Practical Considerations for Chronic Pain Management

Disclosure

MI-CCSI, or the presenter, does not have any financial interest, relationships, or other potential conflicts, with respect to the material which will be covered in this presentation.

OBJECTIVES

At the conclusion of this presentation, the participant will be able to:

- Design a patient-specific opioid tapering strategy, including pre-planning and response to side effects and opioid withdrawal symptoms.
- Participate in patient-centered crucial conversations related to an opioid taper that supports patient engagement throughout the process.
- Apply clinically appropriate next steps for patients unable to proceed with a taper, including patient who have a co-occurring substance use disorder that has not previously been identified.

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Patient-Specific Opioid Tapering

Today's Presenter

Eva Quirion NP, PhD

Lecturer of Nursing, The University of Maine and NP at St. Joseph Internal Medicine, Pain and Recovery Care. She has worked closely with primary care providers to improve patient safety related to chronic pain medications and other controlled substances and has become an expert at tapering chronic controlled substances with compassion.

Why Taper?

- Reduce risk
- Neutral impact on pain
- Patient request
- Intolerable side effects
- Payer or regulatory requirements

*Patients taking > 100 MME for chronic pain are **7x more likely to die** than those taking < 20 MME*

MME = morphine milligram equivalents

Pisansky AJB, et al. Opioid tapering for patients with chronic pain. In: UpToDate, Crowley M (Ed), UpToDate, Waltham, MA, 2020.

Quick MME Refresher

Sample Prescription

Norco (Hydrocodone/APAP) 10/325 mg

Take 1-2 tablets every 4-6 hours as needed

When taken around the clock, per prescribed directions = 120 MME/day

YIKES!

90 MME/Day Equals:

- 90 mg hydrocodone (9 tablets of hydrocodone 10/APAP 325 mg)
- 60 mg of oxycodone (~2 tablets of oxycodone 30 mg sustained release
- ~20 mg of methadone (4 tablets of methadone 5 mg)

Pisansky AJB, et al. Opioid tapering for patients with chronic pain. In: UpToDate, Crowley M (Ed), UpToDate, Waltham, MA, 2020.
Calculating total daily dose of opioids for safer dosage. Centers for Disease Control and Prevention. Available from: https://www.cdc.gov/drugoverdose/pdf/calculating_total_daily_dose-a.pdf. Accessed February 1, 2021.

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Opioid Conversion Calculator

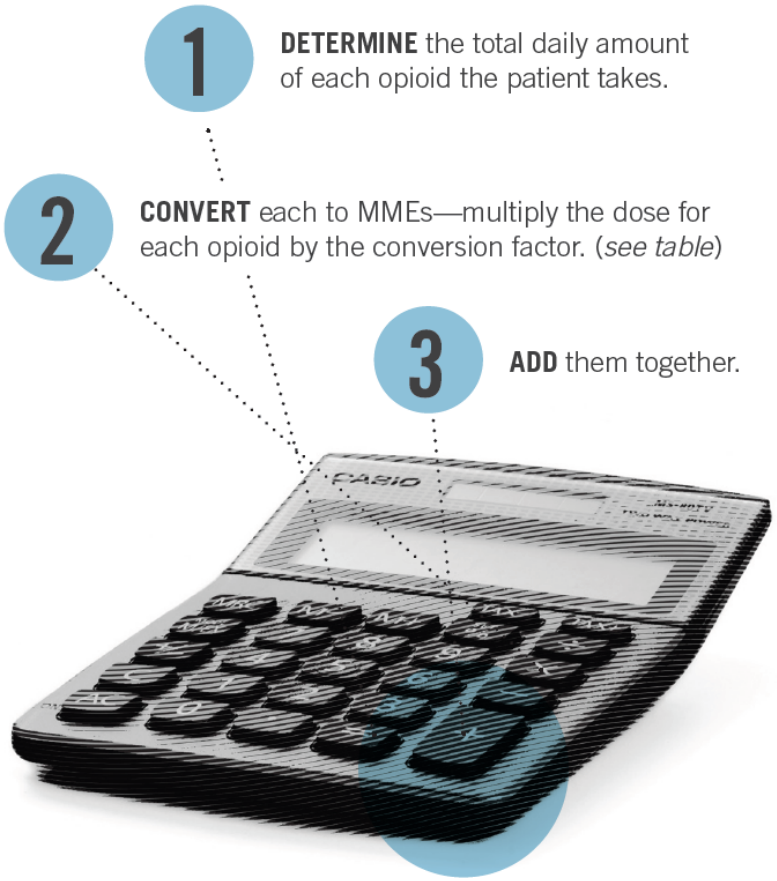
Instructions: Fill in the mg per day for the patient's opioid medications. The daily morphine equivalent dose is calculated automatically.

Opioid:	mg per day:	Morphine Equivalent Dose:
Codeine	0	0
Fentanyl transdermal (in mcg/hr)	0	0
Hydrocodone	0	0
Hydromorphone	0	0
Methadone	0	0
Morphine	0	0
Oxycodone	0	0
Oxymorphone	0	0
Tapentadol	0	0
Tramadol	0	0
	Total	**0**

Is the patient co-prescribed benzodiazepines? ○ Yes ○ No

Opioid Conversion Calculator. Oregon Pain Guidance. Available from: https://www.oregonpainguidance.org/opioidmedcalculator/. Accessed November 11, 2021.

The CDC Opioid Conversion Table



Calculating morphine milligram equivalents (MME)

OPIOID (doses in mg/day except where noted)	CONVERSION FACTOR
Codeine	0.15
Fentanyl transdermal (in mcg/hr)	2.4
Hydrocodone	1
Hydromorphone	4
Methadone	
1-20 mg/day	4
21-40 mg/day	8
41-60 mg/day	10
≥ 61-80 mg/day	12
Morphine	1
Oxycodone	1.5
Oxymorphone	3

These dose conversions are estimated and cannot account for all individual differences in genetics and pharmacokinetics.

WWW.CDC.gov

When to Taper

- > 90 MME/day for chronic non-cancer pain
- Risks > benefits
  - Functional goals of therapy not met
  - Intolerable side effects
  - Signs of opioid use disorder (OUD)
- Painful condition has resolved

Pisansky AJB, et al. Opioid tapering for patients with chronic pain. In: UpToDate, Crowley M (Ed), UpToDate, Waltham, MA, 2020.
Calculating total daily dose of opioids for safer dosage. Centers for Disease Control and Prevention. Available from: https://www.cdc.gov/drugoverdose/pdf/calculating_total_daily_dose-a.pdf. Accessed February 1, 2021.

Prior to Initiating Taper

- Screen for comorbidities that may complicate pain management and/or the taper itself
  - Mental health conditions, OUD, etc.
- Establish goals in collaboration with the patient
  - Define success
- **Offer naloxone** and communicate increased risk of overdose

Pisansky AJB, et al. Opioid tapering for patients with chronic pain. In: UpToDate, Crowley M (Ed), UpToDate, Waltham, MA, 2020.

