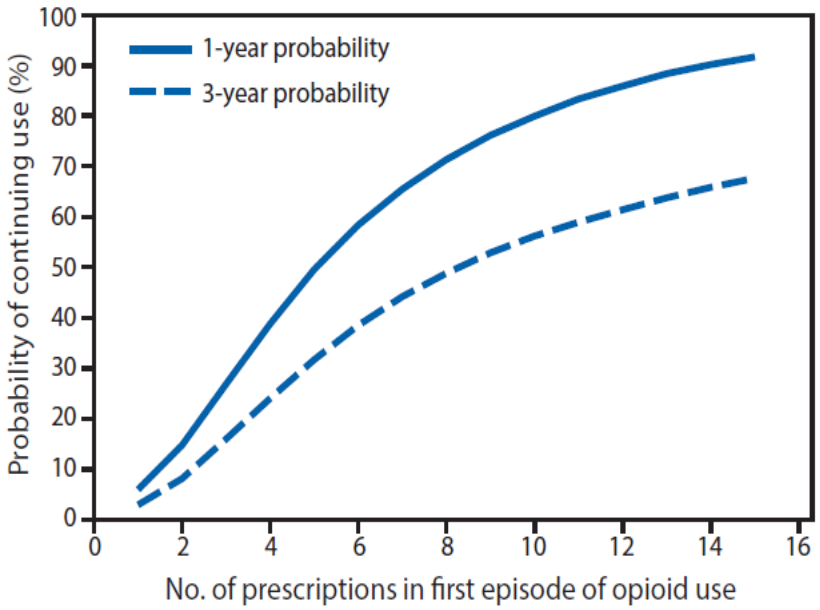
The Downside to Using Opioids Beyond 7-10 Days For Acute Pain: The Risk for Continued Opioid Use Goes Up with Days Supply and Number of Prescriptions in the First Episode of Care

FIGURE 1. One- and 3-year probabilities of continued opioid use among opioid-naïve patients, by number of days' supply* of the first opioid prescription — United States, 2006–2015



* Days' supply of the first prescription is expressed in days (1–40) in 1-day increments. If a patient had multiple prescriptions on the first day, the prescription with the longest days' supply was considered the first prescription.

FIGURE 2. One- and 3-year probabilities of continued opioid use among opioid-naïve patients, by number of prescriptions* in the first episode of opioid use — United States, 2006–2015

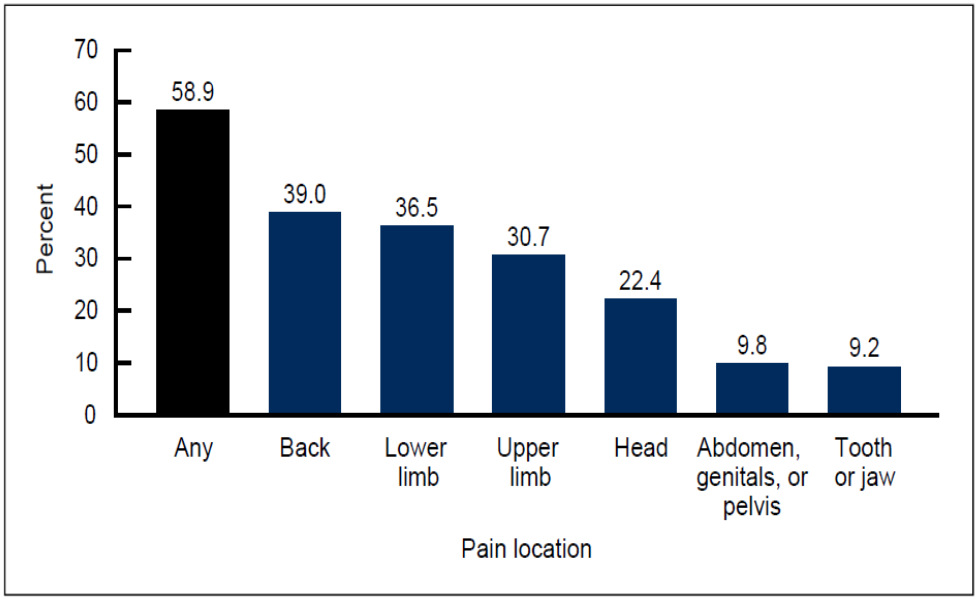


* Number of prescriptions is expressed as 1–15, in increments of one prescription.

The Percentage of Adults With Any Pain

3 in 5 Have Adults Have Experienced Pain Within 3 Months of Being Asked

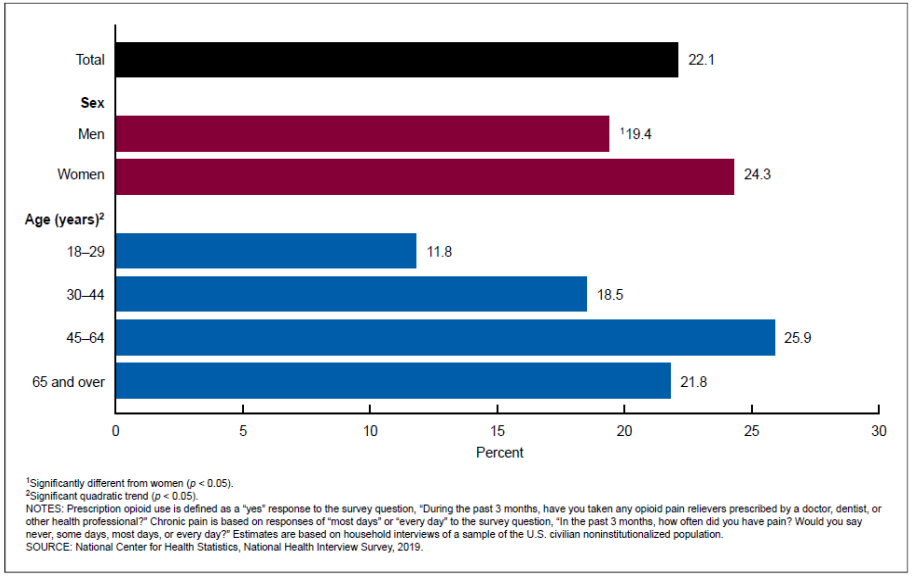
Figure 1. Percentage of adults aged 18 and over with any pain and pain by body region in the past 3 months: United States, 2019



Adult Prescription Opioid Use in Chronic Pain

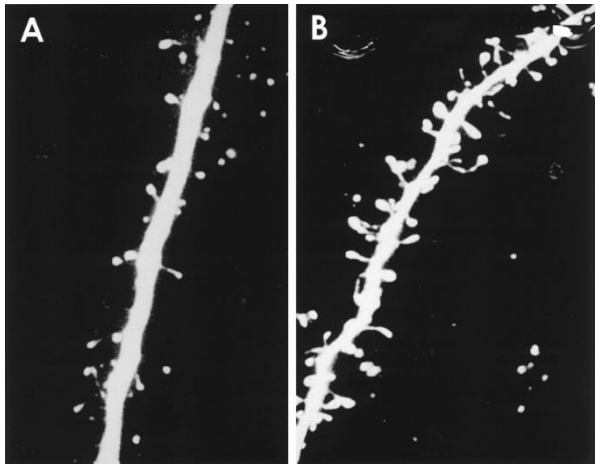
~1 in 5 Patients with Chronic Pain Have Used an Opioid Within 3 Months of Being Asked

Figure 1. Percentage of adults with chronic pain who used prescription opioids in the past 3 months, overall and by sex and age group: United States, 2019



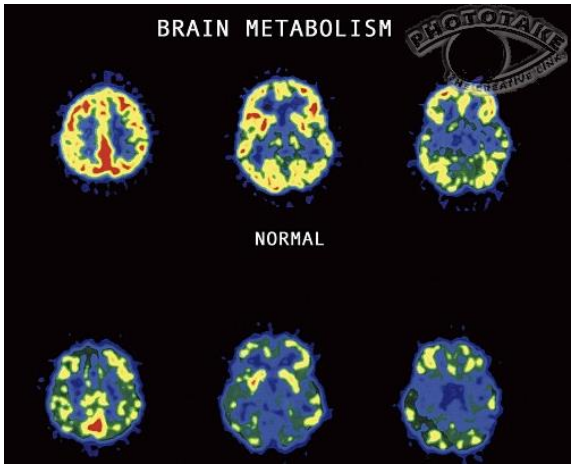
[1]Significantly different from women ($p < 0.05$).
[2]Significant quadratic trend ($p < 0.05$).
NOTES: Prescription opioid use is defined as a "yes" response to the survey question, "During the past 3 months, have you taken any opioid pain relievers prescribed by a doctor, dentist, or other health professional?" Chronic pain is based on responses of "most days" or "every day" to the survey question, "In the past 3 months, how often did you have pain? Would you say never, some days, most days, or every day?" Estimates are based on household interviews of a sample of the U.S. civilian noninstitutionalized population.
SOURCE: National Center for Health Statistics, National Health Interview Survey, 2019.

