Opioids and Me: “The Long and Winding Road”

John P. McGovern Award Lectureship, AMERSA 2019

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Disclosure of Financial Relationships

Daniel P. Alford, MD, MPH

- I am the course director for a safer opioid prescribing CME program (SCOPE of Pain) funded by an unrestricted educational grant awarded to Boston University by the REMS Program Companies as part of the FDA Opioid REMS program.

- I do not receive any direct compensation from industry for this or any activity.
A significant case…

- 29 yo female on methadone 70 mg per day would like to taper off
- OUD hx: prescription opioids at age 14 followed by IV heroin at age 16
- Age 24 presented to an ED with fever, ruled out for endocarditis
- ED provider arranged for treatment in an opioid treatment program
- On methadone maintenance she remained abstinent from opioid use and was adherent with counseling
A significant case (continued):

- From an upper middle class family living in the suburbs
- No family history of addiction
- Completed high school after dropping out
- Married with one son
- Remained on methadone treatment for 5 years despite her family stating that she was “substituting one drug for another”
- Attended NA and was told that she was not “clean” since she was taking methadone
- Now wants to taper off methadone ASAP

What would be your recommendation for her?
Opioid Use Disorders
1996

Boston Medical Center
Inpatient protocol for managing opioid withdrawal
(faded mimeograph at the nurses stations)

• Heroin : methadone conversion
• Don’t tell patients how much methadone you are giving them
### Pain and OUD: Clinician and Patient Perspectives

<table>
<thead>
<tr>
<th>Clinician Theme</th>
<th>Provider fear of deception - Physicians question the “legitimacy” of need for opioid analgesics (“drug seeking” vs. legitimate need)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Themes</td>
<td>No standard approach - The evaluation and treatment of pain and withdrawal is extremely variable among physicians and from patient to patient</td>
</tr>
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<td></td>
<td>Avoidance - Physicians focused primarily on familiar acute medical problems and evaded more uncertain areas of assessing or intervening in the underlying addiction problem-particularly issues of pain and withdrawal</td>
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<td>Patients fear of mistreatment - Patients are fearful they will be punished for their drug use by poor medical care</td>
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We have made a lot of progress...
“Do you want to become the medical director of the Boston Public Health Commission’s Narcotic Addiction Clinic?” “Try it for a year if you don’t like it you can do something else.”

Pay attention to what stands out and write about it.
Current policy, in the committee's view, puts too much emphasis on protecting society from methadone, and not enough on protecting society from the epidemics of addiction, violence, and infectious diseases that methadone can help reduce.
A Medical Treatment for Diacetylmorphine (Heroin) Addiction

A Clinical Trial With Methadone Hydrochloride

Vincent P. Dole, MD, and Marie Nyswander, MD

A group of 22 patients, previously addicted to diacetylmorphine (heroin), have been stabilized with oral methadone hydrochloride. This medication appears to have two useful effects: (1) relief of narcotic hunger, and (2) induction of sufficient tolerance to block the euphoric effect of an average illegal dose of diacetylmorphine. With this medication, and a comprehensive program of rehabilitation, patients have shown marked improvement; they have returned to school, obtained jobs, and have become reconciled with their families. Medical and psychiatric tests have disclosed no signs of toxicity, apart from constipation. This treatment requires careful medical supervision and many social services. In our opinion, both the medication and the supporting program are essential.

ough review of evidence available in 1957, concluded that “The advisability of establishing clinics or some equivalent system to dispense opiates to addicts cannot be settled on the basis of objective facts. Any position taken is necessarily based in part on opinion, and on this question opinions are divided.” With respect to previous trials of maintenance treatment, the Council found that “Assessment of the operations of the narcotic dispensaries between 1919 and 1923 is difficult because of the paucity of published material. Much of the small amount of data that is available is not sufficiently objective to be of great value in formulating any clear-cut opinion of the purpose of the clinics, the way in which they operated, or the results attained.” No new studies bearing on the question
Issues in Maintenance:

HOW MUCH?