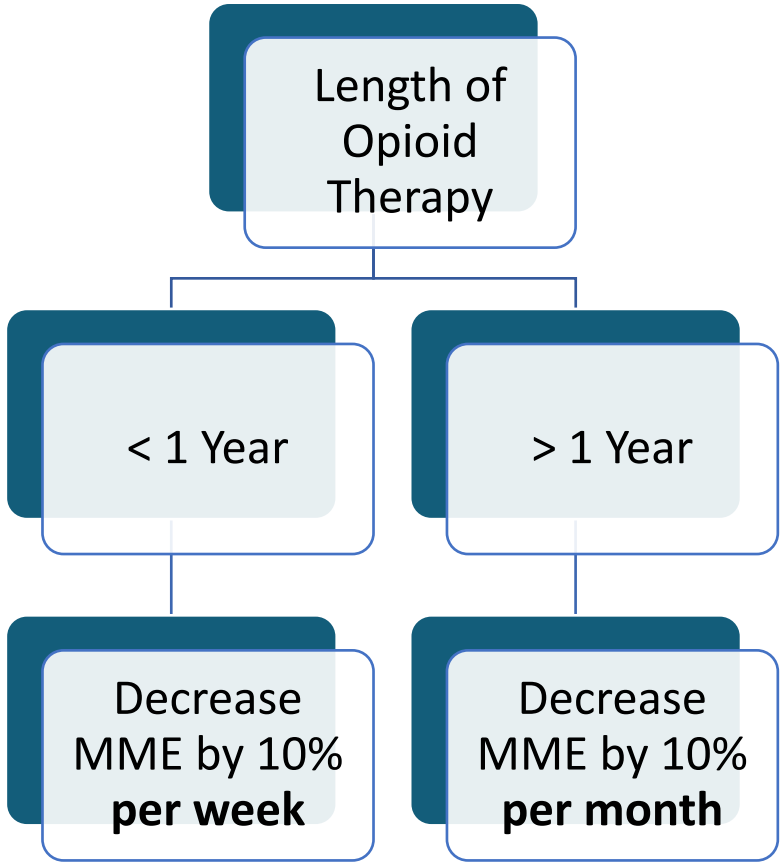
Opioid Taper - General Principals

1. Shared decision making
2. Go slow
3. Provide support
4. Don’t go backwards

Pisansky AJB, et al. Opioid tapering for patients with chronic pain. In: UpToDate, Crowley M (Ed), UpToDate, Waltham, MA, 2020.

Taper Strategy

- Approach guided by length of opioid therapy (LOT)
- Other patient-specific factors to consider:
  - Preferences
  - Safety
  - Ongoing response
- Keep moving in the right direction
- The latest CDC guideline recommend 10% monthly in most cases



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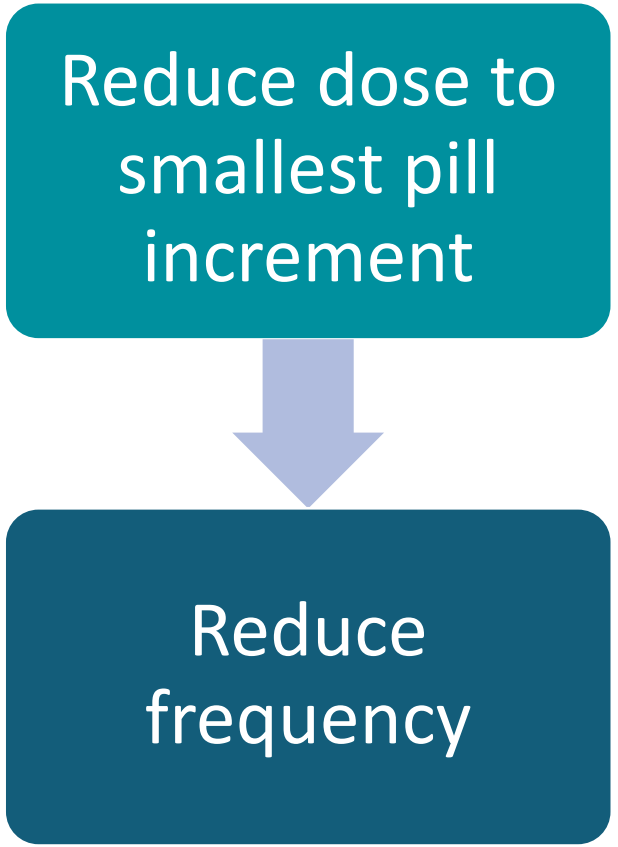
WWW.CDC.gov

Tapering Logistics

- Do not switch drug or formulation
- Taper and discontinue long-acting opioid therapy first
- Monthly (or more frequent) visits throughout the taper
- Optimize side effect management throughout
- Consider buprenorphine when appropriate



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Clinical Pearls

- For a patient who is not ready or willing (and no immediate safety concerns) – reassess quarterly
- PRN (e.g., as needed) opioids
  - Formal tapering plan not necessary
- Continuously monitor and modify the plan as needed

Pisansky AJB, et al. Opioid tapering for patients with chronic pain. In: UpToDate, Crowley M (Ed), UpToDate, Waltham, MA, 2020.

Example 1

- Morphine ER 30 mg three times daily
- Morphine IR 15 mg every 6 hours
- LOT = 2 years
- Baseline MME = 150

Getting started:

1. Reduce MME by 10% per **month** based on LOT
2. Focus on decreasing the dose of the ER product first (dose and THEN frequency)

Pisansky AJB, et al. Opioid tapering for patients with chronic pain. In: UpToDate, Crowley M (Ed), UpToDate, Waltham, MA, 2020.
Opioid Dose Calculator. Agency Medical Directors' Group. Available from:
http://www.agencymeddirectors.wa.gov/Calculator/DoseCalculator.htm. Last Updated: 2015. Accessed September 24, 2020.

Example 1:
Taper Schedule

Month	Morphine Extended-Release Dose (mg)	Morphine Immediate-Release Dose (mg)	MME Per Day	Percent Reduction
Baseline	30-30-30	15-15-15-15	150	--
1	15-30-30	15-15-15-15	135	10%
2	15-15-30	15-15-15-15	120	11%
3	15-15-15	15-15-15-15	105	13%
4	15-15	15-15-15-15	90	14%
5	15	15-15-15-15	75	17%
6	None	15-15-15	45	20%
7	None	15-15	30	33%
8	None	15	15	50%
9	None	None	0	100%

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Opioid Dose Calculator. Agency Medical Directors' Group. Available from: http://www.agencymeddirectors.wa.gov/Calculator/DoseCalculator.htm. Last Updated: 2015. Accessed September 24, 2020.

Example 2

- Norco (hydrocodone/acetaminophen) 5/325 mg 1-2 tablets by mouth every 4-6 hours as needed for pain (max 12 tablets per day)
- Patient takes 12 tablets per day
- LOT = 5 years
- Baseline MME = 60

Getting started:

1. Reduce MME by 10% per **month** based on LOT

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Opioid Dose Calculator. Agency Medical Directors' Group. Available from: http://www.agencymeddirectors.wa.gov/Calculator/DoseCalculator.htm. Last Updated: 2015. Accessed September 24, 2020.
Hydrocodone and acetaminophen. In: Lexicomp Online Database. Hudson (OH): Lexicomp Inc.: 2020.

