Interdisciplinary Pain and Addiction Care: It takes a team to treat the whole person

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Daniel Vilaubi, DPT
Eric Hanson, PhD
Bethany DiPaula, PharmD
Anita Karnik, MD

2022 ASAM Pain and Addiction Pre-Conference

Disclosure Information

- Presenter 1: Aram Mardian, MD
  - Site Director at PVAHCS for the EMPOWER (PCORI funded) and SCEPTER (VA funded) clinical trials
- Presenter 2: Eric Hanson, PhD
  - Co-PI at the PVAHCS for the EMPOWER (PCORI funded) and SCEPTER (VA funded) clinical trials
- Presenter 3: Daniel Vilaubi, DPT
  - Co-I at the PVAHCS for the SCEPTER (VA funded) clinical trial
- Presenter 4: Bethany DiPaula, PharmD
  - No Disclosures
- Presenter 5: Anita Karnik, MD
  - Site Director at the PVAHCS for the Brave (VA funded) clinical trial

Disclosure/Introduction Information

Interdisciplinary Pain and Addiction Care: It takes a team to treat the whole person

March 31, 2022

Aram Mardian, MD

Chief, Chronic Pain Wellness Center, Phoenix VA Health Care System (PVAHCS)

Clinical Associate Professor, Department of Family, Community and Preventive Medicine, UACOM-P

- Site Director at the PVAHCS for the EMPOWER and SCEPTER clinical trials
- Views presented are my own and not those of the Department of Veterans Affairs or the federal government

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March 31, 2022

Daniel Vilaubi, DPT

Chronic Pain Physical Therapist, Chronic Pain Wellness Center, PVAHCS

Clinical Specialist in Orthopaedic Physical Therapy

Therapeutic Pain Specialist

Certified Strength and Conditioning Specialist

- CO-I at the PVAHCS for the SCEPTER clinical trials
- Views presented are my own and not those of the Department of Veterans Affairs or the federal government

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Program Manager and Lead Pain Psychologist, Chronic Pain Wellness Center, PVAHCS

Clinical Assistant Professor, Department of Psychiatry, UACOM-P

- Co-PI at the PVAHCS for the EMPOWER and SCEPTER clinical trials
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March 31, 2022

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University of Maryland School of Pharmacy

- No Disclosures

Disclosure/Introduction Information

Interdisciplinary Pain and Addiction Care: It takes a team to treat the whole person

March 31, 2022

Anita Karnik, MD

Program Director, UACOM-P Addiction Medicine Fellowship

Clinical Assistant Professor, Department of Psychiatry, UACOM-P

Addiction Psychiatrist, Chronic Pain Wellness Center, PVAHCS

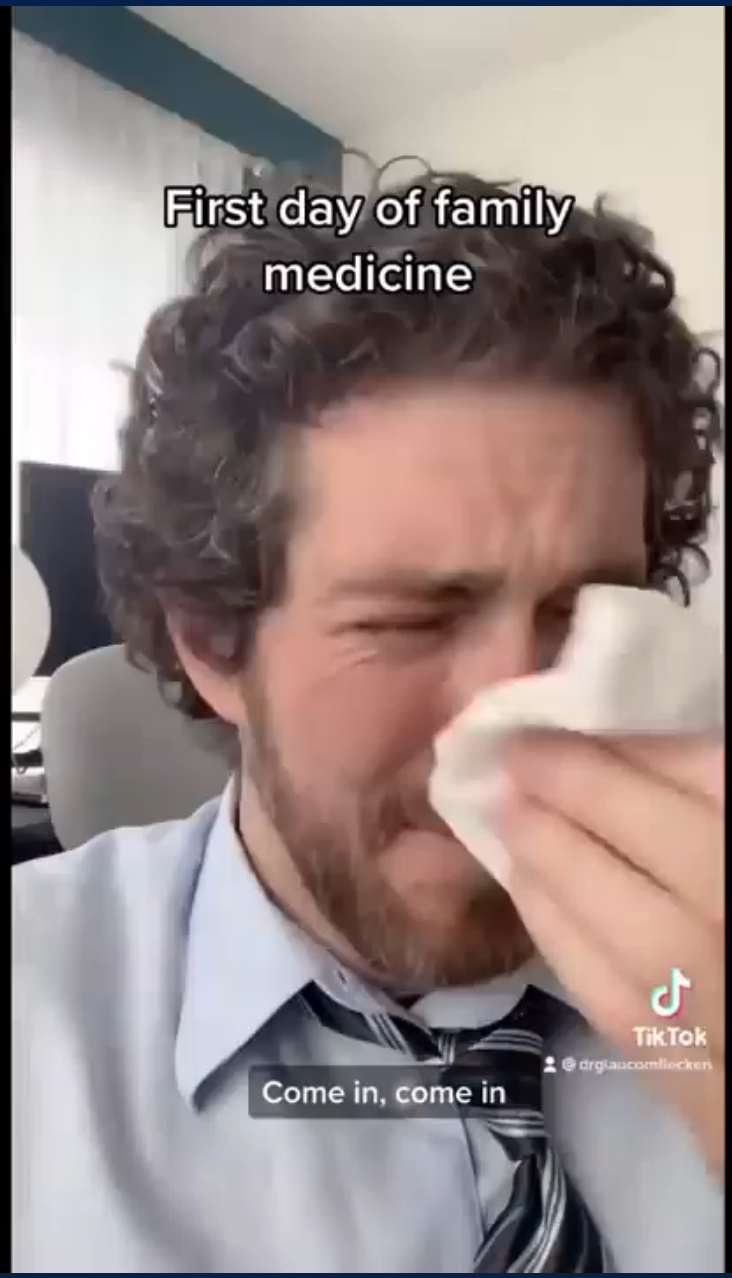
- Site Director at the PVAHCS for the Brave clinical trials
- Views presented are my own and not those of the Department of Veterans Affairs or the federal government