&

HOW LONG?

How Long Does OAT Last?

Long Enough!!

... As long as patient desires and benefits from continued treatment

How Much?

ENOUGH!!
Stigma

Lessons Learned

• “I don’t believe in methadone”

• Response: It is not a religion

• Which patients do hospital, law enforcement, criminal justice system personnel see?

• Answer: The individuals not doing well…there are no methadone pride parades

• George and the liver transplant
What stood out for me?

A 29-year-old woman reported severe right arm pain after fracturing her olecranon process. She had a history of injection heroin use and received methadone, 90 mg/d, in a methadone maintenance program. In the emergency department, she had a tender, swollen, intramuscular, site, and the patient was in obvious pain. She described the pain as constant.

**Annals of Internal Medicine**

**Perspective**

**Acute Pain Management for Patients Receiving Maintenance Methadone or Buprenorphine Therapy**

Daniel P. Alford, MD, MPH; Peggy Compton, RN, PhD; and Jeffrey H. Samet, MD, MA, MPH

More patients with opioid addiction are receiving opioid agonist therapy (OAT) with methadone and buprenorphine. As a result, physicians will more frequently encounter patients receiving OAT who develop acutely painful conditions, requiring effective treatment strategies. Undertreatment of acute pain is suboptimal medical treatment, and patients receiving long-term OAT are at particular risk. This paper acknowledges the complex interplay among addictive disease, OAT, and acute pain management and describes 4 common misconceptions resulting in suboptimal treatment of acute pain. Clinical recommendations for providing analgesia for patients with acute pain who are receiving OAT are presented. Although challenging, acute pain in patients receiving this type of therapy can effectively be managed.

For author affiliations, see end of text.
Drug Addiction Treatment Act of 2000

Our 1st patient 2003

- Call on Sun PM from a friend of a friend regarding her 19 yo daughter
  - heroin use (IN→IV) for 2 years
  - In bed in acute withdrawal after detox
  - Completed 6 detoxes in the past 12 months
  - Dropped out of Berklee School of Music
- Started her on MOUD in primary care the next morning!!!!!!!!!
- Maintained on buprenorphine
- Graduated from Berklee School of Music w/ honors
- Moved to NYC and remains in long-term recovery for 16 years...
Will there be enough work?

Treating Homeless Opioid Dependent Patients with Buprenorphine in an Office-Based Setting

Daniel P. Alford, MD, MPH1,2,3, Colleen T. LaBelle1,3, Jessica M. Richardson1, James J. O’Connell, MD4, Carole A. Hohl, MHS4, Debbie M. Cheng, ScD1,5, and Jeffrey H. Samet, MD, MA, MPH1,2,6

Collaborative Care of Opioid-Addicted Patients in Primary Care Using Buprenorphine

Five-Year Experience

Daniel P. Alford, MD, MPH; Colleen T. LaBelle, RN; Natalie Kretsch, BA; Alexis Bergeron, MPH, LCSW; Michael Winter, MPH; Michael Botticelli, MEd; Jeffrey H. Samet, MD, MA, MPH

Office-Based Opioid Treatment with Buprenorphine (OBOT-B): State-wide Implementation of the Massachusetts Collaborative Care Model in Community Health Centers

Colleen T. LaBelle, B.S.N., R.N.-B.C., C.A.R.N. a,b,*, Steve Choongheon Han, B.A. b, Alexis Bergeron, M.P.H. L.C.S.W. a, Jeffrey H. Samet, M.D., M.A., M.P.H. a,b,c
% DATA Waivered by Profession

<table>
<thead>
<tr>
<th></th>
<th>All MD/DO</th>
<th>PCP</th>
<th>NP</th>
<th>PA</th>
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<tr>
<td>Waivered</td>
<td>57,152</td>
<td>57,152</td>
<td>13,124</td>
<td>3,454</td>
</tr>
<tr>
<td>Total</td>
<td>951,061</td>
<td>456,389</td>
<td>164,794</td>
<td>88,006</td>
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</table>
Dr. P was reluctant to obtain a waiver to prescribe buprenorphine for the treatment of OUD until her patient (Ms. L) with longstanding OUD died from a fatal opioid overdose…

• “Caring for these patients has become the most meaningful part of my practice.”