Example 2:
Taper Schedule

Month	Hydrocodone/ Acetaminophen 5/325 mg (tablets)	MME Per Day	Percent Reduction
Baseline	12	60	--
1	11	55	8%
2	10	50	9%
3	9	45	10%
4	8	40	11%

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Opioid Dose Calculator. Agency Medical Directors' Group. Available from: http://www.agencymeddirectors.wa.gov/Calculator/DoseCalculator.htm. Last Updated: 2015. Accessed September 24, 2020.
Hydrocodone and acetaminophen. In: Lexicomp Online Database. Hudson (OH): Lexicomp Inc.: 2020.
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Naloxone for Harm Reduction

- Tapering is a vulnerable time
- Tolerance to opioid therapy can be lost very rapidly during an opioid taper
  - **As little as seven days**
- Increased risk of overdose if the patient returns to their previously prescribed dose of opioid therapy or takes illicit opioids during a taper
- Naloxone and relevant education should be prescribed for **all patients** undergoing an opioid taper

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Naloxone Access

- Prescribed naloxone
- Community pharmacy, via Michigan's naloxone standing order
- Community organizations

Opioid Resources: Naloxone. State of Michigan. Available from: https://www.michigan.gov/opioids/0,9238,7-377--480835--,00.html. Last Updated: 2020. Accessed September 23, 2020.

Withdrawal Symptoms

- Patient-specific onset, order, and severity
- Slow and gradual approach to tapering reduces the risk
- Do not reverse the taper if symptoms occur
- Management will be like treatment under other circumstances

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Image available from: https://elitetrack.com/slow-down-to-speed-up/. Accessed February 1, 2021.

Withdrawal Symptoms

Gastrointestinal Distress

Flu-Like Symptoms

Sympathetic and CNS Arousal

Other

Pisansky AJB, et al. Opioid tapering for patients with chronic pain. In: UpToDate, Crowley M (Ed), UpToDate, Waltham, MA, 2020.

Withdrawal Symptoms

General Approach

- Open communication with patient (prior to taper and throughout)
- Avoid pre-treatment
- Slow or pause the taper (do not reverse) and consider medication therapy if symptoms occur
- Refer to a specialist for a patient unable to tolerate a taper

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Managing Withdrawal Symptoms

- Alpha-2 adrenergic agonists
  - Most effectively relieve autonomic symptoms
  - Least effective for myalgias, restlessness, insomnia, and cravings

Alpha-2 Adrenergic Agonist	Typical Dosing	Notes
Clonidine	0.1-0.2 mg every 6-8 hours	• Most widely used • Monitor BP and hold if BP < 90/60
Lofexidine	0.54 mg 4 times daily (every 5 to 6 hours)	• Approved in 2018 • Equal in efficacy to clonidine • Trend towards reduced likelihood of hypotension
Tizanidine	2-4 mg every 6-8 hours as needed	• Used primarily to relieve muscle spasms during withdrawal

Lofexidine. In: Lexicomp Online Database. Hudson (OH): Lexicomp Inc.: 2020.
Pain Management Opioid Taper Decision Tool. A VA Clinician's Guide. U.S. Department of Veterans Affairs. Available from: https://www.pbm.va.gov/AcademicDetailingService/Documents/Pain_Opioid_Taper_Tool_IB_10_939_P96820.pdf. Last Updated: October 2016. Last Accessed September 28, 2020.
Pisansky AJB, et al. Opioid tapering for patients with chronic pain. In: UpToDate, Crowley M (Ed), UpToDate, Waltham, MA, 2020.
Severino KA. Medically supervised opioid withdrawal during treatment for addiction. . In: UpToDate, Saxon AJ (Ed), UpToDate, Waltham, MA, 2020.

Targeted Symptom Relief

GI Distress

Abdominal Cramps	• Dicyclomine 10-20 mg every 6-8 hours as needed (max: 160 mg/day)
Diarrhea	• Bismuth 524 mg every 30-60 minutes as needed (max: 4200 mg/day) • Loperamide 4 mg followed by 2 mg after each loose stool (max: 16 mg/day)
Nausea and Vomiting	• Ondansetron 4-8 mg every 12 hours as needed (max 16 mg/day) • Alternatives: prochlorperazine or promethazine

Sevarino KA. Medically supervised opioid withdrawal during treatment for addiction. . In: UpToDate, Saxon AJ (Ed), UpToDate, Waltham, MA, 2020.

Targeted Symptom Relief

Insomnia

- Trazodone 25-100 mg at bedtime
  - Can be titrated to 300 mg at bedtime, if needed
- Alternatives (dose at bedtime)
  - Doxepin 6-50 mg
  - Mirtazapine 7.5-15 mg
  - Quetiapine 50-100 mg
  - Zolpidem 5-10 mg (max 5 mg for female patients)

Sevarino KA. Medically supervised opioid withdrawal during treatment for addiction. . In: UpToDate, Saxon AJ (Ed), UpToDate, Waltham, MA, 2020.

Targeted Symptom Relief

Muscle Aches

- Ibuprofen 400 mg every 4-6 hours as needed (max 2400 mg/day)
- Alternatives
  - Acetaminophen
  - Ketorolac
  - Naproxen

Sevarino KA. Medically supervised opioid withdrawal during treatment for addiction. . In: UpToDate, Saxon AJ (Ed), UpToDate, Waltham, MA, 2020.

Targeted Symptom Relief

Anxiety/Restlessness

- Diphenhydramine 50-100 mg every 4-6 hours as needed (max 300 mg/day)
- Alternatives
  - Hydroxyzine
  - Clonazepam
  - Lorazepam
  - Oxazepam

Exercise caution with benzodiazepine therapy
- **Avoid if possible**
- **Short term use only**

Sevarino KA. Medically supervised opioid withdrawal during treatment for addiction. . In: UpToDate, Saxon AJ (Ed), UpToDate, Waltham, MA, 2020.

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Crucial Conversations

Today's Presenter

Eva Quirion NP, PhD
Lecturer of Nursing, The University of Maine. She has worked closely with primary care providers to improve patient safety related to chronic pain medications and other controlled substances and has become an expert at tapering chronic controlled substances with compassion.

The Art of the Difficult Conversation

ALWAYS	NEVER
• Center around the patient • Take responsibility • Be kind and patient • Be direct and honest	• Center around anyone else • Blame someone • Get emotional • Dance around the topic

Keep in Mind

- Your patient did not prescribe to themselves
- Someone told them that they NEED these medications
- Maybe YOU told them that they need this medication
- Pain and anxiety = fear
- The threat of increasing pain and anxiety = MORE fear
- People who are scared don’t always act right

Breaking the News

BEFORE

- Know your plan
- Know your rationale

DURING

- Face to face if possible
- Video conference as a minimum
- Eye contact and watch your body language

AFTER

- Reflect and ask, “what could have gone better?” and “what went well?”
- The more you do this, the better you will get

Case Study

Meet Patient X

- A 72-year-old female patient you have inherited from a trusted local provider who recently retired
- She has a PMH of rheumatoid arthritis, osteoarthritis, insomnia, Barret's Esophagus
- She has not tolerated any medications used for rheumatoid arthritis due to GI upset
- Medication list:
  - Omeprazole 20 mg daily
  - Oxycodone 30 mg x 6 pills daily (180 mg/day = 270 MME)
  - Zolpidem 10 mg every night
- She is a businesswoman with no intention of retiring and enjoys her high-stress job.
- She is divorced, has 2 sons, 1 granddaughter. She lives by herself.
- She does not use any illegal drugs, no marijuana, she drinks 2-3 glasses of wine after dinner most nights.

