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Health

Chronic Pain Management in Primary Care

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Overview

- Discuss recent recommendations on opioids in chronic pain
- Recognize the importance of addressing chronic pain in patients with addiction disorders
- Review how, if an opioid is needed, to use buprenorphine for chronic pain.

Introduction

- Questions as we go – put in chat
- Ok to reach out to me for content questions and resources – I am on MPCA SUD resource list
- 4066970976 smulvehill@rimrock.org
- Sharon Mulvehill MD – board certified in family medicine and addiction medicine, Program Director of Addiction Medicine Fellowship – Montana Family Medicine Residency
- I take students at both locations

Pain and Addiction

- Patients with an addiction disorder are very likely to have chronic pain – trauma, chronic medical conditions unaddressed, fragmented health care for pain. Up to 50%.
- The majority of patients with OUD have chronic pain – over 60%
- How many patients with chronic pain develop an addiction disorder– difficult to know – most have dependence - +1 = DSM addiction diagnosis

Patients' perceptions of the pathways linking chronic pain with problematic substance use

Wyse, Jessica J.[a,b,*]; Lovejoy, Jennette[c]; Holloway, Julia[d]; Morasco, Benjamin J.[b,e]; Dobscha, Steven K.[b,e]; Hagedorn, Hildi[f,g]; Lovejoy, Travis I.[b,e]

Author Information

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ASAM 2025

- AMA is now PDD – patient directed discharge – patient centered and less stigmatizing
- Lots of promise for GLP-1's in addiction treatment – RCT's ongoing – consider early in treatment of DM and obesity in the setting of addiction disorders.

ASAM 2025

- New ASAM guidelines on BZD taper – key info – continuously/regulary address risk/benefit.
- Taper – multiple guidelines – go slow

- WACO Guide – psych in primary care - app

ASAM 2025

- Long acting buprenorphine – in the setting of OUD – might be the best option for those with chronic pain as blood levels of buprenorphine are consistent.

- Hospital initiation of MAT/MOUD improves linking to f/u addiction treatment

Contingency Management

- Consistent good data for CM in the setting of stimulant use disorder
- Able to use in Montana for Medicaid patients – private insurance reimbursement varies
- Now up to $750/year in small vouchers for behaviors – coming to appt, UDS as expected
- Training available

New Case

- Patient with AUD and back pain – was using oxycodone and dilaudid, several near fatal overdoses, pcp transitioned patient to suboxone, he started going to ED's to get oxycodone
- PMH – htn, elevated lipids
- Transitioned to buprenorphine – titrated to 32mg – pain well controlled.

Case #1

- 72 year old male on opioids for neck and back pain – imaging c/w osteoarthrisis, mild disc dz
- PMH – CHF with preserved ejection fraction, HTN, ED, elevated lipids
- Meds –Atorvastatin, Lasix, KCL, Jardiance
- Methadone 5 mg tid (MED ?)
- PCP left the practice and patient was reassigned

Structured Team Based Approach

- Interdisciplinary, patient centered, individualized approach
- Multimodal treatment
- Includes specific pain assessment metrics, goals, screening tools
- Addresses behavioral health
- Aim is for improved overall function

Chronic Pain is a chronic disease

- Evaluation takes longer than 20 minutes
- History (including social hx) and physical exam occur prior to treatment
- Often collateral information review is required – old records, imaging, prior tx and diagnosis
- Multiple visits to complete evaluation/tx plan

Three Visit Process – Visit One

- Nursing - PEG, PHQ-9, GAD-7, ROI UDS HPI,
- Provider - review PDMP, review labs or order needed labs – recent CMP most to assess renal and liver function.
- Provider - Address other needs (establish space for chronic pain mgmt.)
- Education about chronic pain management in primary care

Visit Two

- Nursing – complete items not done at visit one
- Provider – review old records, complete physical exam, consider behavioral health referral if needed.
- Diagnosis – discuss if further evaluation (referral) and or imaging needed.

Visit Three

Review what patient is currently doing to manage pain, what is working what is not.

Establish treatment plan to include management of anxiety, sleep hygiene, goals, exercise, and medication plan.