• “Providing some sense of normalcy for patients whose lives are roiled by overdose and estrangement is the most profound therapeutic intervention I’ve engaged in as a caregiver.”

• “I did not know what Ms. L. meant all those years ago when she said that she only wished to feel normal again. I wish that I’d listened more closely. I wish that I had not been afraid.”
An accomplishment resulting in the greatest number of email congrats...

The New York Times

Tuesday, July 12, 2011   Last Update: 1:35 PM ET

QUOTATION OF THE DAY

"It's not surprising to us now that when you stop the treatment, people relapse. It doesn't mean that the treatment doesn't work, it just means that you need to continue treatment."

DR. DANIEL ALFORD, on the limits of brief rehabilitation programs in treating addiction.
Some exciting new developments…

- MOUD for incarcerated individuals and linkage upon release
- MOUD for individuals in long-term care (SNFs) facilities
- Expansion of clinicians able to become waivered to prescribe buprenorphine for MOUD
- Extended release formulations for MOUD
- Starting patients with MOUD in the ED and inpatient service
- Urgent care for starting on MOUD and linking to long-term care
- Addiction consultation services
- Harm reduction strategies
A naïve question with an important lesson…

A conversation in July 1996 with a young man requesting methadone for his addiction to Percocet which were prescribed long-term after a rotator cuff injury and multiple shoulder surgeries…

Dr. Alford:

“How can I prevent addiction in my primary care patients who suffer from pain?”

Patient:

“Don’t ever prescribe percocets.”
Safer Opioid Prescribing for Pain
A Rocky Start in 1998

• I was invited to give my first Grand Rounds presentation on the use of opioids to treat chronic pain at the Bedford VA…

• My talk was going to focus on promoting a balanced approach to safer use of opioids…

• While being escorted, down a very long hallway to the auditorium, the chair of medicine told me how excited he was that someone (me) was finally going to tell his doctors to stop prescribing opioids…
Is the patients pain real if I can see it?

Woolf CJ. *Lancet* 1999
Acute versus Chronic Pain

**Acute Pain**
*Life sustaining symptom*

- **Adaptive** by eliciting motivation to minimize harm and allow healing

**Chronic Pain**
*Can be a disease in itself*

- **Maladaptive**, pathologic, disorder of the somatosensory pain signaling pathways influenced by genetic and epigenetic factors

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Dzau VJ, Pizzo PA. *JAMA*. 2014
The Tragedy of Needless Pain

Contrary to popular belief, the author says, morphine taken solely to control pain is not addictive. Yet patients worldwide continue to be undertreated and to suffer unnecessary agony.

by Ronald Melzack

JCAHO Pain Management Standards Are Unveiled

Donald M. Phillips on health care organizations. With the release of the National Consensus Conference on Pain Management in 1994, a high level of interest and activity was generated in the pain management arena.

BARRIERS TO PAIN CONTROL

Perry G. Fine, MD, professor of anesthesiology at the University of Utah School of Medicine and associate medical director of the Pain Management Center in Salt Lake City, summarized the shortcomings of current pain control. He said there were common barriers to effective pain control.