Case Study

Patient X is coming to her first visit

- She made the appointment urgently because she is out of her oxycodone and is requesting a refill
- This refill is 1 week early (6 x 7 = 42 pills short)
- You look back at her PDMP and she has filled several days early x 6 in the past 12 months
- She arrives for her appointment 10 minutes late and she is a very well put together elderly woman, articulate, intelligent and tells you that her pain was worse, so she took extra pain pills, but sure that she didn't take 42 pills extra. She says that maybe she has some pills in her desk at work, maybe has some pills in the pocket of her bath robe and might have some pills in her car. She tells you that she never had any issues with filling "what I need" while under the care of her previous physician.

Now what???!!!

- Stop and take a moment to think about this.
- What are your concerns? Prioritize your concerns.
- Consider your style of care with your patients.
- How comfortable are you with conflict?
- How do you think this patient would want you to communicate with her?
- How do you preserve her dignity and autonomy while addressing your concerns?

The Conversation

- The **ENTIRE** conversation should be framed around the patient and their safety
- Do not say: “I am not comfortable…” or “the law says…” or “there is an epidemic…”
- Do say: “I will walk beside you.” “I will work with you to treat your discomfort in other and sustainable ways.”

REFRAMING

The purpose of the medications

"You no longer take XYZ medication for pain/anxiety, you are taking it to avoid being sick while we taper."

Normalize body sensations

"Many people feel anxious, have trouble sleeping, feel achy. These things are normal and will regulate in time. This is NOT your new baseline."

Planning the Taper

- Why are you tapering?
  - If the taper is due to a medication agreement issue or immediate safety concern – taper faster
  - If the taper is for the long-term health in someone who is not yet having problems – you can go slower
- Have it figured out
  - But be flexible
- No surprises
  - Be sure that your patient knows what the NEXT refill will be before they leave you

The Cast of Characters

The Negotiator

The Sad Face

The Angry Bird

The Eager Beavers

The Inheritance

The Negotiator

The Negotiator

- There are patients who will think of every reason they need to stay on the medication that is being tapered
- Some will tell you they don't care if they die
- Some will tell you that they will start buying opioids on the street
- Some will tell you that they will start drinking again
- Some will offer veiled or overt threats of suicide
  - This is called **non-reassuring behavior**

"I care about you and do not want to see you harmed."

"We do not treat suicidal thoughts with opioids."

The Sad Face

The Sad Face

- This is a breech of trust to the patient
- Some feel like they are being punished, “I have done everything you told me to do.”
- “I thought you were different. I thought I could trust you.”
- There could be tears
- Disbelief
- They think that you might not understand how much they hurt. “But I have BULGING disks!”

“I care about you, and I will help you find sustainable ways to help you manage your pain/anxiety.”

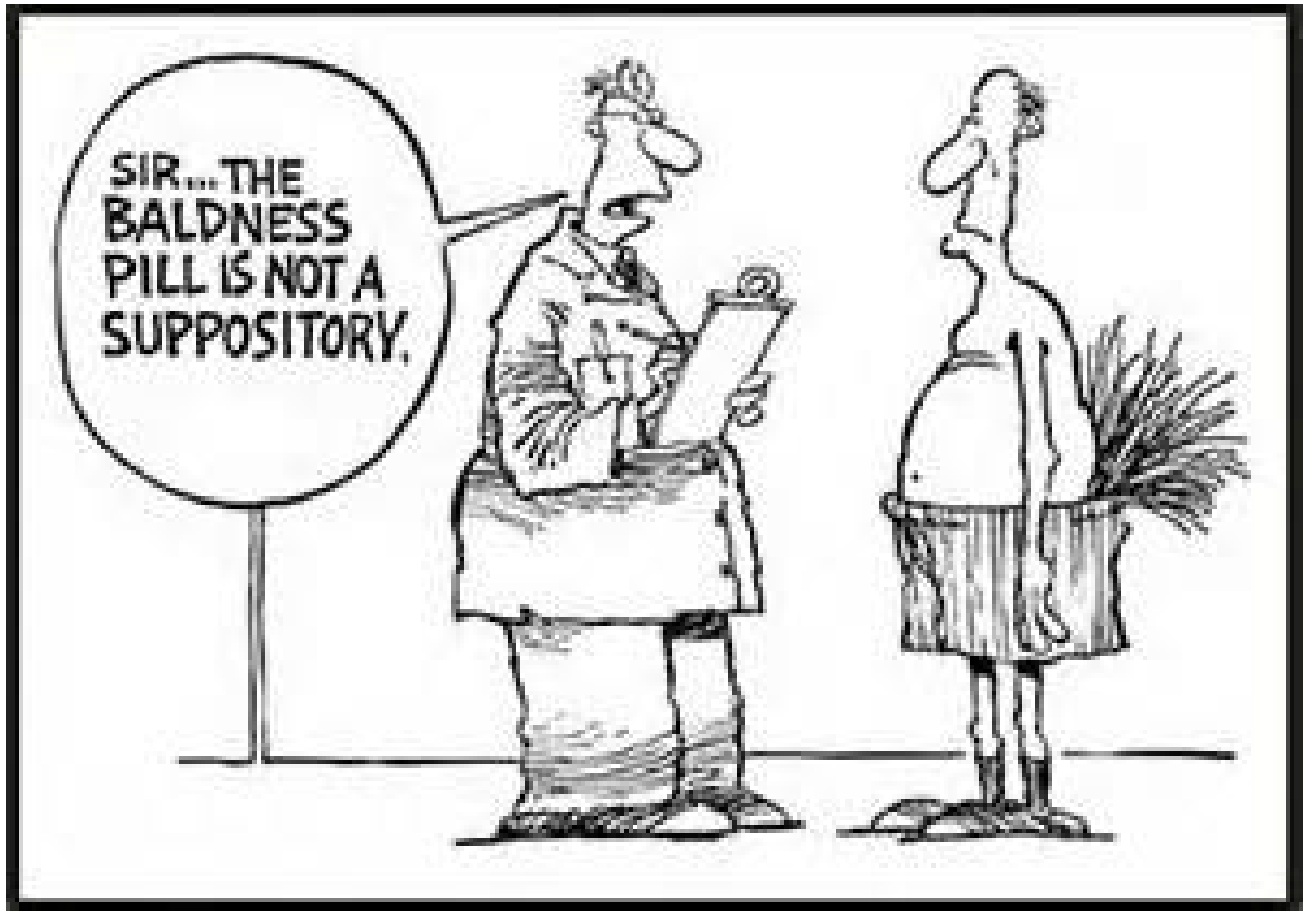
“I don’t want to put you on any medication that I might have to take away as you age.”