Long-Term Opioid Exposure Can Lead to Neurodegenerative and Neurocognitive Disorder



Loss of Neural Dendrites (Prolonged Drug Exposure)

Normal Dendrites



Loss of Brain Function Including the Frontal Lobe

Biological and Social Consequences of Ongoing Tolerance, Dependence and Addictive Behavior

- Prolonged exposure leading to downregulated epigenetic control of nerve cell structure and function (decreased neurotransmitters, receptors and structural proteins)
- The brain can no longer synthesize these molecules and requires exogenous source of these molecules until cells can resume synthesizing them
- Loss of self control and executive function, ie, judgement
- Inability to calculate risk versus benefit
- Possible severe, uncontrollable drug seeking to satisfy craving and avert withdrawal symptoms when opioids are rapidly discontinued
- Potential Loss of Family, Job and Shelter Leading to Possible Petty Theft, Larger Crimes, Arrest and Incarceration
- Possible Accidental overdose, cardiorespiratory arrest, anoxic-hypoxic brain injury and death

NOTE: A person's health is determined by their genes and the environment they live in. Epigenetics is the study of functional, and sometimes inherited, changes in the regulation of gene activity and expression that are not dependent on gene sequence.

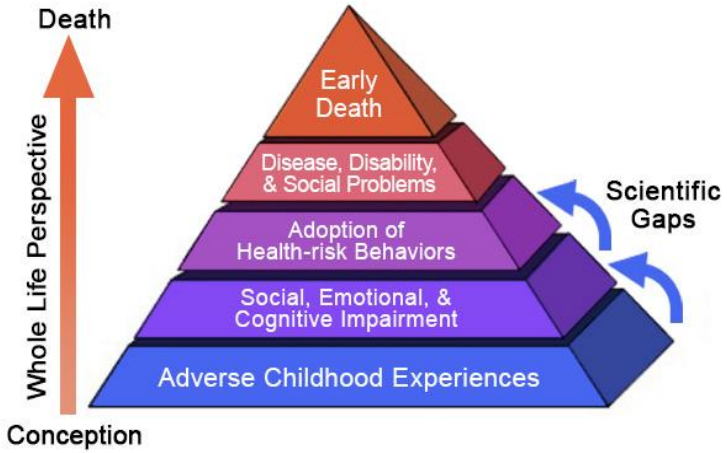
Substance Misuse Can Promulgate From Generation to Generation with the Cyclical Nature of Post-traumatic Stress Triggers and Adverse Childhood Events (ACE's) That Lead to Aberrant Behaviors

Landmark study of 17,000 participants from 1995-1997 by the Centers for Disease Control in partnership with Kaiser Permanente

Aberrant Adult Behaviors Increase Risk for ACE's

- Physical abuse
- Sexual abuse
- Emotional abuse
- Physical neglect
- Emotional neglect
- Intimate partner violence
- Mother treated violently
- **Substance misuse within household**
- Household mental illness
- Parental separation or divorce
- Incarcerated household member

Findings: A person's ACEs score has a strong relationship to numerous health, social and behavioral problems across a lifespan, including substance use disorders



ACE's Increase Risk for Aberrant Adult Behaviors

- Alcoholism and alcohol abuse
- Chronic obstructive pulmonary disease (COPD)
- Depression
- Fetal death
- Health-related quality of life
- **Illicit drug use**
- Ischemic heart disease (IHD)
- Liver disease
- Risk for intimate partner violence
- Multiple sexual partners
- Sexually transmitted diseases (STDs)
- Smoking
- Suicide attempts
- Unintended pregnancies
- Early initiation of smoking
- Early initiation of sexual activity
- Adolescent pregnancy
- Diabetes
- Lung cancer

https://www.samhsa.gov/capt/practicing-effective-prevention/prevention-behavioral-health/adverse-childhood-experiences

9. Introducing the New 2022 CDC Guideline

Introducing the New 2022 CDC Guideline

Process for Updating the Opioid Prescribing Guideline | CDC's Response to the Opioid Overdose Epidemic | CDC – Accessed 4/30/2022

CDC Clinic Practice Guideline for Prescribing Opioids – United States, 2022

Summary

1. **For all patients with acute, subacute, or chronic pain**
   - Initiate the lowest opioid dose to achieve expected effects
   - For opioid naïve patients, start with immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids
   - Use extreme caution when prescribing opioids, benzodiazepines and other sedating substances concurrently
     - consider whether benefits outweigh risks
     - Taper cautiously to a less risky dose or discontinue
   - Check the state prescription drug monitoring program (PDMP) also known as the Michigan Automated Prescription Service (MAPS), to determine whether the patient is receiving opioid dosages or combinations that put the patient at high risk for overdose
     - When initiating therapy
     - Periodically when continuing
   - Consider toxicology testing to assess for prescribed medications as well as other prescribed and non-prescribed controlled substances
   - Offer naloxone and other overdose mitigation strategies when risk factors for opioid overdose are present
2. **For acute pain, consider initiating opioid therapy only if benefits are anticipated to outweigh risks to the patient**
   - Nonopioid therapies are effective for many common types of acute pain
   - Prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids

URL - CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States, 2022 (Accessed 5/20/22)