F/u one month, see monthly until stable

Team Based Approach

- Behavioral health visits with patient at least once in a warm handoff and helps with treatment plan, offers but not requires further visits
- Helps with goals of care, sleep hygiene, managing anxiety, options for exercise
- Provider focus is medication regimine

Medication management

- NSAIDS and acetaminophen - scheduled
- SNRI – duloxetine
- Gabapentinoids - Neurontin or Lyrica
- Topical therapies – diclofenac gel, capsacein
- Buprenorphine if opioid indicated. Use buprenorphine/naloxone if hx of opioid use disorder

Opal Trial – June 26, 2023-Lancet

- OPIOID analgesia for acute back and neck pain for at least 12 weeks –randomized placebo controlled trial
- 347 participants randomized to guideline care + oxycodone (up to 20mg/day) or guideline care + placebo.
- Primary outcome was pain

Findings

- Mean pain score at 6 weeks was slightly higher in the opioid group and complications were higher in the opioid group
- Opioids should not be recommended for acute non-specific low back pain or neck pain given that we found no significant difference in pain severity compared with placebo. This finding calls for a change in the frequent use of opioids for these conditions

Legacy Patients

- Chronic pain on long term opioids
- Perhaps you would not have started a patient with this diagnosis on chronic pain management – but now you are asked to take care of them
- Concerns about risk of ongoing pure opioid agonist treatment.
- Convert to buprenorphine

VA DoD 2023 Guidelines

Rethinking the Appropriateness of Opioids

The U.S. is undergoing a cultural transformation in the way pain is viewed and treated. Experts agree that opioids should not be considered first line or routine therapy for chronic pain, outside of active cancer, palliative, and end-of-life care. (p. 7)[1]

We recommend **against** the initiation of opioid therapy for the management of chronic non-cancer pain (for non-opioid treatments for chronic pain, see the VA/DOD CPGs for Low Back Pain,[2] Headache,[3] and Hip and Knee Osteoarthritis[4]). (p. 35)[1]

For patients receiving daily opioids for the treatment of chronic pain, **we suggest** the use of buprenorphine instead of full agonist opioids due to lower risk of overdose and misuse. (p. 43)[1]

Messaging to Patients

Did You Know?

- Healthcare providers used to think that opioids alone were safe and effective in treating chronic pain. Now we know this isn't true.
- New information has shown that chronic pain treatment requires a multimodal approach. This type of approach includes various treatment options and disciplines working together to help a patient with their pain condition. It also includes self-management options.
- Long-term opioid use can lead to multiple problems including loss of pain-relieving effects, increased pain, accidental death, opioid use disorder or addiction, and problems with sleep, mood, hormones, and the immune system.
- It is now understood that the best treatments for chronic pain are not opioids.
- When considering the benefits and harms of various treatments, non-medication treatments may provide the most benefit with the least risk of harm.

Does fine until….

Stimulant Interpretation	See Below	-
Methadone-U	Present *	Cutoff:25 -
Hydrocodone, U	Not Detected	Cutoff:25 - ng/mL
Hydromorphone, U	Present *	Cutoff:25 - ng/mL

Nordiazepam, U	Not Detected
Norfentanyl, U	Present *
Norhydrocodone, U	Not Detected
Methadone-U	Present *

Notes :

Methadone has been associated with disproportionate numbers of overdose deaths relative to the frequency with which it is prescribed for chronic pain, due in part to its long and variable half-life. In addition, methadone is associated with cardiac arrhythmias along with QT prolongation on the electrocardiogram. **Methadone should not be the first choice for an ER/LA opioid. Increasing methadone doses over 30 mg/day is not recommended.**

Conversion Factor

There is limited evidence and no consensus on the conversion factors to use for methadone. We use a 3 to 1 ratio that is consistent with CMS, the State of Oregon PDMP, and research studies by Von Korff (Clin J Pain 2008;24:521-7) and Krebs (Pain 2011;152:1789-95). The WA State AMDG calculator uses higher conversion ratios that increase at higher doses (0-20 mg 4:1 ratio, 21-40 mg 8:1 ratio, 41-50 mg 10:1, over 51 mg 12:1 ratio)

For the dose entered, these two conversion ratios are:

45mg *(this calculator)*	**60mg** *(AMDG calculator)*

What is going on?