Patient Satisfaction, Prescription Drug Abuse, and Potential Unintended Consequences

Aleksandra Zgierska, MD, PhD
Michael Miller, MD
David Rabago, MD

haviors. Medical quality committees and even licensure boards can determine that care is substandard if clinicians exclude these components. Before prescribers may be expected to recommend

Mularski RA et al.
J Gen Intern Med 2006

JAMA 2000

Pain the 5th Vital Sign

• Pain levels documented more often (82% vs 31%)
• Quality of care unchanged before and after pain initiative

JAMA 2012
Opiophobia in the 1980s

American Opiophobia: Customary Underutilization of Opioid Analgesics

John P. Morgan, MD

Adv Alcohol Subst Abuse, 1985

ABSTRACT. American physicians markedly undertreat severe pain based on an irrational and undocumented fear that appropriate use will lead patients to become addicts. Such irrational fear-opiophobia-resists educational intervention as phobic fears resist rational explanation and exploration. Because this phobia has become fixed in the customary behavior of physicians, it is particularly resistant to change. Re-education might better be directed to the changing of mistaken attitudes about drug use and abuse that are part of the American culture and which are not amenable to alteration by medical education.

- “undertreat severe pain based on an irrational …fear that appropriate use will lead patients to become addicts.”
- “Opioids are consistently prescribed so as to diminish the amount administered.”
- “They have learned…customary prescribing... from their superior house staff, private attendings and full-time hospital staff physicians.”
Chronic Use of Opioid Analgesics in Non-Malignant Pain: Report of 38 Cases

Russell K. Portenoy and Kathleen M. Foley

Pain Service, Department of Neurology, Memorial Sloan-Kettering Cancer Center, and Department of Neurology, Cornell University Medical College, New York, NY 10021 (U.S.A.)

We conclude that opioid maintenance therapy can be a safe, salutary and more humane alternative to the options of surgery or no treatment in those patients with intractable non-malignant pain and no history of drug abuse.

Pain. 1989

Clinical Note

Opioid pseudoaddiction — an iatrogenic syndrome

David E. Weissman * and J. David Haddox **

* Division of Hematology/Oncology, and ** Departments of Anesthesiology and Psychiatry, Medical College of Wisconsin, Milwaukee, WI (U.S.A.)

(Paper 1 received 1 June 1988, accepted 16 November 1988)

Pain. 1989

Summary

A case is presented of a 17-year-old with leukemia, pneumonia and chest-wall pain. Inadequate treatment of the patient’s pain led to behavioral changes similar to those seen with idiopathic opioid psychologic dependence (addiction). The term pseudoaddiction is introduced to describe the iatrogenic syndrome of abnormal behavior developing as a direct consequence of inadequate pain management. The natural history of pseudoaddiction includes progression through 3 characteristic phases including: (1) inadequate prescription of analgesics to meet the primary pain stimulus, (2) escalation of analgesic demands by the patient associated with behavioral changes to convince others of the pain’s severity, and (3) a crisis of mistrust between the patient and the health care team. Treatment strategies include establishing trust between the patient and the health care team and providing appropriate and timely analgesics to control the patient’s level of pain.

ADDICTION RARE IN PATIENTS TREATED WITH NARCOTICS

To the Editor: Recently, we examined our current files to determine the incidence of narcotic addiction in 39,946 hospitalized medical patients who were monitored consecutively. Although there were 11,882 patients who received at least one narcotic preparation, there were only four cases of reasonably well documented addiction in patients who had no history of addiction. The addiction was considered major in only one instance. The drugs implicated were meperidine in two patients, Percodan in one, and hydromorphone in one. We conclude that despite widespread use of narcotic drugs in hospitals, the development of addiction is rare in medical patients with no history of addiction.