CDC Clinic Practice Guideline for Prescribing Opioids – United States, 2022

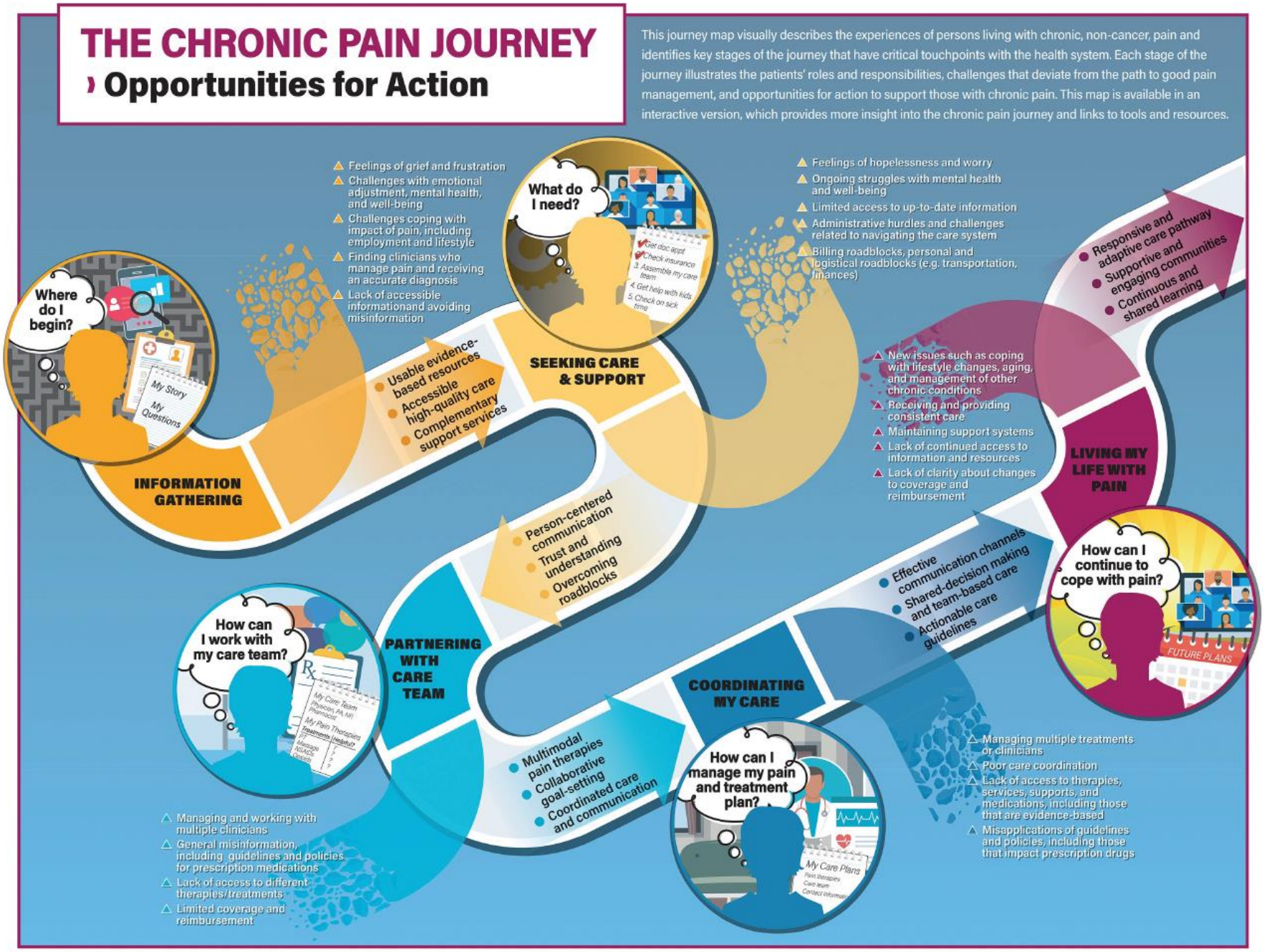
Summary

3. **For subacute and chronic pain, consider initiating opioid therapy only if expected benefits for pain and function are anticipated to outweigh risks to the patient**
   - Work with patients to establish treatment goals for pain and function
   - Nonopioid therapies are preferred
   - Discuss the known risks and realistic benefits of opioid therapy
   - Consider how opioid therapy will be discontinued when benefits do not outweigh risks
   - If opioids are continued
     - use caution when prescribing opioids at any dosage
     - avoid increasing dosage above levels likely to yield diminishing returns in benefits relative to risks to patients
     - re-evaluate benefits and risks after starting opioid therapy or when escalating dose
     - Initially at 1 to 4 weeks
     - Then every 3 months (or more frequently as indicated)
4. **Carefully weigh benefits and risks for patients already receiving higher opioid dosages**
   - Do not abruptly discontinue opioid therapy unless there are indications of a life-threatening issue, such as warning signs of impending overdose (e.g., confusion, sedation, or slurred speech)
   - Exercise care when reducing or continuing opioid dosage
   - Work closely with patients to optimize other therapies
   - Gradually taper to lower dosages if risks outweigh benefits of continued opioid therapy
   - Taper and discontinue opioids if warranted based on the individual clinical circumstances of the patient
   - Consider transitioning to buprenorphine if opioids cannot be sufficiently tapered or discontinued
5. **Offer Medications for Opioid Use Dosorder (MOUD) to patients without pain and exhibiting opioid used disorder (OUD)**

URL - CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States, 2022 (Accessed 5/20/22)

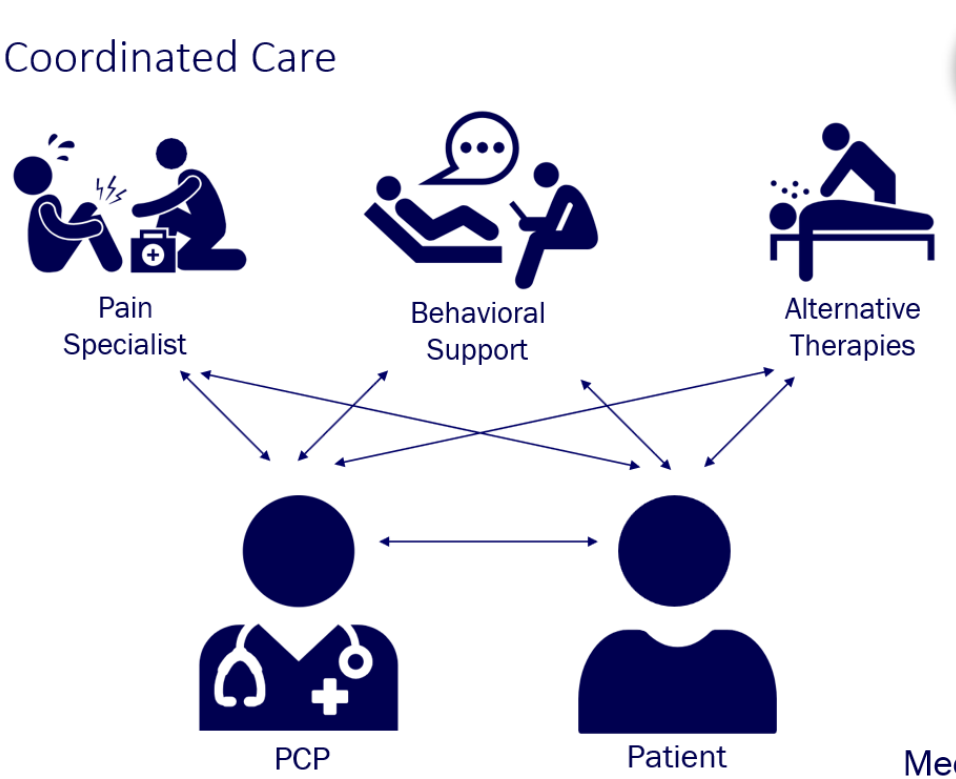
10. Approaches to Treat Acute and Chronic Pain in 2023

Be the Guide On the Patient's Journey to Adequate Care



[Chronic Pain Journey Map - National Academy of Medicine (nam.edu)](#) – Accessed 5/9/22