Learning Objectives

- Develop an interdisciplinary approach for patients with pain and addiction within a range of clinical settings
- Incorporate three behavioral medicine strategies into the treatment plan for individuals with chronic pain
- Integrate Pain Neuroscience Education talking points into the care of patients with chronic pain
- Develop awareness of a buprenorphine microinduction for a patient with chronic pain

Case

- Vanessa is a 57 y/o female with LBP x 30 years. She presents to your office in distress and opioid withdrawal stating that her prior PCP “is cutting her off her pain pills”
- Hx: oxycodone 30mg TID was reduced to 10mg TID 1 wk prior
- What is your next step?



Dr. Glaucomflecken – with permission https://www.youtube.com/watch?v=qoYG0gK3yBQ&t=626s

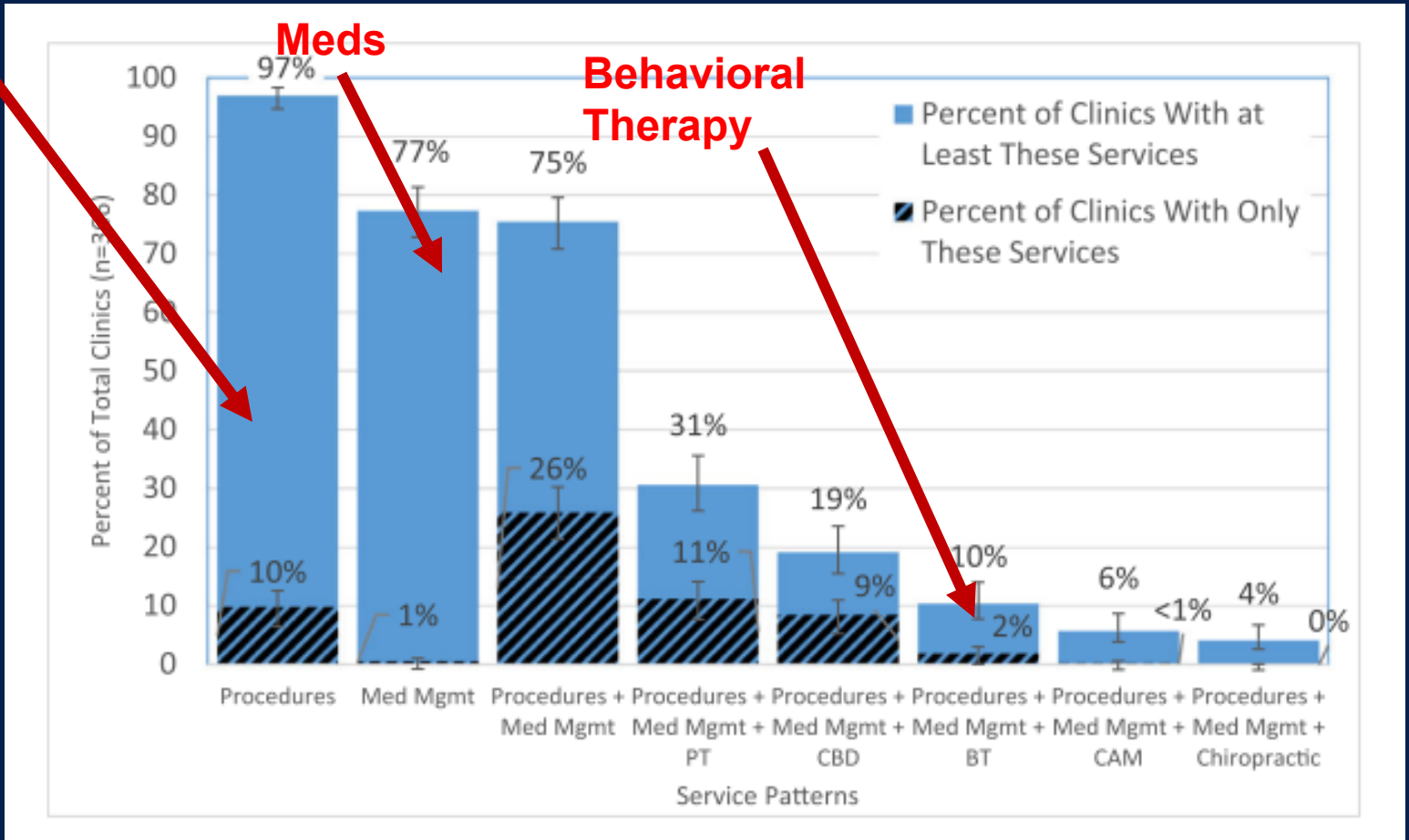
Access to Multimodal Pain Management for Patients with Chronic Pain: an Audit Study