Jane Porter

Hershel Jick, M.D.
Boston Collaborative Drug Surveillance Program

Waltham, MA 02154

“Rate Hypothesis”

The faster a drug occupies a receptor the more euphoria, reinforcement and addiction, therefore extended release formulations should be less addicting.
• Unrealistic expectations
• “painkillers”
• Which is perceived as a more powerful medication?
  • 24 tablets no refills, no early refills if you take more than prescribed, see you in 2 weeks vs..
  • 90 tablets 6 refills…see you in 3 months
Opioid Over-Prescribing

- Societal medication mania
- Confrontation phobia
- Time pressure (“15 minute visits”)
- Financial misalignment favoring use of medications
- Lack of training at all levels of health professional education
- Lack of access/coverage to comprehensive pain management services
- Lack of pain specialists
- Opioids last choice coupled with no analgesic ceiling led to high dose, high risk prescribing
- Measuring benefits (pain, function, quality of life) and harms are subjective
“The Opioid Morbidity and Mortality Crisis”

Opioid Prescribing for Acute Pain

<table>
<thead>
<tr>
<th>Surgery</th>
<th>Unused Opioids</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thoracic</td>
<td>71% taking half or less</td>
<td>Bartels et al. Plos One. 2016</td>
</tr>
<tr>
<td>C-section</td>
<td>83% taking half or less</td>
<td>Bartels et al. Plos One. 2016</td>
</tr>
<tr>
<td>Upper extremity</td>
<td>77% taking half or less</td>
<td>Rodgers et al. J. Hand Surg. 2012</td>
</tr>
</tbody>
</table>

Opioid prescriptions for opioid naïve patients decreased (2012-2017)

- 57% decrease in new prescriptions for more than 3-day supply
- 68% decrease in new prescriptions for more than 7-day supply

Opioid Prescribing Trends

What is the right amount?
More judicious or more fearful prescribing?
Trends in Opioid Overdose Deaths

https://www.cdc.gov/drugoverdose/epidemic/index.html
Not guilty plea in death of Ky. doctor

CORNETTsville, Ky. — A patient who is charged with fatally shooting a popular community doctor at a rural clinic a few hours after being denied narcotics pleaded not guilty yesterday.

John Combs, 46, was charged with murder and was held on $10 million bail in the death of Dr. Dennis Sandlin, 57. Authorities said Sandlin, who had worked at the clinic for almost two decades, was shot while he stood in a hallway outside exam rooms, apparently filling out a medical chart.

“He was shot in the head,” Perry County Coroner Jimmy Maggard said. “He had a pen in his hand.”

Police don’t yet have a motive, Trooper Tony Watts of the Kentucky State Police said. Combs had been a patient of Sandlin’s earlier in the day.

A Perry County sheriff’s deputy said Combs had asked the clinic for narcotics but was required to give a urine sample, which he refused to do.

ASSOCIATED PRESS

Law enforcement is clamping down on doctors who prescribe high doses of the most powerful and dangerous pain killers. Is this protecting patients—or hurting them? BY DRAKE BENNETT

UNTIL HE CLOSED his northern Virginia prac- tice in 2003, Dr. William E. Houston was a man using their pain killers routinely or turning around and selling them to a convenience store.

Crackdown on Drugs Hits Chronic-Pain Patients

Amid Tighter Regulation Of Painkillers, Physicians Pull Back on Prescriptions

The DEA has been aggressively prosecuting doctors who prescribe large amounts of painkillers that wind up on illegal markets. The agency is trying to reduce the number of so-called pill mills—unsuspected doctors who write prescriptions for narcotics to anyone who asks. The DEA has se
Opioid Analgesics

- Turn on descending inhibitory systems
- Prevent ascending transmission of pain signal
- Inhibit terminals of C-fibers in spinal cord
- Inhibit activation of peripheral nociceptors
- Vary by response (not all patients respond the same opioid the same way)
  - >3,000 polymorphisms in human MOR gene
  - Single nucleotide polymorphisms (SNPs) affect opioid metabolism, and activity at receptors and ion channels

- Activate the reward pathway

Smith HS. *Pain Physician*. 2008
Undertreating pain, we are admonished… it violates the basic ethical principles of medicine. On the other hand, we are lambasted for overprescribing pain medications… creating an epidemic of overdose deaths.