Coordinate Care With a Multimodality Treatment Plan



Medications

+

Behavioral Health Approaches

+

Restorative Therapies

+

Complementary and Integrative Health

+

Interventional Approaches

=

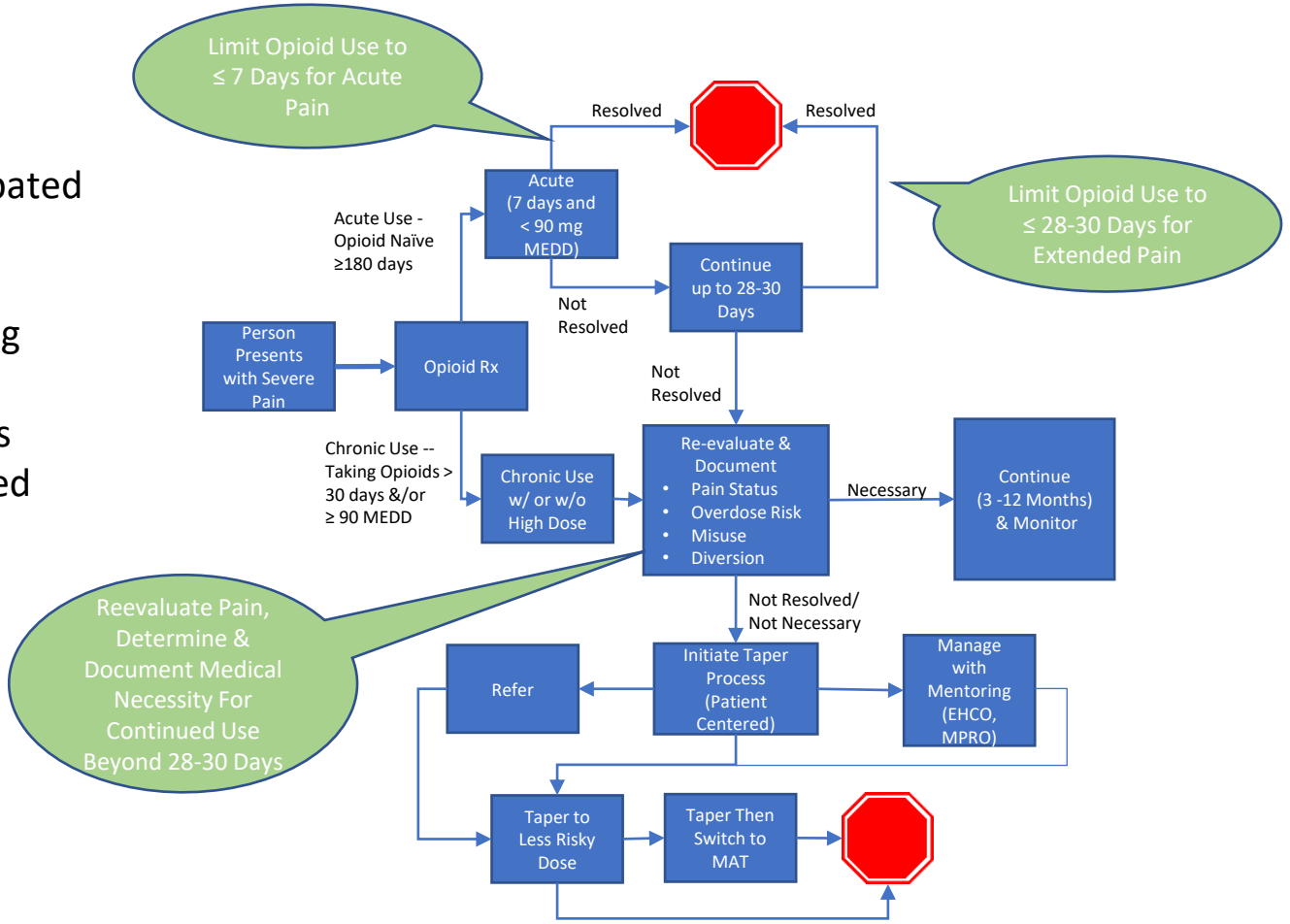
Effective Multimodal Treatment

U.S. Department of Health and Human Services. Pain Management Best Practices Inter-Agency Task Force Report. 2019.

Utilize a Systematic Approach to Reducing Unnecessary Opioid Prescription Use, Misuse and Diversion

Recommendations

1. Assess Severity and Anticipated Duration of Pain
2. Assess Overdose Risk
3. Limit Initial Dose & Ongoing Duration
4. Securely Store Medications
5. Promote Disposal of Unused Doses



Don't Ignore or Abandon Inherited "Legacy" Pain Patients Already on Opioids

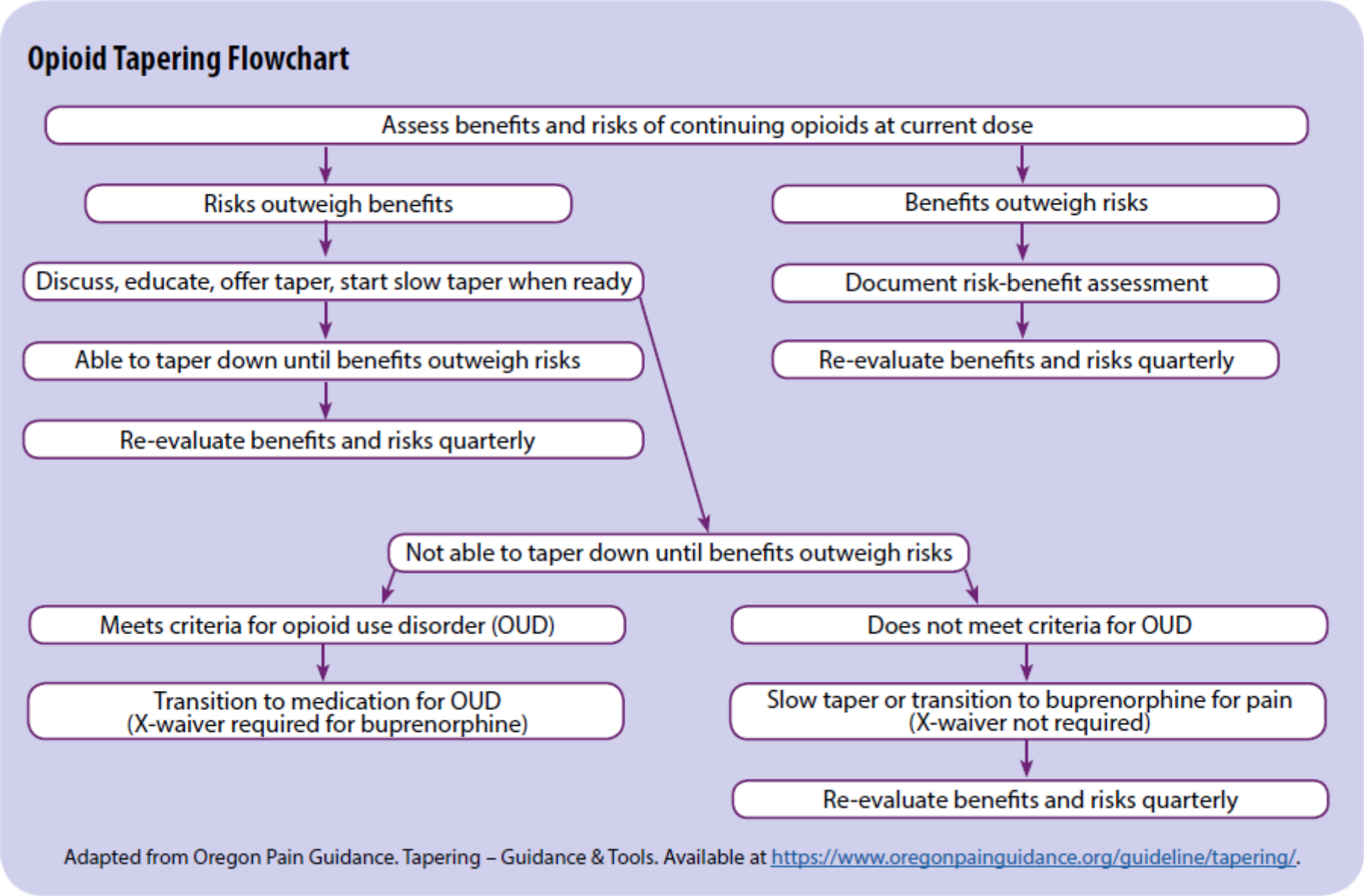
Inherited Patients Taking Opioids for Chronic Pain — Considerations for Primary Care

Phillip O. Coffin, M.D., and Antje M. Barreveld, M.D.

Steps in Caring for Patients with Chronic Pain Who Have Received Long-Term Opioid Therapy from a Previous Clinician.