The Angry Bird

The Angry Bird

- Again, some feel betrayed and may get angry at you for this clinical decision.
- Agree that it's OK for a provider and patient to disagree on a clinical decision, but both the patient and provider should agree to be respectful.
- Remind the patient that the decision is made to improve medication safety.
- Do NOT take the anger personally.
- If you encounter abusive behavior, redirection and defusing is best. "It's OK for you to be angry, but you do not have permission to yell at staff."
- Offer reassurance again and again! Be very direct and speak plainly. This person probably has a history of trauma.

The Eager Beavers



The Eager Beavers

- Surprisingly, some patients are happy to think about being free from controlled medications.
- “Chemical cuffs.”
- They are excited
- Caution them to not get too far ahead of the taper or they may unintentionally sabotage their own efforts.
- Opioid withdrawal is uncomfortable, but not life threatening.
- Benzo withdrawal can be life threatening.

The Inheritance

The Inheritance

- May have abandonment issues.
- May have hero worship for their previous provider.
- DO NOT just continue with someone else's plan as a matter of routine.
- Explain to patients that you will be different than their previous provider and that you plan to help them through any changes.

"I think your doctor/NP/PA was a wonderful provider, we just do things differently."

"I don't' think that this medication is helping you as much as we would like for something so high risk."

"I am sure that all your providers have treated you with the desire to help."

Rules of the Road

- NO early refills
- If a patient is going to go without opioids for a few days and will withdraw…
- DO NOT REFILL in order to continue the taper
- Provide comfort medications
- If the patient will withdraw from benzodiazepines, they may need inpatient detox
- You can also shorten the # of pills they get and they would have to fill every couple of days

Tidbits

- NEVER reverse your taper
- The majority of your patients will do just as well
- Pain and anxiety generally regulates, remember the canoe
- Much of the time … they do BETTER
- “I thought I had Alzheimer’s, turns out I was just medicated.”
- “I thought you were crazy to take me off these medications, I can’t believe I’m better!”
- “I didn’t realize how benzos made me irritable.”
- Look for the positives and highlight functional gains, there will be some

FINAL THOUGHTS

- Work to gather a team around your patient
- Be sure that all treatments are exhausted
- Work with your patient in the spirit of “lifestyle medicine.”
- Anti-inflammatory diet, yoga, exercise, weight loss, stop smoking
- CBT, biofeedback, acupuncture, counseling, massage, chiro, OMT, PT
- Restore the spirit, the personality, the relationships
- Pills DO NOT = compassion
- Compassion = compassion
- Teach your patient how to find joy

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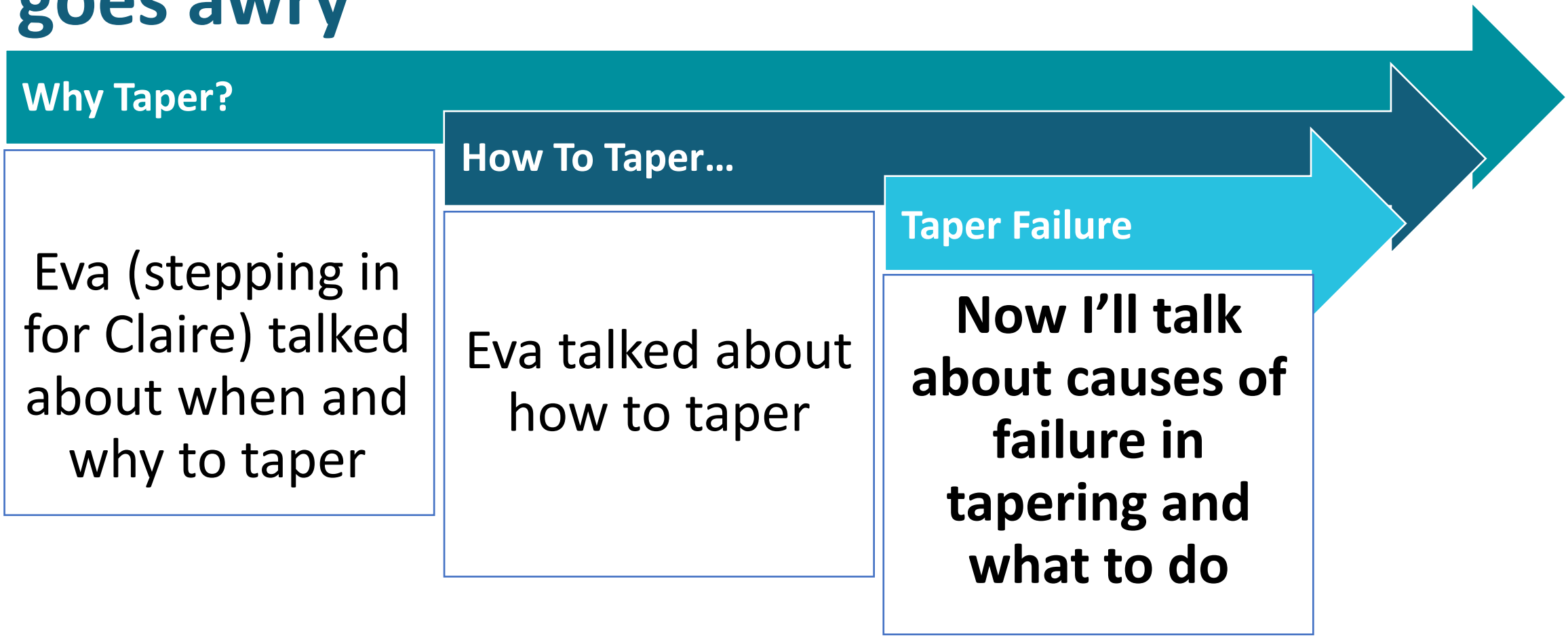
Tapering Difficulties

Today's Presenter

Glenn V. Dregansky, DO FAAFP
Assistant Professor, Department of Community and Family Medicine at WMU Homer Stryker MD School of Medicine.
Diplomate ABPM, Addiction Medicine

Things to consider when tapering goes awry



When things go awry

- The number one cause of failure to taper is undiagnosed opioid use disorder (OUD)
- Claire talked about screening before starting a taper plan
- How is that accomplished?

The second most common cause of tapering failure is communication which Eva covered already

When things go awry

Screening for OUD

- There are excellent methods for screening for OUD so we need not reinvent the wheel

Screening needs to be normalized

- Similar to the PHQ-2

SUD or High Risk Behavior?

- How are you going to know if you are dealing with early SUD or high- risk behavior?
- If you never look for it, you will only find the most egregious cases of SUD, or rather, they will find you.
- There are validated tools that practitioners can use to screen for high- risk use and SUD. The purpose of this portion of the workshop is to familiarize you with those tools and give you a framework to include screening in your everyday practice.

What we need to remember is that 35-50% of patients receiving chronic opioids have undiagnosed OUD

They meet DSM 5 criteria for OUD

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One validated method for screening, intervening and referring for treatment, when necessary is SBIRT

What is SBIRT?