For patients with chronic pain, especially those with syndromes that don’t fit into neat clinical boxes, being judged by doctors to see if they “merit” medication is humiliating and dispiriting. This type of judgment, with its moral overtones and suspicions, is at odds with the doctor-patient relationship we work to develop.

“As Mr. W. and I sat there sizing each other up, I could feel our reserves of trust beginning to ebb. I was debating whether his pain was real or if he was trying to snooker me. He was most likely wondering whether I would believe him…”

Danielle Ofri, MD, Associate Professor at NYU and a physician at Bellevue Hospital, August 2015
Opioids and Chronic Pain

“The problem is, there’s no evidence that opioids work for chronic pain, according to guidelines released in 2016 by the CDC”

Julia Lurie – reporter, *Mother Jones*, April 27, 2018
Opioid Efficacy for Chronic Pain

Meta-analyses (3-6 m f/u)

- **Opioids vs placebo**
  (high quality studies)
  Opioids with statistically significant, but small, improvements in pain and physical functioning.\(^1,2\)

- **Opioids vs nonopioids**
  (low-mod quality studies)
  Similar benefits\(^2\)

RCT\(^3\) found opioids **not superior** to nonopioids for improving musculoskeletal pain-related function over 12 months

**Study limitations:** \(^4\)
- Excluded patients already on long-term opioids
- 89% of eligible patients declined to be enrolled

Two longer term follow-up studies found **44.3%** on chronic opioids for chronic pain had **at least 50% pain relief** \(^5\)

Multidimensional Care for Chronic Pain

**Physical Exercise**
- Manual therapies
- Orthotics
- TENS
- Other modalities (heat, cold, stretch)

**Medication**
- NSAIDs
- Anticonvulsants
- Antidepressants
- Topical agents
- Opioids
- Others

**Procedural**
- Acupuncture
- Nerve blocks
- Steroid injections
- Trigger point injections
- Stimulators
- Pumps

**Psycho-behavioral**
- CBT/ACT
- Tx mood/trauma issues
- Address substances
- Meditation

**SELF CARE**

- Culture Well-being
- Improve Quality of Life
- Reduce Pain
- Restore Function

Studies on all pharmacologic and nonpharmacologic treatments for chronic pain are ≤ 12 months, vast majority are ≤ 12 weeks


Multimodal approaches are more cost-effective than single modality options

Patrick LE, et al. Spine. 2004

Slide Courtesy of Seddon Savage, MD, MS
Lesson #1

- Patient: “I am never going back to that doctor!”
- Dr. Alford: “What happened?”
- Patient: “He didn’t even examine me!!”

Lesson #2

“The only time I am pain free is when I am at the casino playing the slot machine”
Assessing Worrisome Behaviors

Pain Relief Seeking
- Disease progression
- Poorly opioid responsive pain
- Opioid analgesic tolerance
- Withdrawal mediated pain
- Opioid-induced hyperalgesia

Drug Seeking
- Opioid use disorder/Addiction
- Other psychiatric diagnosis
- Criminal intent (diversion)

Pain Relief and Drug Seeking
- *e.g.*, patient with chronic pain, with co-morbid opioid use disorder, taking opioids for pain and diverting some for income

Alford DP. *JAMA*. 2013
Does my patient have an OUD?

**Loss of Control**

1. Tolerance*
2. Withdrawal*
3. Larger amounts and/or longer periods
4. Inability to cut down on or control use
5. Increased time spent obtaining, using or recovering

**Continued Use Despite Negative Consequences**

6. Craving/Compulsion
7. Role failure: work, home, school
8. Social, interpersonal problems
9. Reducing social, work, recreational activity
10. Physical hazards
11. Physical or psychological harm

*Mild OUD: 2-3 Criteria
Moderate OUD: 4-5 Criteria
Severe OUD: ≥6 Criteria

*This criterion is not considered to be met if taking opioids under appropriate medical supervision

APA. (2013). *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.)
<table>
<thead>
<tr>
<th>When to initiate/continue opioids</th>
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</thead>
<tbody>
<tr>
<td>1. Do not use opioids as 1st-line therapy. If used, combine w/other therapies</td>
</tr>
<tr>
<td>2. Before starting opioids establish realistic goals. Continue opioids only if meaningful improvements outweighs risks</td>
</tr>
<tr>
<td>3. Before starting and then periodically discuss risks and benefits of opioids</td>
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</table>
I will be in chronic pain until I die…I accept it.