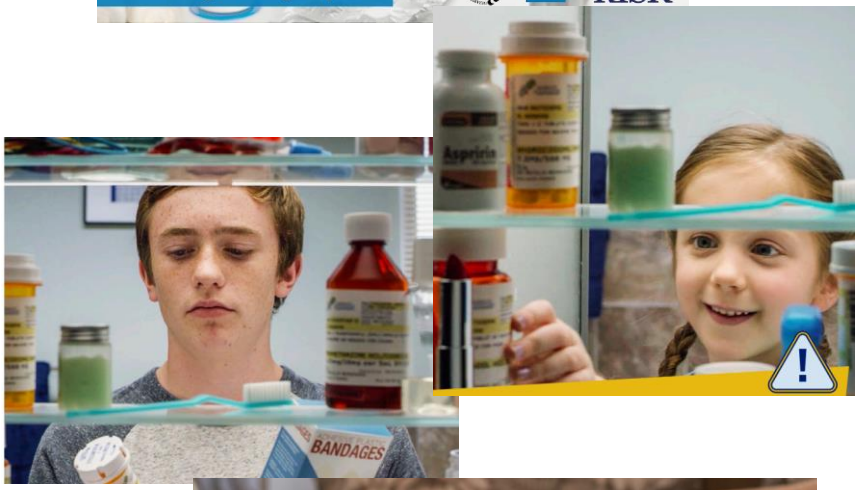
1. **Review the case with the former clinician if possible.** Try to develop a treatment plan that slowly adjusts to your style of management while avoiding a radical divergence from the previous plan of care.
2. **Consider providing a therapeutic bridge for the patient until a plan of care is determined, given the risks associated with stopping opioid therapy.** Abruptly tapering or stopping opioid therapy can be dangerous for multiple reasons. Opioids may be crucial for the patient's condition (e.g., sickle-cell disease), and the patient may be at risk for other harms when opioids are tapered or discontinued (see figure).
3. **Develop a patient-centered care plan.** If a taper is needed, empower the patient to make decisions, including which medications to taper first and how fast. Successful tapers may take years.
4. **Assess the patient for opioid use disorder and start discussing medication options right away.** Patients may find it challenging to accept an opioid use disorder diagnosis; give them time.
5. **Document opioid stewardship and the rationale for the treatment plan.** Investigations into opioid prescribing are often based on insufficient documentation.

When Using Opioids Long-term – Consider a Taper or Switch to Buprenorphine If and When Possible, Then Go Slow



Adapted from Oregon Pain Guidance. Tapering – Guidance & Tools. Available at https://www.oregonpainguidance.org/guideline/tapering/.

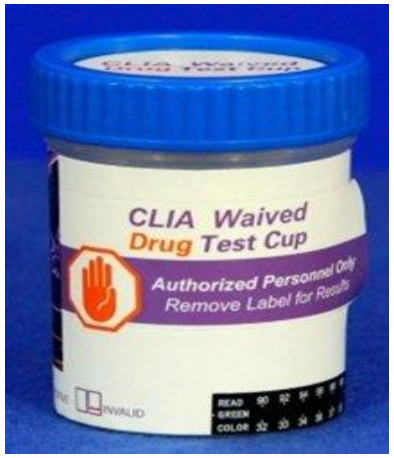
Orient Patients to Dispose of Expired or Unused Medications to Avoid Pilfering and Accidental Overdose



Safe Opioid Disposal - Remove the Risk Outreach Toolkit | FDA (Accessed 9/5/22)

Check for Anticipated and Unanticipated Medications and Other Substances

- If you don't check, you will have no idea.
- Qualitative - in Office
  - Test either positive or negative
  - Immunoassay
- Quantitative (in Lab)
  - Test measures concentration of drug
  - GC/MS or LC/MS
  - Can check for all psychoactive substances prescribed and unprescribed
  - Matrix - Urine, Saliva, Blood, Hair, Exhaled Air (breathalyzer), etc.



11. Approaches to Enhance Medical Documentation, Communication and Coordination of Care

Identify and Treat the Pain Source (Starting with a Good History)

Patient Instructions: Please fill out both sides of this questionnaire as completely as possible.

1. HISTORY OF THE PAIN

YES

► *Do you believe the pain is due to:*

☐ a car accident
- date: ____/____/____
- time: ____:____ a.m. / p.m.

☐ a work-related injury
- date: ____/____/____
- time: ____:____ a.m. / p.m.

☐ physical trauma *(examples: a fall, a fight, sports injury, etc.)*
- type : _____
- date: ____/____/____
- time: ____:____ a.m. / p.m.

☐ other: _____
- date: ____/____/____
- time: ____:____ a.m. / p.m.

☐ unknown cause

► *How long have you had this pain?*

☐ hours — how many? _____

☐ days — how many? _____

☐ weeks — how many? _____

☐ months — how many? _____

► *Did the pain appear:*

☐ suddenly

☐ gradually

► *Right now, is the pain:*

☐ better

☐ worse

☐ unchanged

2. LOCATION AND INTENSITY OF PAIN

► *The most intense pain is located:* _____.

► *On the diagrams to the right:*
- mark an X or a series of X's where you feel pain.
- shade the areas where you have numbness.
- use arrows to point to where the pain radiates or travels to.

► *Has the pain changed in its location?*

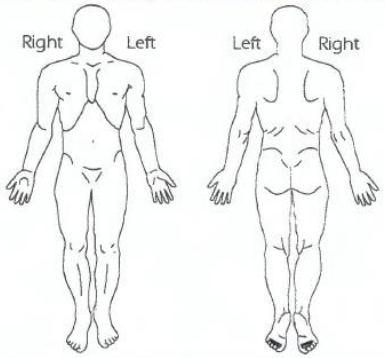
_____

_____

_____

► *On the scale below, mark an X where it best describes the intensity of your pain:*

0 1 2 3 4 5 6 7 8 9 10
No Pain — Moderate Pain — Worst Possible Pain



3. DESCRIPTION OF THE PAIN

YES

► *Is the pain:*

☐ continuous *(no relief)*

☐ intermittent *(periods of relief)*
- amount of time **pain** usually lasts: _____
- amount of time **relief** usually lasts: _____

☐ other _____

_____

_____

_____

YES

► *Would you describe the pain as:*

☐ sharp, stabbing

☐ dull, aching

☐ throbbing

☐ burning like a hot poker

☐ steady, persistent

☐ waxing and waning

☐ feeling like a tight band

☐ easy to pinpoint

☐ difficult to pinpoint

☐ other _____

YES

► *Does pain occur:*

☐ upon awakening

☐ in the morning

☐ in the afternoon

☐ in the evening

☐ 2-3 hours after falling asleep

☐ any time day or night

☐ only on weekends

☐ only at work

☐ only at home

☐ other _____

→

4. DO YOU ALSO HAVE:

YES

☐ runny, bloodshot eyes
☐ blurred or double vision
☐ nasal congestion/runny nose
☐ high blood pressure
☐ muscle weakness
☐ numbness in arms or hands
☐ numbness in legs or feet
☐ felt a "sudden snap"
☐ felt a "tearing" sensation
☐ muscle aches and pains
☐ joint pains
☐ morning joint stiffness
☐ fever
☐ abdominal pain

YES

☐ nausea or vomiting
☐ diarrhea
☐ constipation
☐ bloody stools
☐ frequent or burning urination
☐ sudden loss of urine
☐ inability to urinate
☐ bloody urine
☐ weight gain or loss
☐ depression
☐ other: _____

► *Female patients only:*

☐ vaginal discharge
☐ heavy menstrual bleeding

YES

☐ bleeding between periods
☐ pelvic infection
☐ ovarian cysts
☐ uterine fibroids
☐ painful intercourse
☐ hot flashes
☐ other: _____

► *Male patients only:*

☐ prostate trouble
☐ restricted or painful urination
☐ interrupted sleep to urinate
☐ swollen or painful testicles
☐ penis discharge
☐ other: _____

5. PREVIOUS MEDICAL WORKUP INCLUDES:

YES

☐ seeing other doctors name(s): _____

_____

_____

☐ skull x-rays

YES

☐ neck x-rays
☐ lumbar and pelvis x-rays
☐ EEG/brain wave study
☐ CT scan
☐ brain scan