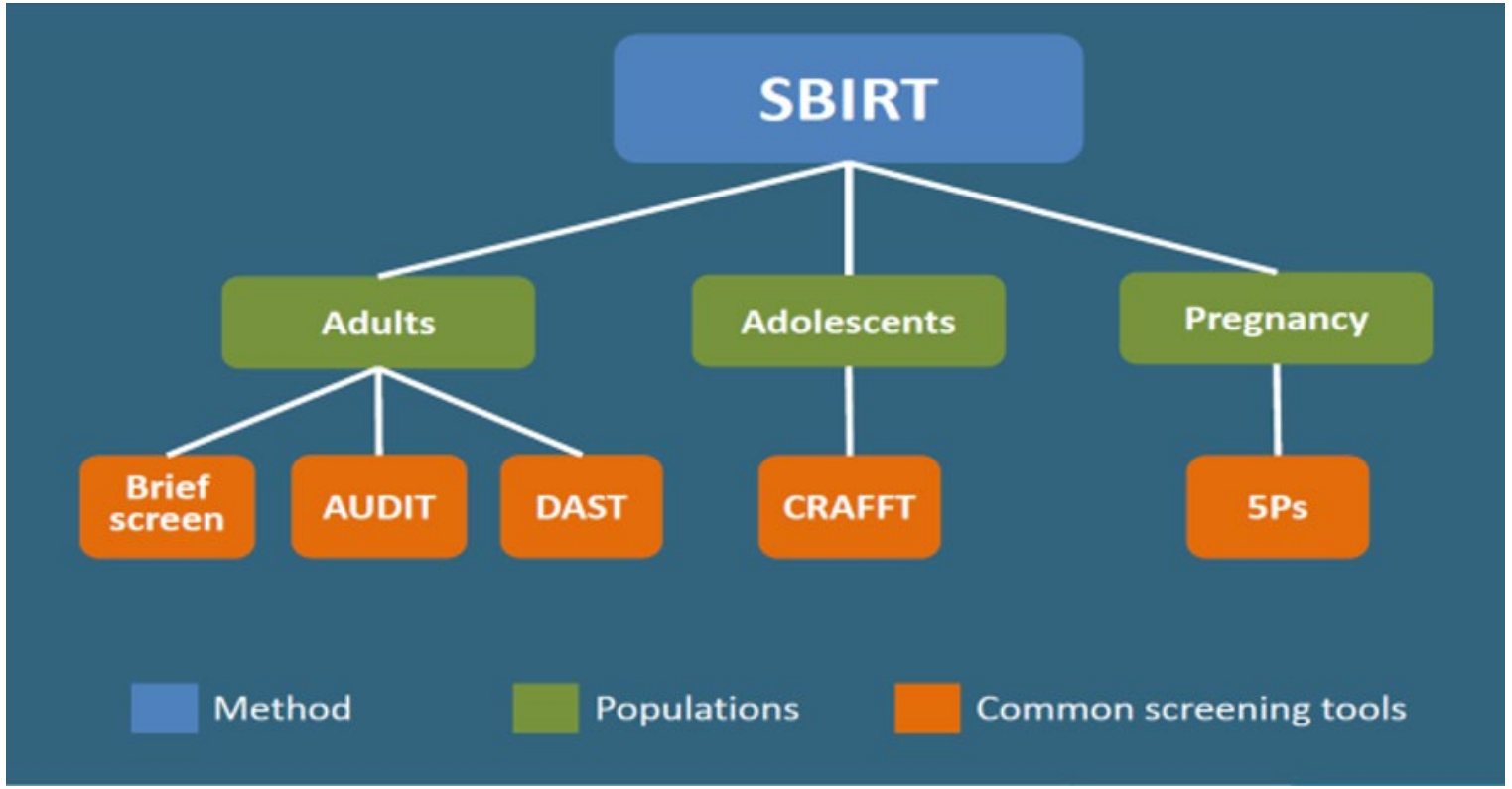
Screening

Brief Intervention

Referral to Treatment

"A public health approach to the delivery of early intervention and treatment services for people with substance use disorders and those at risk of developing these disorders."

SBIRT Common Terms

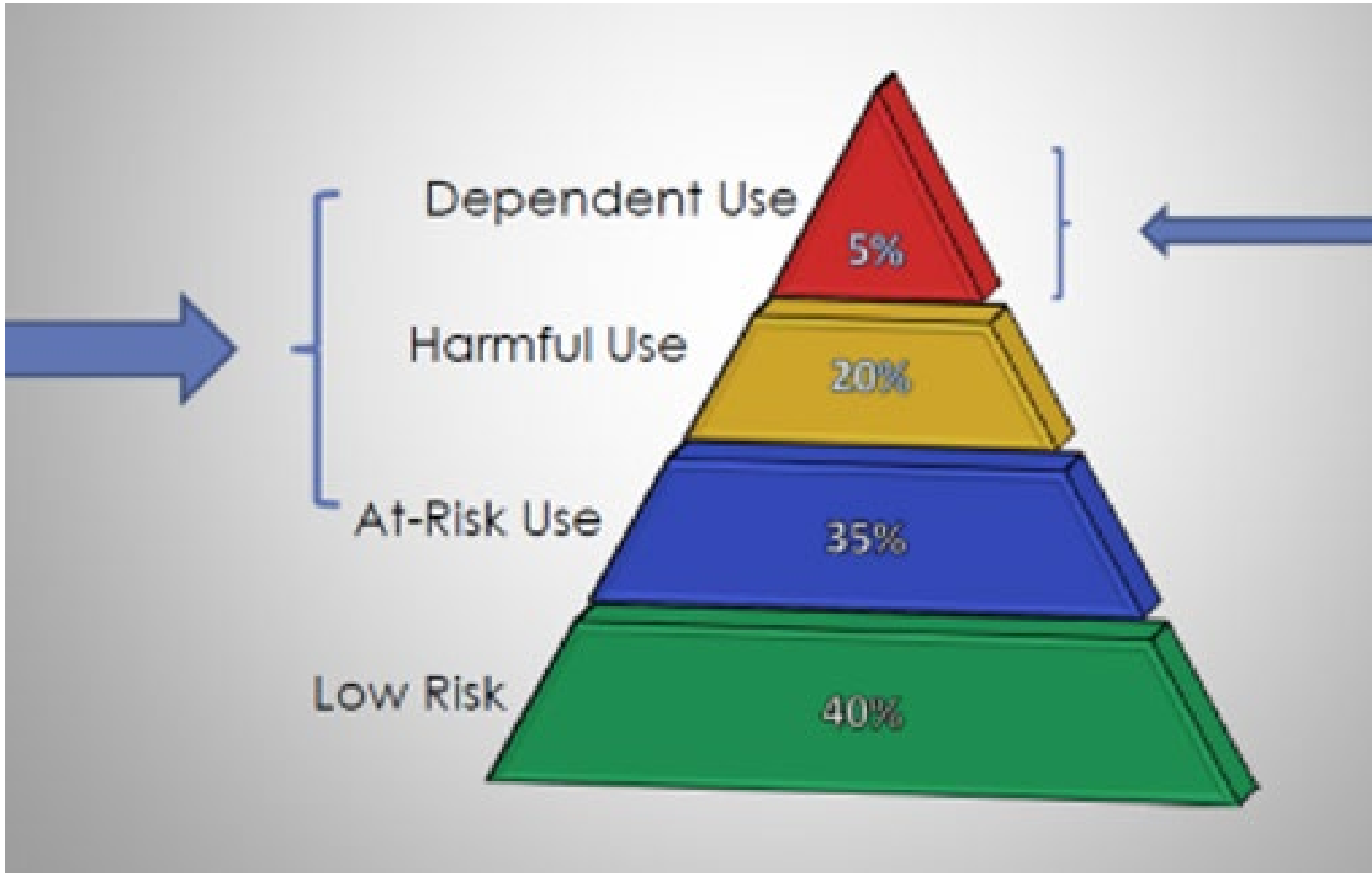


SBIRT

Historic Response to Substance Abuse

- Previously substance use intervention and treatment focused primarily on substance abuse universal prevention strategies and on specialized treatment services for those who met the abuse and dependence criteria.
- There was a significant gap in service systems for at-risk populations.