Pain medication is inadequate. But with it I am more consistently functional (homeowner, spouse, parent, teacher, writer, editor).

Abuse of prescription pain medications is a serious problem; people are dying.

Ever-tighter regulations…are of dubious value in reducing [abuse] – while causing grave harm to those of us in chronic pain, to the overwhelming majority who take medications for appropriate reasons.

"Increasingly I am a suspect, treated less as a patient and more as a criminal."

Donald N.S. Unger, MFA, PhD, February 2015
Patient-Centered Safer Opioid Prescribing

It should not be about checking off boxes…

✔ Patient provider agreement signed
✔ Urine drug test sent
✔ Pill count completed
✔ Prescription drug monitoring program checked
It takes a second to process what the secretary just did, in part because her eyes are downcast and she’s speaking a little more softly than usual. Then you focus on the piece of paper she just gave you: it’s not the prescription you came in to pick up; it’s a lab slip.

Of course. She’s sorry. Of course. She can’t release the pain med script until you go downstairs. And pee in a bottle…

The woman at the lab desk is a little more flat and pro forma, but stops you as you head into the bathroom. Can’t bring that in with you, she says, pointing her chin at your bag. She doesn’t seem all that sorry, just a little bored and low-level irritated.
• At least she isn’t patting you down—making sure you don’t smuggle in a clean sample…at least for you—they aren’t requiring observed urination. Yet.

• But the annual, mandatory, Pain Management Agreement is a living document, ever-growing, morphing, and contorting—forcing you to constantly stretch and adjust, as well…

• On the compliance side, they want to see that you’re only peeing metabolites for the drugs you’ve been prescribed—no freelancing and no doctor shopping.

• Peeing clean? That’s potentially criminal. You’re not taking your pills? Who is? Are you selling them? Trying to cut back? Not acceptable: Sounds like pill hoarding!
• The agreement is, potentially, a One-Strike-and-You’re-OUT contract: a lifetime ban on the prescription of pain medication by any practitioner in the entire managed care network...

• You fork over the bag, duck into the bathroom, urinate—as ordered. On emerging, you hand over the warm plastic bottle, reclaim your property, head back upstairs to pick up your prescription.

• At the pharmacy they need to see ID, both when you drop the prescription off and after ten minutes of sitting in view of the cash register when you pick it up. The young woman who rings you up is... sorry. Nothing personal; just rules.
• At any rate, this is a better result than what can happen…when your physician is on vacation.

• We’re not comfortable, is the term of art with which the covering physician often begins, renewing this for you at this time; not quite sure about the dosage or the frequency. So that refusal isn’t…personal…

• And it’s not really a refusal either, it’s just—we’re sure you understand—a matter of respecting the comfort level of the medical professional. . . who is refusing to address your pain in accordance with the treatment plan laid out and amply documented by your primary care provider.
• You consider using the analogy of insulin: If a covering physician refused to renew an insulin prescription—uncomfortable regarding dosage and frequency—simply suggested the patient come back next week, would that not be construed as medical malpractice? But arguing is bad; it makes things...personal.

• Yelling—most especially, but really any kind of demonstrated intensity—would be a very bad idea at this point: it’s suggestive of drug-seeking behavior, and that’s a phrase you really don’t want jotted down, in indelible ink, in your permanent record.

• Of course if you don’t argue, well, that’s a pretty clear indicator that your pain can’t be all that serious after all.
And if you know, with too high a degree of precision and specificity, what does and does not work for you, as a matter of medication or dosage... that’s a little disturbing—and suspicious.