YES

☐ MRI
☐ Evoked potentials
☐ EMG
☐ blood work
☐ other: _____

6. DOES ANY BLOOD RELATIVE HAVE A HISTORY OF:

YES

☐ arthritis
☐ diabetes
☐ aortic aneurysm
☐ cerebral aneurysm
☐ migraines
☐ high blood pressure

YES

☐ stroke
☐ brain tumor
☐ spinal cord tumor
☐ poor leg circulation
☐ disk problems
☐ spinal stenosis

YES

☐ multiple sclerosis (MS)
☐ muscular dystrophy
☐ arteriovenous malformation
☐ Lou Gehrig's disease
☐ other neurological disease: _____

7. IS THE PAIN MADE WORSE OR BETTER BY:

FEELS WORSE	FEELS BETTER		FEELS WORSE	FEELS BETTER		FEELS WORSE	FEELS BETTER	
☐	☐	inactivity or sleep	☐	☐	lifting _____ lbs.	☐	☐	menstrual periods
☐	☐	mild activity	☐	☐	carrying _____ lbs.	☐	☐	massage
☐	☐	exercising or stretching	☐	☐	stooping	☐	☐	heat
☐	☐	heavy work	☐	☐	twisting	☐	☐	trying to forget about it
☐	☐	climbing stairs	☐	☐	reaching overhead	☐	☐	spinal manipulation
☐	☐	walking	☐	☐	coughing/sneezing	☐	☐	spinal injections (blocks)
☐	☐	standing	☐	☐	sudden movement	☐	☐	physical therapy
☐	☐	sitting	☐	☐	other movement: _____	☐	☐	surgery
☐	☐	car riding				☐	☐	other: _____
☐	☐	straining at stool	☐	☐	touching a certain point: _____	☐	☐	other: _____
☐	☐	reclining or lying down						*Medications:*
☐	☐	lying on a firm bed or on the floor	☐	☐	sexual intercourse	☐	☐	_____
			☐	☐	drinking alcohol	☐	☐	_____
☐	☐	lying on one side	☐	☐	emotional tension	☐	☐	_____
☐	☐	getting up from bed	☐	☐	fatigue	☐	☐	_____
☐	☐	bending forward	☐	☐	changes in weather	☐	☐	_____

Confirm Medical Necessity and Appropriateness of Care (DIRE Score)

Name: _____ DOB___/____/___

DIRE Score: Patient Selection for Chronic Opioid Analgesia

For each factor, rate the patient's score from 1-3 based on the explanations in the right-hand column

SCORE	FACTOR	EXPLANATION
	DIAGNOSIS	1 = Benign chronic condition with minimal objective findings or no definite medical diagnosis. Examples: fibromyalgia, migraine headaches, non-specific back pain. 2 = Slowly progressive condition concordant with moderate pain, or fixed condition with moderate objective findings. Examples: failed back surgery syndrome, back pain with moderate degenerative changes, neuropathic pain. 3 = Advanced condition concordant with severe pain with objective findings. Examples: severe ischemic vascular disease, advanced neuropathy, severe spinal stenosis.
	INTRACTABILITY	1 = Few therapies have been tried and the patient takes a passive role in his/her pain management process. 2 = Most customary treatments have been tried but the patient is not fully engaged in the pain management process, or barriers prevent (insurance, transportation, medical illness). 3 = Patient fully engaged in a spectrum of appropriate treatments but with inadequate response.
	RISK	(**R** = Total of **P+C+R+S** below)
	Psychological	1 = Serious personality dysfunction or mental illness interfering with care. Example: personality disorder, severe affective disorder, significant personality issues. 2 = Personality or mental health interferes moderately. Example: depression or anxiety disorder. 3 = Good communication with clinic. No significant personality dysfunction or mental illness.
	Chemical Health	1 = Active or very recent use of illicit drugs, excessive alcohol, or prescription drug abuse. 2 = Chemical coper (uses medications to cope with stress) or history of chemical dependence (CD) in remission. 3 = No CD history. Not drug-focused or chemically reliant.
	Reliability	1 = History of numerous problems: medication misuse, missed appointments, rarely follows through. 2 = Occasional difficulties with compliance, but generally reliable. 3 = Highly reliable patient with meds, appointments & treatment.
	Social Support	1 = Life in chaos. Little family support and few close relationships. Loss of most normal life roles. 2 = Reduction in some relationships and life roles. 3 = Supportive family/close relationships. Involved in work or school and no social isolation.
	EFFICACY SCORE	1 = Poor function or minimal pain relief despite moderate to high doses. 2 = Moderate benefit with function improved in several ways (or insufficient info - hasn't tried opioid yet or very low doses or too short of a trial). 3 = Good improvement in pain and function and quality of life with stable doses over time.

_____ **Total score= D + I + R + E**

Score 7-13: Not a suitable candidate for long-term opioid analgesia

Score 14-21: May be a good candidate for long-term opioid analgesia

NOTES

A DIRE Score of :513 indicates that the patient may not be suited to long-term opioid pain management. Used with permission by Miles J. Belgrade, MD |

Assess for Opioid Use Disorder (DSM-5 Criteria)

A problematic pattern of opioid use leading to clinically significant impairment or distress, as manifested by at least 2 of the following, occurring within a 12-month period:

1. Opioids are often taken in larger amounts or over a longer period than was intended.
2. There is a persistent desire or unsuccessful efforts to cut down or control opioid use.
3. A great deal of time is spent in activities necessary to obtain, use, or recover from the effects of opioids.
4. Craving, or a strong desire or urge to use opioids.
5. Recurrent opioid use resulting in a failure to fulfill major role obligations at work, school, or home.
6. Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids.
7. Important social, occupational, or recreational activities are given up or reduced because of opioid use.
8. Recurrent opioid use in situations in which it is physically hazardous.
9. Continued opioid use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.
10. Tolerance, as defined by either of the following:
    a. A need for markedly increased amounts of opioids to achieve intoxication or desired effect, or
    b. Markedly diminished effect with continued use of the same amount of an opioid.
    Note: This criterion is not considered to be met for those taking opioids solely under appropriate medical supervision.
11. Withdrawal, as manifested by either of the following:
    a. The characteristic opioid withdrawal syndrome, or
    b. Opioids (or a closely related) substance is taken to relieve or avoid withdrawal symptoms.
    Note: This criterion is not considered to be met for those taking opioids solely under appropriate medical supervision.

Mild: Presence of 2-3 symptoms

Moderate: Presence of 4-5 symptoms

Severe: Presence of 6 or more symptoms

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Assess for Signs of Withdrawal (Using COWS)

PATIENT NAME:	DATE OF ASSESSMENT:
PATIENT DATE OF BIRTH:	MEDICAL RECORD NUMBER:

Clinical Opioid Withdrawal Score (COWS)

For each item, write in the number that best describes the patient's signs or symptom. Rate only the apparent relationship to opiate withdrawal. *For example: If heart rate is increased because the patient was jogging just prior to assessment, the increased pulse rate would not add to the score.*