The Shift in Focus



SBIRT

Levels of Alcohol/Drug Conditions

- **Dependence** – a cluster of behavioral, cognitive, and physiological symptoms that develop after repeated use (addicts, alcoholics)
- **Harmful Use** – use causes some harm (physical / mental / social)
- **Hazardous Use** – use causes elevated risk (no harm **yet**)

SBIRT is Proven to Work in Alcohol and Data Suggests it also Works in Drug Use

Research Demonstrates Effectiveness

- A growing body of evidence about SBIRT's effectiveness – including cost-effectiveness – has demonstrated its positive outcomes.

- The research shows that SBIRT is an effective way to reduce drinking and substance abuse problems.

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Screening Tools

Why Use Them?

- Asking / answering questions is normal and expected.
- Adding questions on alcohol drub use normalizes the conversation.
- Self-report screening is quick, accurate, and inexpensive.
- May be combined with screening for tobacco, other health risk factors.

Screening Tools

- Many written and electronic screening tools exist
  - Check your EHR or create (steal) an electronic screening form
- Prescreen with one question tools either before the appointment or after rooming
  - Support staff can give the screening
  - This is analogous to the way we use PHQ-2 and PHQ-9 in primary care
- Screening should be part of an annual wellness visit, new patient visit, or sports physical for adolescents.
  - Never pass up an opportunity to screen
  - You will be amazed how much alcohol and drug risky behavior or use disorder you will uncover
  - Or you can live in the delusion that SUB and risky use don't exist in your practice.

Brief Health Screen

Brief health screen

We ask all our adult patients about substance use and mood because these factors can affect your health. Please ask your doctor if you have any questions. Your answers on this form will remain confidential.

Patient name: _____

Date of birth: _____

Alcohol: One drink =  12 oz. beer  5 oz. wine  1.5 oz. liquor (one shot)

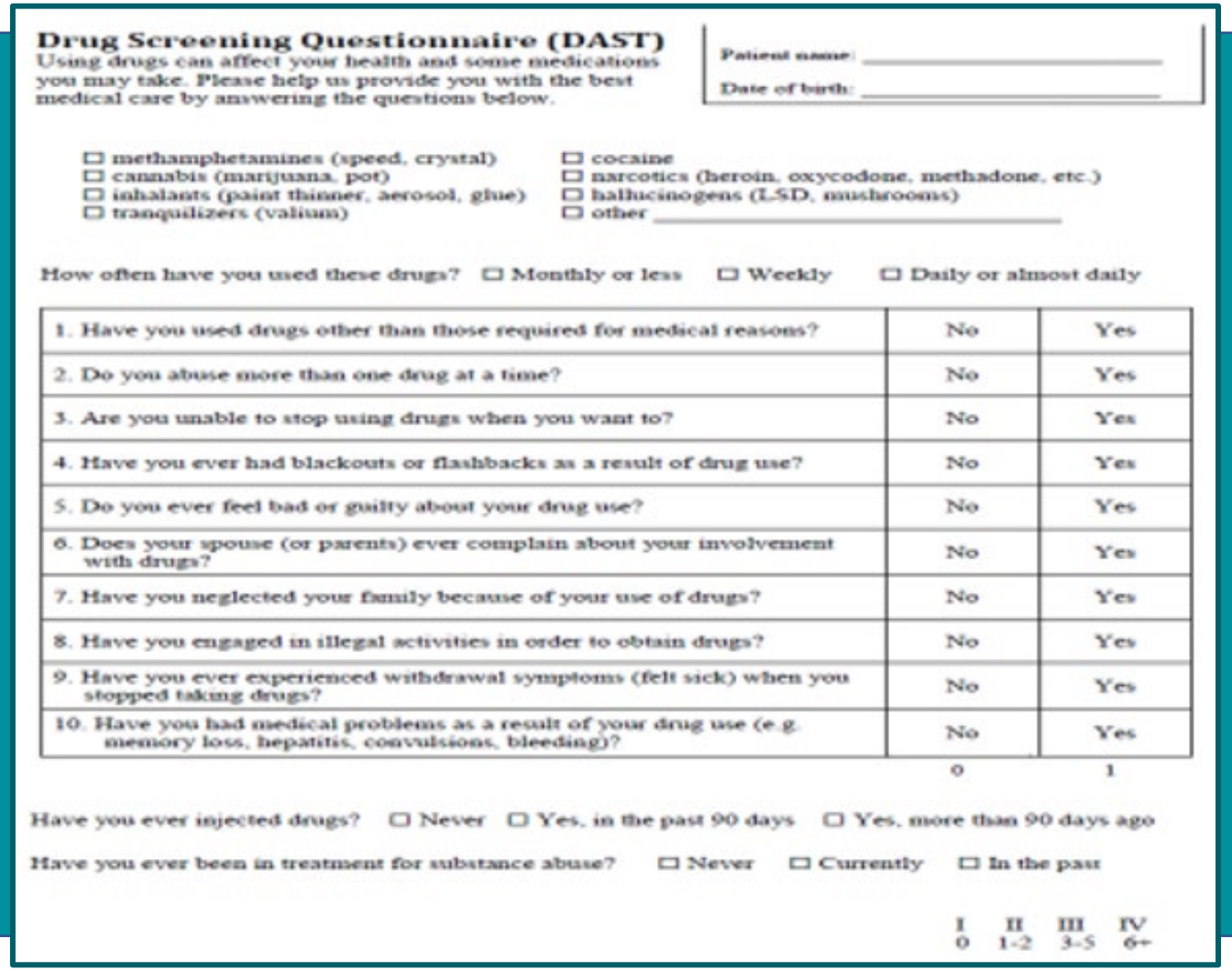
	None	1 or more
MEN: How many times in the past year have you had 5 or more drinks in a day?	○	○
WOMEN: How many times in the past year have you had 4 or more drinks in a day?	○	○

Drugs: Recreational drugs include methamphetamines (speed, crystal) cannabis (marijuana, pot), inhalants (paint thinner, aerosol, glue), tranquilizers (Valium), barbiturates, cocaine, ecstasy, hallucinogens (LSD, mushrooms), or narcotics (heroin).