J Gen Intern Med 36(3):818–20

Procedures

Meds

Behavioral Therapy



Lagisetty et al., *J Gen Intern Med*, 2020)

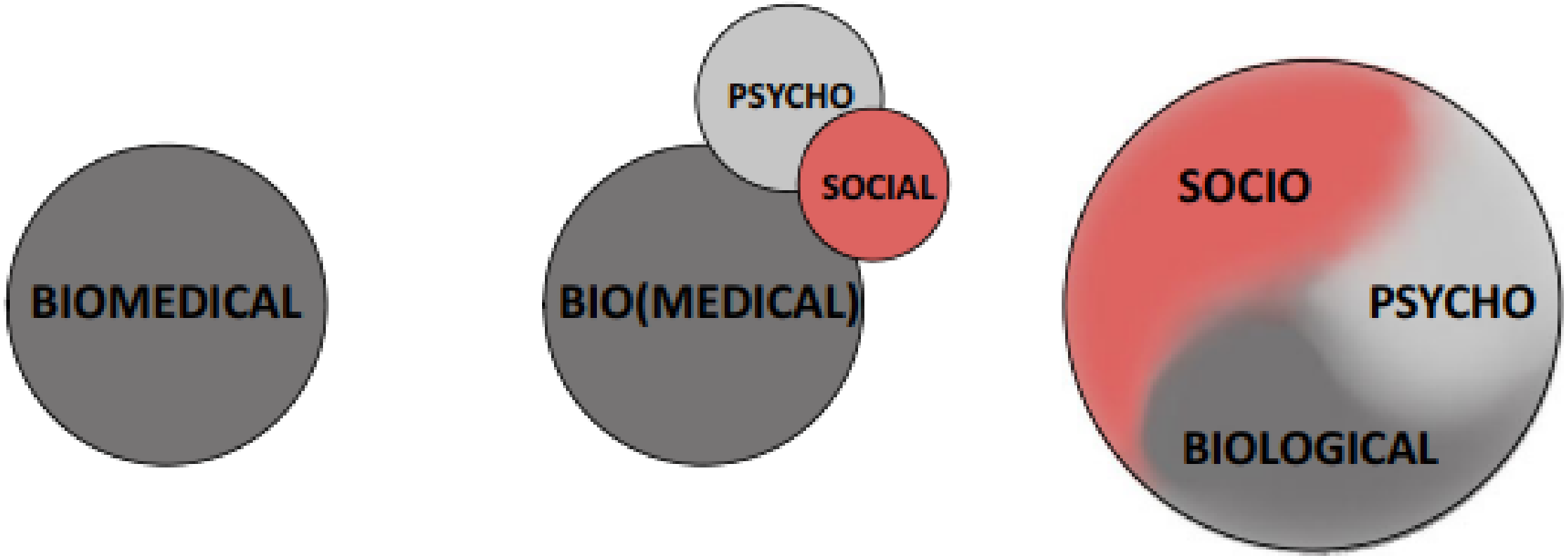
Paradigm Shift - From Biomedical Model…

Find Pain Generator

DESTROY
NUMB
BURN
REMOVE

Roth, Mardian et al

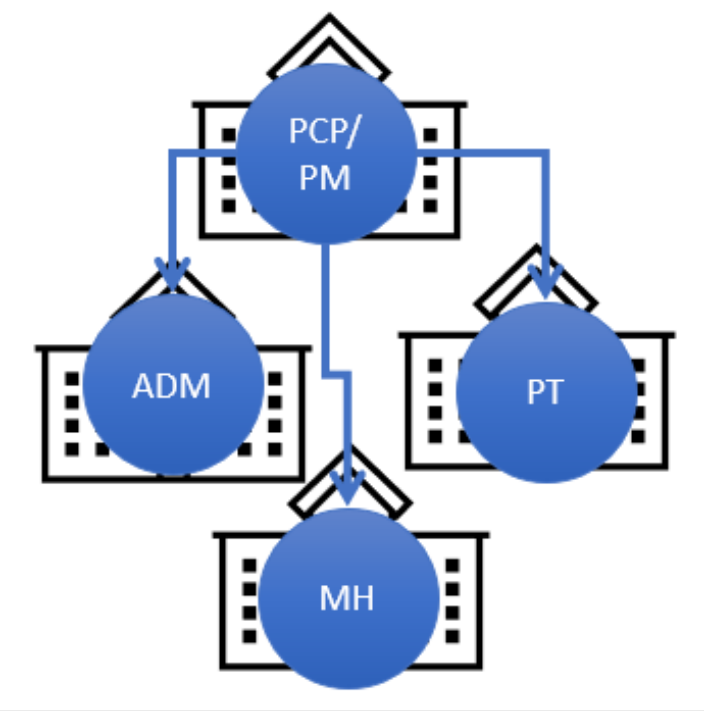