Enter scores at time zero, 30 minutes after first dose, 2 hours after first dose, etc.	Time:	Time:	Time:	Time:
Resting Pulse Rate: *Record beats per minute after patient is sitting or lying down for one minute* • 0 - pulse rate 80 or below • 1 - pulse rate 81–100 • 2 - pulse rate 101–120 • 4 - pulse rate greater than 120				
Sweating: *Over past ½ hour not accounted for by room temperature or activity* • 0 - no chills or flushing • 1 - subjective chills or flushing • 2 - flushed or observable moistness on face • 3 - beads of sweat on brow or face • 4 - sweat streaming off face				
Restlessness: *Observation during assessment* • 0 - able to sit still • 1 - reports difficulty sitting still, but is able to do so • 3 - frequent shifting or extraneous movement of legs/arms • 5 - unable to sit still for more than a few seconds				
Pupil size • 0 - pupils pinned or normal size for light • 1 - pupils possibly larger than normal for light • 2 - pupils moderately dilated • 5 - pupils dilated that only rim of the iris is visible				
Bone or joint aches: *If patient was having pain previously, only the additional component attributed to opiate withdrawal is scored* • 0 - not present • 1 - mild/diffuse discomfort • 2 - patient reports severe diffuse aching of joints/muscles • 4 - patient is rubbing joints or muscles and is unable to sit still because of discomfort				
Runny nose or tearing: *Not accounted for by cold symptoms or allergy* • 0 - none present • 1 - nasal stuffiness or unusually moist eyes • 2 - nose running or tearing • 4 - nose constantly running or tears streaming down cheeks				
GI upset: *Over last ½ hour* • 0 - no GI symptoms • 1 - stomach cramps • 2 - nausea or loose stool • 3 - vomiting or diarrhea • 5 - multiple episodes of diarrhea or vomiting				
Tremor: *Observation of outstretched hands* • 0 - no tremor • 1 - tremor can be felt, but not observed • 2 - slight tremor observable • 4 - gross tremor or muscle twitching				
Yawning: *Observation during assessment* • 0 - no yawning • 1 - yawning once or twice during assessment • 2 - yawning three or more times during assessment • 4 - yawning several times/minute				
Anxiety or irritability • 0 - none • 1 - patient reports increasing irritability or anxiousness • 2 - patient obviously irritable or anxious • 4 - patient so irritable or anxious that participation in the assessment is difficult				
Gooseflesh skin • 0 - skin is smooth • 3 - piloerrection of skin can be felt or hairs standing up on arms • 5 - prominent piloerrection				
5—12 = mild; ***13—24 = moderate;*** ***25—36 = moderately severe;*** ***> 36 = severe withdrawal*** **TOTAL** OBSERVER INITIALS				

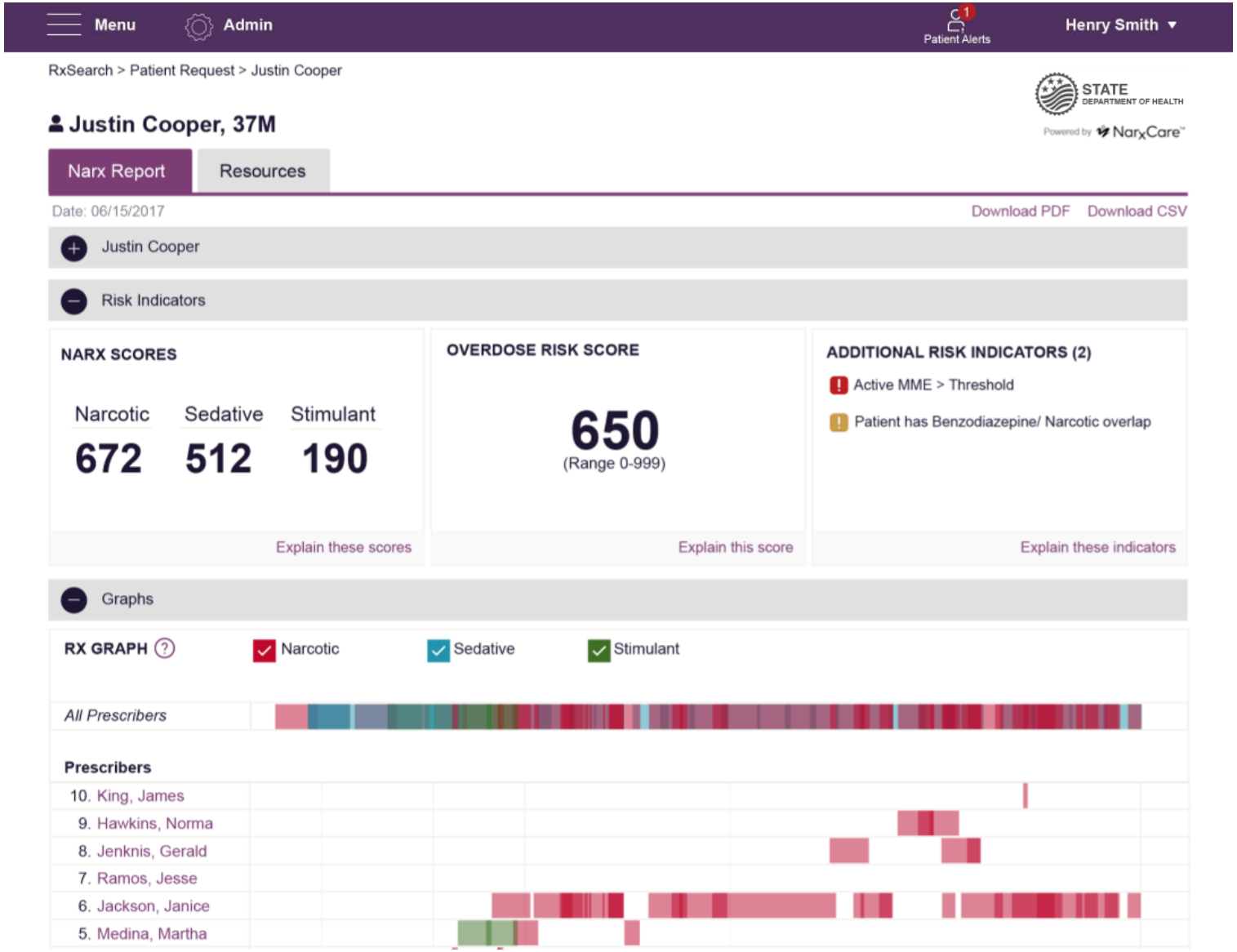
Journal of Psychoactive Drugs Volume 35 (2), April - June 2003Source: Wesson, D. R., & Ling, W. (2003). The Clinical Opiate Withdrawal Scale (COWS). *J Psychoactive Drugs, 35*(2), 253–9.

Assess Risk for Overdose (Using RIOSORD)

Risk Index for Overdose or Serious Opioid-Induced Respiratory Depression (RIOSORD)		
Question	Points for Positive Response	Actual Response
In the past 6 mo, has the patient had a health care visit (outpatient, inpatient, or emergency department) involving any of the following health conditions		
Substance use disorder (abuse or dependence), including alcohol, amphetamines, antidepressants, cannabis, cocaine, hallucino- gens, opioids, and sedatives	25	
Bipolar disorder or schizophrenia	10	
Stroke or other cerebrovascular disease	9	
Kidney disease with clinically significant renal impairment	8	
Heart failure	7	
Nonmalignant pancreatic disease (e.g., acute or chronic pancreatitis)	7	
Chronic pulmonary disease (e.g., emphysema, chronic bronchitis, asthma, pneumoconiosis, asbestosis)	5	
Recurrent headache (e.g., migraine)	5	
Does the patient use any of the following substances?		
Fentanyl	13	
Morphine	11	
Methadone	10	
Hydromorphone	7	
Does the patient use an extended-release or long-acting formulation of any prescription opioid?	5	
Prescription benzodiazepine (e.g., diazepam, alprazolam)	9	
Prescription antidepressant (e.g., fluoxetine, citalopram, venlafaxine, amitriptyline)	8	
Is the patient's current maximum prescribed daily morphine- equivalent dose ≥100 mg for all opioids used on a regular basis?	7	
Total possible score	**146**	

Risk Classes and Predicted Probability of Serious Opioid-Induced Respiratory Depression during the Next 6 Months.			
Risk Class	RIOSORD Score	Average Predicted Probability (Percent)	Actual Observed Incidence (Percent)
1	<5	1.9	2.1
2	5–7	4.8	5.4
3	8–9	6.8	6.3
4	10–17	15.1	14.2
5	18–25	29.8	32.2
6	26–41	55.1	58.8
7	≥42	83.4	82.4

Check the Michigan Automated Prescription Service (MAPS) to Assess for Potential Misuse, Abuse, Diversion, or Overdose Risk



https://michigan.pmpaware.net

Create a Multi-Modal Chronic Pain Management Plan

Name	
DOB	

Visit		Visit 1	Visit 2	Visit 3	Visit 4	Visit 5
Date						

Disease/Conditions Causing Pain

1						
2						
3						
4						
5						
6						

Pain Levels

Worst Pain Level:						
Current Pain Level:						
Achieveable Pain Level:						