- First abnormal UDS - patient is unsure, son has a history of substance use, wife has pain medication at home, thinks he mixed up meds
- Second abnormal UDS – patient is unsure how he got fentanyl in his urine…..does admit to vaping THC products that might have been laced with fentanyl.

Visit with MOUD provider and LAC

- Discuss transitioning to buprenorphine as a safer option, discuss adjuvant meds, exercise, goals, sleep, phq9 and gad7
- Patient willing to try conversion
- Developed a conversion strategy, rx buprenorphine
- Before patient filled buprenorphine rx he is admitted to the hospital for syncope and prolonged QT interval
- Cardiology says stop methadone

Treatment Plan

- Bernese method to transition to buprenorphine
- Clear medication schedule
- Follow up phone calls
- Follow up visit with provider starting buprenorphine and pcp
- Does well on 2mg bid of buprenorphine

Buprenorphine

- Mu-opioid receptor partial agonist
- When bound there is a natural ceiling effect that reduces the risk of overdose
- Strong mu-opioid receptor affinity means it can displace full mu-opioid agonists and cause withdrawal symptoms

BUPRENORPHINE FORMULATIONS FOR CHRONIC PAIN MANAGEMENT IN PATIENTS WITH OPIOID USE DISORDER OR ON LONG-TERM OPIOID THERAPY WITH PHYSIOLOGIC TOLERANCE

Buprenorphine Inj, Buprenorphine TDS, Buprenorphine SL Film, Buprenorphine/Naloxone SL tabs

Recommendations for Use

Rev. April 2023

VA Pharmacy Benefits Management Services, Medical Advisory Panel, and VISN Pharmacist Executives; National Mental Health Office; Substance Use Disorders; National Pain Management Strategy Coordinating Committee

The following recommendations are based on medical evidence, clinician input, and expert opinion. The content of the document is dynamic and will be revised as new information becomes available. Local adjudication should be used until updated guidance and/or CPG are developed by the National PBM. The purpose of this document is to assist practitioners in clinical decision-making, to standardize and improve the quality of patient care, and to promote cost-effective drug prescribing.

The Product Information should be consulted for detailed prescribing information.

Pharmacotherapeutic Considerations on the use of Buprenorphine for Pain Management

Conversion Methods

- Taper MED's at 10%/week then convert to buprenorphine
- Bernese method – conversion over 5-14 days
- Convert directly to buprenorphine by having patients be in moderate withdrawal.

- Shared decision making, provider comfort, supportive services will affect choices

Equianalgesic dosing

- Butrans patch –
  - 5mcg patch starting dose if on <30MED's
  - 10mcg patch starting dose in on 30-80 MED's
  - Ok to supplement with short acting analgesics until analgesic efficacy is attained
  - >80 MED's – consider another formulation - belbuca

Belbuca – Buccal Film

- BID medication
- Less than 30 MED – 75mcg q 12 hrs
- 30-90 MED's - 150mcg q 12 hrs
- 90-160 MED's – 300mcg q 12 hrs
- >160 consider buprenorphine

Buprenorphine

- 2-4mg/day in divided doses is adequate for most
- BID or TID dosing better for pain
- Stop opioids the day prior – patient should be in moderate withdrawal
- Pain doses/day much lower than mg needed to treat OUD
- Patients with OUD and chronic pain may need more or less depending on their recovery

Bernese Method

Outpatient microdosing induction schedule for buprenorphine–naloxone

- Day 1: 0.5 mg once a day
- Day 2: 0.5 mg twice a day
- Day 3: 1 mg twice a day
- Day 4: 2 mg twice a day
- Day 5: 3 mg twice a day
- Day 6: 4 mg twice a day
- Day 7: 12 mg (stop other opioids)

Slow method

- Taper opioids 10% a week.
- Do prescriptions one week at a time.
- Ok to pause a week if needed.
- Titrate to 90 MED
- Individualized treatment plan

No OUD/ICD-10 Opioid Dependence

OUD/ICD-10 Opioid Dependence

BUP TDS (BUTRANS)
For patients transitioning from
≤ 80 mg MEDD*

Or
BUP BF (BELBUCA)
For patients transitioning from
≤ 160 mg MEDD

Or
BUP/NAL (SUBOXONE) or BUP (SUBUTEX)
For patients transitioning from
≥ 160 mg MEDD

BUP/NAL (SUBOXONE, first-line) or BUP (SUBUTEX, if a contraindication to naloxone)

Adequate Response ?