	None	1 or more
How many times in the past year have you used a recreational drug or used a prescription medication for non-medical reasons?	○	○

Mood:	No	Yes
During the past two weeks, have you been bothered by little interest or pleasure in doing things?	○	○
During the past two weeks, have you been bothered by feeling down, depressed, or hopeless?	○	○

Drug Screening Questionnaire (DAST)



Drug Screening Questionnaire (DAST)

Using drugs can affect your health and some medications you may take. Please help us provide you with the best medical care by answering the questions below.

Patient name: _____

Date of birth: _____

- ☐ methamphetamines (speed, crystal)
- ☐ cannabis (marijuana, pot)
- ☐ inhalants (paint thinner, aerosol, glue)
- ☐ tranquilizers (valium)
- ☐ cocaine
- ☐ narcotics (heroin, oxycodone, methadone, etc.)
- ☐ hallucinogens (LSD, mushrooms)
- ☐ other _____

How often have you used these drugs? ☐ Monthly or less ☐ Weekly ☐ Daily or almost daily

1. Have you used drugs other than those required for medical reasons?	No	Yes
2. Do you abuse more than one drug at a time?	No	Yes
3. Are you unable to stop using drugs when you want to?	No	Yes
4. Have you ever had blackouts or flashbacks as a result of drug use?	No	Yes
5. Do you ever feel bad or guilty about your drug use?	No	Yes
6. Does your spouse (or parents) ever complain about your involvement with drugs?	No	Yes
7. Have you neglected your family because of your use of drugs?	No	Yes
8. Have you engaged in illegal activities in order to obtain drugs?	No	Yes
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	No	Yes
10. Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding)?	No	Yes
	0	1

Have you ever injected drugs? ☐ Never ☐ Yes, in the past 90 days ☐ Yes, more than 90 days ago

Have you ever been in treatment for substance abuse? ☐ Never ☐ Currently ☐ In the past

I	II	III	IV
0	1-2	3-5	6+

DAST Scoring

(For the health professional)

Scoring and interpreting the DAST:

"Yes" responses receive one point each and are added for a total score. The score correlates with a zone of use that can be circled on the bottom right corner of the page.

Score	Zone of use	Indicated action
0	I – Healthy (no risk of related health problems)	None
1 - 2, plus the following criteria: No daily use of any substance; no weekly use of drugs other than cannabis; no injection drug use in the past 3 months; not currently in treatment.	II – Risky (risk of health problems related to drug use)	Offer advice on the benefits of abstaining from drug use. Monitor and reassess at next visit. Provide educational materials.
1 - 2 (without meeting criteria)		Brief intervention
3 - 5	III – Harmful (risk of health problems related to drug use and a possible mild or moderate substance use disorder)	Brief intervention or Referral to specialized treatment
6+	IV – Severe (risk of health problems related to drug use and a possible moderate or severe substance use disorder)	Referral to specialized treatment

Brief intervention: Patient-centered discussion that employs Motivational Interviewing concepts to raise an individual's awareness of his/her substance use and enhancing his/her motivation towards behavioral change. Brief interventions are typically performed in 5-15 minutes, and should occur in the same session as screening. The recommended behavior change is to abstain from illicit drug use.

Patients with numerous or serious negative consequences from their substance use, or patients with likely dependence who cannot or will not obtain conventional specialized treatment, should receive more numerous and intensive interventions with follow up.

Referral to specialized treatment: A proactive process that facilitates access to specialized care for individuals who have been assessed to have substance use dependence. These patients are referred to drug treatment experts for more definitive, in-depth assessment and, if warranted, treatment. The recommended behavior change is to abstain from use and accept the referral.

More resources: www.sbirtoregon.org

Let's now consider what to do when you find undiagnosed OUD

- First, tapering likely will fail
  - The discussion must shift from chronic pain and opioids to OUD
  - This often generates anger and hostility from patients
  - Remember, people with OUD typically have strong defenses used to justify what any reasonable person would consider insanity
  - I like to start by staying in a position of inquiry
    - What do the pills do that is positive?
    - Do you see any harmful effects?
  - Assess the patient's readiness to stop using and enter treatment
  - Most primary care practitioners refer patients for treatment for OUD but it can be managed in most primary care settings
  - What are the treatment options?

Treatment options for OUD

- Most do not need inpatient rehab
- Most would benefit from medications for opioid use disorder (MOUD) but less than a third receive MOUD
  - Access is a huge problem especially for economically challenged patients
  - Less than 30% of people who meet DSM 5 criteria for OUD receive treatment
- MOUD has several flavors
  - Suboxone
  - Methadone
  - Naltrexone (Vivitrol)
  - All these meds have a role in treating OUD

Know the Options for OUD Treatment

MI-CCSI
Center for Clinical Systems Improvement

- **Private practitioners**
- **Clinics**
- **Rehab facilities**
- **CMH**

References:

Amaro, H., Reed, E., Rowe, E., Picci, J., Mantella, P., et al. (2010). Brief screening and intervention for alcohol and drug use in a college student health clinic: Feasibility, implementation, and outcomes. *Journal of American College Health, 58*(4), 357–364.

Babor, T. F., McRee, B. G., Kassebaum, P. A., Grimaldi, P. L., Ahmed, K., & Bray, J. (2007). Screening, Brief Intervention, and Referral to Treatment (SBIRT): Toward a public health approach to the management of substance abuse. *Substance Abuse*, *28*(3), 7–30.

Bertholet, N., Daeppen, J.-B., Wietlisbach, V., Fleming, M., & Burnand, B. (2005). Reduction of alcohol consumption by brief alcohol intervention in primary care: systematic review and meta-analysis. *Archives of Internal Medicine* 165, 986–995.

Bradley, K. A., DeBenedetti, A. F., Volk, R. J., Williams, E. C., Frank, D., & Kivlahan, D. R. (2007). AUDIT-C as a brief screen for alcohol misuse in primary care. *Alcoholism, Clinical and Experimental Research*, *31,* 1208–1217.

Kaner, E. F., Dickinson, H. O., Beyer, F., Pienaar, E., Schlesinger, C., & Campbell, F., et al. (2009). The effectiveness of brief alcohol interventions in primary care settings: A systematic review. Drug and Alcohol Review, 28(3), 301–323.

Levy, S., & Knight, J. R. (2008). Screening, brief intervention, and referral to treatment for adolescents. Journal of Addiction Medicine, 2(4), 215–221

National Institute on Alcohol Abuse and Alcoholism (NIAAA). (2005a). Alcohol alert number 66: Brief interventions. Rockville, MD: U.S. Department of Health and Human Services, National Institute on Alcohol Abuse and Alcoholism. Retrieved June 4, 2010 from http://pubs.niaaa.nih.gov/publications/AA66/AA66.pdf.

U.S. Preventive Services Task Force (USPSTF). (2004). Screening and behavioral counseling interventions in primary care to reduce alcohol misuse: Recommendation statement. Annals of Internal Medicine, 140(7), 554-556.

Substance Abuse and Mental Health Services Administration (2011). Screening, Brief Intervention and Referral to Treatment (SBIRT) in Behavioral Healthcare. Available at: www.samhsa.gov/prevention/sbirt/SBIRTwhitepaper.pdf

Questions?