Insulin! you want to scream. Would you accuse—yes, that’s really the right word; this is personal—a diabetic of knowing too much about what would or would not effectively control their blood sugar? Isn’t that what a responsible, educated, and involved patient is supposed to do?

But—of course!—I understand. There’s an opioid crisis; precautions need to be taken. I’m sorry if I made you feel that this was - personal.
Prescriber education is a more finely tuned approach to addressing the opioid-misuse epidemic, allowing us to individualize care on the basis of a patient’s needs after a careful benefit–risk assessment. That, after all, is the way we manage all chronic diseases.

Though managing chronic pain is complicated and time consuming and carries risk, we owe it to our patients to ensure access to comprehensive pain management, including the medically appropriate use of opioids.
Safer Opioid Prescribing Education Must Address the Complex Realities of Clinical Practice

- 1. Initiating opioid therapy
- 2. Aberrant opioid taking behavior
- 3. Lack of opioid benefit and excessive risk
- 4. High dose opioids in an inherited patient
- 5. Illicit drug use in a patient
- 6. PDMP questionable activity
- 7. PDMP questionable activity
A National Education Strategy
FDA Opioid Risk Evaluation and Mitigation Strategy (REMS)

- **Goal:** “to reduce serious adverse outcomes … while maintaining patient access to pain medications”

- **Federal Government** – FDA mandated the **class-wide** opioid REMS and developed the **curricular Blueprint** (there is NO restrictions on additional content)

- **RPC** – REMS Program Companies representing manufacturers of opioid analgesics provided **unrestricted educational grants** to **accredited CME/CE providers**

- **CE Accreditors** – ACCME, ANCC, ACPE, AOA, AAFP responsible for auditing adherence with covering all components of the FDA curricular Blueprint
Feb 2013 – Oct 2019
- 163,203 trained
- 92% completed online program
- 184 meetings in 27 states

Original Research Article

SCOPE of Pain: An Evaluation of an Opioid Risk Evaluation and Mitigation Strategy Continuing Education Program

- Increased knowledge
- 67% increased confidence in safer opioid prescribing
- 86% implemented practice changes

Senator Markey Questions Role Opioid Manufacturers Play in Designing Education Courses for Prescribers

Thursday, May 24, 2018
NO! The hallmark of accredited CME is independence from promotion or marketing

• ACCME standards ensure that accredited CME is relevant, practice-based, and independent of commercial influence or bias

• Companies providing funding for accredited CME are prohibited from having any influence over faculty or content; cannot pay attendees or faculty for travel, registration, or honoraria; and cannot influence who can attend
• “You are the best doctor…”
• “I need Dilaudid!”
• Why are some patients resistant to decreasing their opioid dose?
• Why do you think I want to make this change?
• How can I continue to treat a patient who lies to me?
• You are abandoning the treatment…not the patient
Some exciting new developments…

• Emphasis on more judicious opioid prescribing
• More research on effective treatments for pain
• Moving from an exclusive focus on opioid supply reduction to demand reduction
• Advocacy for making multi-modal comprehensive pain treatment more readily available
• Lots of education for the entire healthcare team
• Lots of education for all levels of trainees
Tapered to methadone 15 mg was admitted to a 28 day residential program left AMA, told she would likely relapse…

Summary: 29 yo female with severe OUD on methadone 70 mg for 5 years who wants to taper due to pressure from family and NA members

- This case took place in the 1970s in Needham, MA and the patient is my older sister Rachel
- She has been in recovery for over 37 years…
- Earned her Associates in mental health counseling
- Puts on an AA commitments monthly at a correctional institution for woman (MCI Framingham) and a women’s "holding" program, (Willow House) and sponsors women in family shelters
- She works as an orthodontist administrator, has 2 sons and 2 grandchildren who are all doing well
Thanks!!

Questions??

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