NO

Try the next buprenorphine formulation in the listed order. If patient fails all three buprenorphine formulations, consider tapering off buprenorphine and use of alternate pain management modalities.

YES

Medication formulations

- Belbuca and butrans patch – pharmacy many need to order
- Many insurances have a preferred formulation
- If you expect titration prescribe at least two weeks supply and see patient weekly – allows time for pharmacy to stock the medication.
- First rx to a pharmacy you know and can easily communicate with.
- Nursing makes follow up phone calls in between visits

VA/DoD Guidelines 2023

- Recommends against initiation of long-term opioid therapy for chronic pain.
- **In all cases** non-opioid and non-pharmacologic alternatives for pain management must be part of the treatment plan
- Provider should be prepared to provide long term tx with buprenorphine is those with opioid dependence or OUD.

Rimrock Foundation

- Specialty care – patients continue treatment with their pcp for primary care problems
- Tolerance and withdrawal occur with chronic opioid use
- One other behavioral problem = ICD-10 opioid dependence diagnosis
- BH Problems include: Persisting with opioid use despite harmful consequences OR difficulties in controlling opioid use OR strong desire to take opioids

Rimrock Foundation

- Patients with opioid dependence not doing well in primary care may be referred for evaluation by addiction medicine provider or LAC
- Patients with OUD or opioid dependence and co-morbid pain who are stabilized on BUP (opioid dependence) or BUP/NAL (OUD) may be transitioned back to their PCP via warm hand-off once on a stable dose regimine.

Rimrock Foundation

- Comprehensive residential and outpatient addiction medicine treatment
- CMO board certified in family medicine and addiction medicine
- PA's and NPP's -primary care/addiction medicine.
- Access to LAC/BH/Psychiatry/Peer Support/ case management

Rimrock Case

- 72 year old male followed in the chronic pain clinic in Billings for several years.
- Change in providers led to a lapse in medication
- When he returns to the pain clinic his urine comes back with fentanyl
- Pain clinic dismissed the patient, refers the patient to Rimrock for evaluation