Pain Management Goals

1						
2						
3						
4						
5						
6						

Pain Medication

1						
2						
3						
4						
5						
6						

Name	
DOB	

Visit		Visit 1	Visit 2	Visit 3	Visit 4	Visit 5
Date						

Specialty Consultation

1	General Surgery					
2	Orthopedic Surgery					
3	Interventional Pain Medicine					
4	Physical Medicine & Rehabilitation					
5	Manual Medicine (OMM/PT/Chiropractic)					
6	Neurology					
7	Sleep Medicine					
8	Accupuncture					
9	Hypnosis/Biofeedback					
10	Other: _____					

Self Care

1	Ice/Heat Therapy					
2	Exercise					
3	Substance Management					
	Caffeine					
	NicotineTobacco					
	Marijuana					
	Vaping					
	Kratom					
	Other: _____					
3	Nutrition					
4	Weight Management					
5	Sleep Hygiene					

Obtain Meaningful Informed Consent (Sample)

Controlled Medication Management Agreement and Informed Consent

Patient Name: _____

DOB: ___/___/___

Provider: _____

Facility: _____

Date: ___/___/___

#	Controlled Medication	Dose	Quantity	Directions	New Start	Refill	Switch
1							
2							
3							
4							
5							
6							
7							
8							

The terms "I", "my" and "you" in this document refer to the patient. Where the patient is under age 18, or an adult for whom a guardian is signing the Agreement, the terms "I", "my" and "you" refer to the patient and to his or her parent or guardian.

This document lists commitments I will make before beginning one or more of these medications or continue them, if already being taken. I have received and have read the following patient education:

- ☐ Opioids *(Opioid Medication for Chronic Pain fact sheet)*
- ☐ Stimulants *(Stimulant Medicine for ADHD fact sheet)*
- ☐ Benzodiazepines, Sedatives, Hypnotics and Sleeping Pills *(Sedatives and Sleeping Pills: Understanding the Risks fact sheets)*
- ☐ Gabapentin (*Gabapentin fact sheet*)
- ☐ Others *(Describe)* _____

1. I will work with my provider(s) in a collaborative manner to develop a balanced treatment plan that considers both benefits and risks to any given treatment.
2. I have discussed the medication(s) and had the chance to ask questions about the medications being prescribed with my provider(s).
   a. all my questions have been answered in a way I understand.
3. I will engage in all activities to continue my ongoing therapy
4. I acknowledge that I might develop tolerance, dependence, addiction or other serious and potentially life-threatening conditions when taken improperly, either individually or in combination with other controlled medications or addictive substances.
5. I will refrain from taking actions that could endanger myself or the public.
6. I understand that insurers and regulatory authorities have the right to review my records when taking controlled substances
   a. I understand that my medical and insurance claims records may be reviewed by an independent review team to evaluate my ongoing opioid and controlled substance usage.
   b. the Michigan Department of Licensing and Regulatory Affairs (LARA) maintains and makes available a database of my controlled drug prescriptions to all medical providers providing my care.
7. I acknowledge that unwillingness or inability to work collaboratively with my provider(s) and adhere to this agreement may result in discharge from the provider's care
   a. Any action on my part that may be threating to safety of your provider(s) and their staff may be subject to subsequent action
8. I acknowledge that my provider and I have reviewed this document.
9. I acknowledge the potential benefits and risks of controlled substances prescribed by my provider along with the responsibility of properly managing my medication as stated above.
10. For OPIOID USE ONLY, I understand that there are inherent risks for using opioids that are associated with increasing doses and when used in combination with other drugs. Naloxone, also known as Narcan, is an antidote that can reverse overdose of opioids by blocking their sedating effects that may slow down breathing and lead to cardiopulmonary arrest. Narcan can be helpful to reverse over sedation and may be lifesaving when too much opioid is taken by myself or others. I acknowledge that Naloxone has been offered by prescription from my provider and is also available by request at participating pharmacies under standing orders of the Chief Medical Executive for the State of Michigan. Additional information regarding Naloxone and its proper use can be found at https: //www.michigan.gov /opioids/0,9238,7-377--480835--,00.html.

My signature confirms that I have had an opportunity to ask questions about this agreement, and that I understand and agree to all the statements above. I have been given a copy of this Agreement and agree to keep the copy for my future reference.

Patient or Legal Guardian:

X _____

Date: _____

*(*Patients aged 12 to 17 may sign in addition to the parent or guardian)*

Patient (aged 12-17)

X _____

Date: _____

Provider:

X _____

Date: _____

Confirm the Need for Chronic Pain Management and Palliative Care

Chronic Pain Management & Palliative Care Certification Form

Patient Information

Patient Name:		Telephone #:	
Date of Birth:		Fax #:	
Address:		Cellphone #:	
City, STATE, Zip:		Email:	

Primary Diagnoses (relating to persistent intractable pain)

Certication Criteria

	Palliative Care Criteria
☐ YES ☐ NO	The underlying disease is protracted with an unpredictable outcome and/or is uncurable
☐ YES ☐ NO	Pain is persistent and intractable despite using non-opioid therapies that have been maximized and reached maximal therapeutic benefit
☐ YES ☐ NO	Symptomatic pain treatment has a good probability to improve functionality and existing quality of life
☐ YES ☐ NO	Anticipated benefit exceeds potential risk for overdose and/or diversion
☐ YES ☐ NO	Pain management is a component of all aspects of palliative care including management of other treatable conditions and symptoms

Certification

I have performed a comprehensive and detailed examination for_____ and have developed a collaborative palliative care plan.

I have determined that this person has intractable pain and satisfied the criteria for Palliative Care Status. Support documentation is included in the patient's medical record with this certification.

I, hereby, certify this pain management and palliative care plan is medically necessary. This plan will be recertified annually or sooner if there is substantive change beforehand.

PROVIDER

Signature of Provider: _____Date: ___/___/___

Provider Name Printed:_____

PATIENT

By signing below, and I hereby agree to all terms and conditions set forth under this certification document and accompanying treatment agreement.

Signature of Patient: _____Date: ___/___/___

Patient Name Printed:_____

Implement a Taper Plan Whenever Practicable

Name: _____ **DOB**___/____/___

Opioid and/or Benzodiazepine Tapering Plan Agreement

The purpose of this document is to develop a specific tapering plan with a timeline for discontinuation or reaching a taper "target dose".

We will work with you to develop a plan that is safe, effective and will minimize any symptoms that may be associated with tapering. Enclosed is a sample of a tapering schedule that can be used to help keep everyone apprised.

Taper Schedule

Visit	Date	Medication	Taper Frequency (# weeks)	Single Dose	Dose Frequency	Total Daily Dose	Total Dose/Day	Quantities Needed
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								

We will allow for gradual dose reductions and will reassess regularly and adjust accordingly.

Sign and Date below:

Patient or Patient's Representative (required):

_____ Date: _____

Mature Minor Patient:

_____ Date: _____

Physician Signature or Provider:

_____ Date: _____

Program Summary

1. We must continue to effectively treat pain but still mitigate overdose risk
2. We cannot abandon the “pain refugee” because many will go to the street
3. We must improve access to care for both Pain Management Services and Substance Use Disorders
4. We must help diminish supply and demand for illicit opioids, benzodiazapines and stimulants through community-based initiatives
5. **The updated 2022 CDC Guideline for prescribing opioids focuses on patient centered decision-making, multi-modality pain management and clarifies key outstanding misconceptions and misinterpretations**
6. We can improve care with how we communicate, coordinate and collaborate with patients and professional colleagues, including better documentation
7. CMS is paving the way to compensate for extended services through Chronic Care Management (CCM)
8. We as Health Care Professionals are well positioned to help lead the way

Discussion