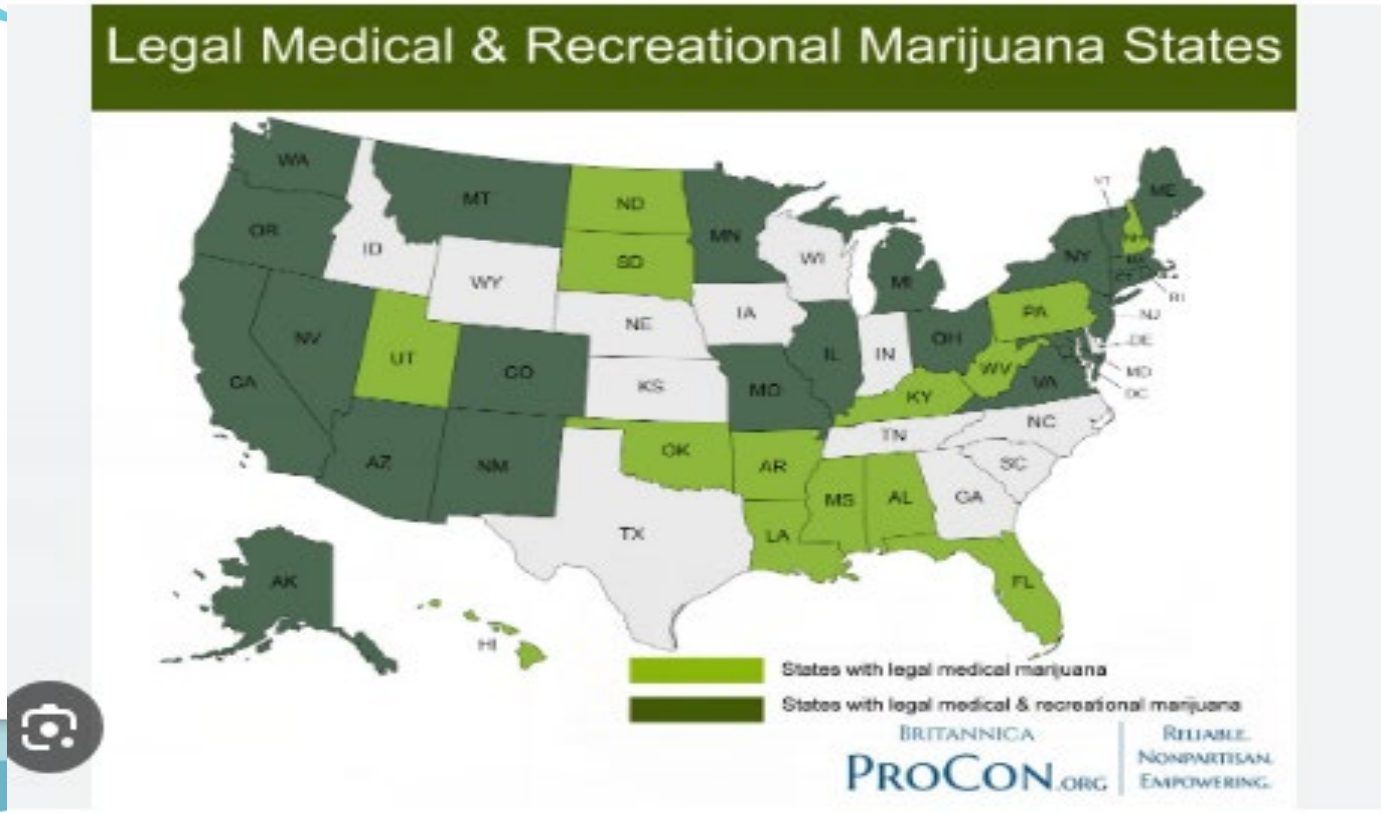
Evaluation at Rimrock

- Review MPDR, request old records
- Patient missed an appointment, his provider left, new provider rescheduled the patient but he ran out of medication
- His aunt recently died and he found her aunt's fentanyl patch while he was out of medication
- Denies hx substance use, denies fentanyl/heroin/meth/alcohol, denies injecting or inhaling drugs. Hep C and HIV neg. No prior UDS's with unexpected results at pain clinic or local hospitals. MPDR appropriate.

Treatment PLan

- Discuss nsaids/Tylenol
- Discuss exercise/treatment goals/sleep/phq9 and gad7
- He was out of medication so started buprenorphine 2mg bid
- Pain is adequately controlled
- Transition back to PCP

A Word about Medical Marijuana



Data is conflicting

- General recommendations:
  - Not recommended for pregnant women – no data to support that it is safe
  - Not recommended for pediatric patients – no data to support that it is safe
  - If people use THC products to control symptoms – buy from a dispensary, avoid sharing THC products

More on THC

- Adults should keep THC products in a secure location, preferably locked up if there are children/adolescents in the home
- Oral use preferred – start low go slow
- Providers can discuss medical use/recreational use/substance use
- Avoid driving, heavy machinery etc

THC

- Thc on a UDS is not a reason to fire a patient or discontinue their pain treatment plan.
- THC is present in employee UDS and can be a reason for not getting a position of employment
- Watch as studies come out – data to come…

References

- VA DoD: https://www.healthquality.va.gov/guidelines/pain/cot/
- Patient handout –buprenorphine for chronic pain:
- https://www.pbm.va.gov/PBM/AcademicDetailingService/Documents/Academic_Detailing_Educational_Material_Catalog/IB_1497_Provider_BupChronicPain.pdf

References

- Buprenorphine for chronic pain management – provider information:
- https://www.va.gov/formularyadvisor/DOC_PDF/CRE_Buprenorphine_Formulations_for_Pain_Management_RFU_Rev_APR23.pdf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