Shift To SocioPsychoBiological Model



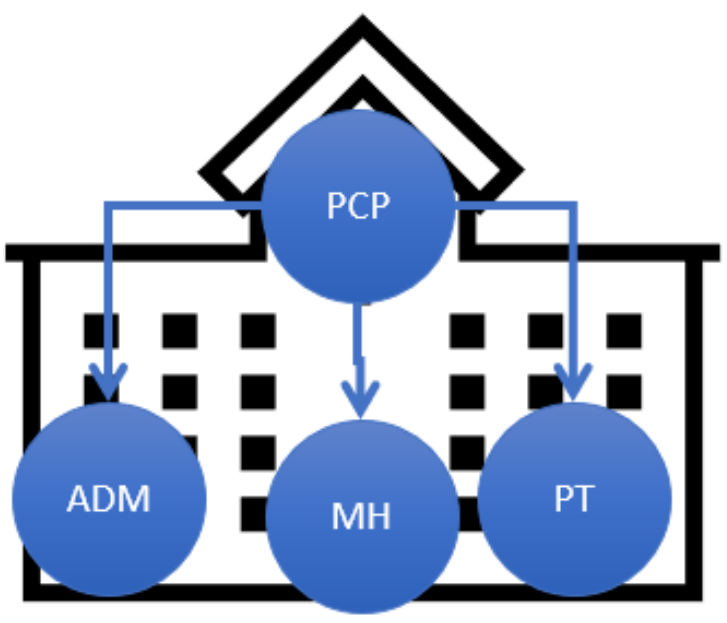
Mardian et al, *Pain Med*, 2020

Continuum of Team Integration

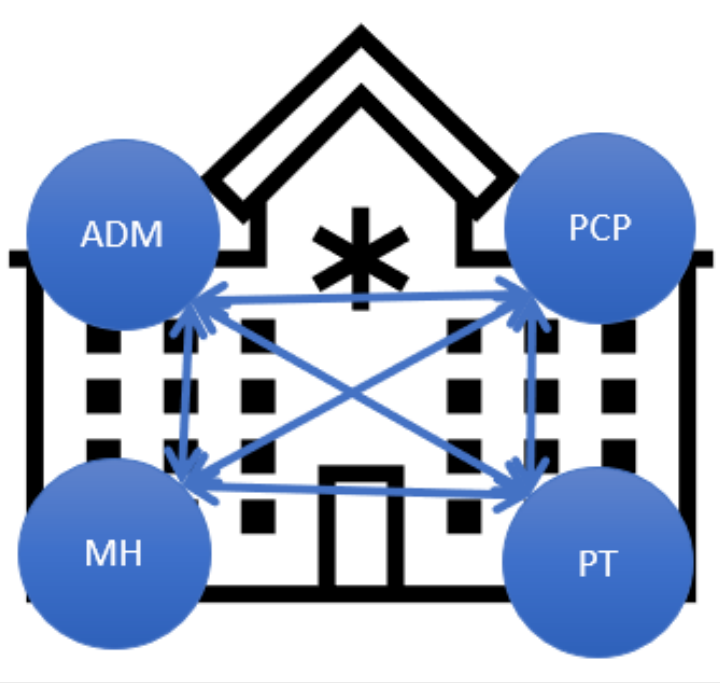
Single Discipline Practices



Multidisciplinary Team



Interdisciplinary Team



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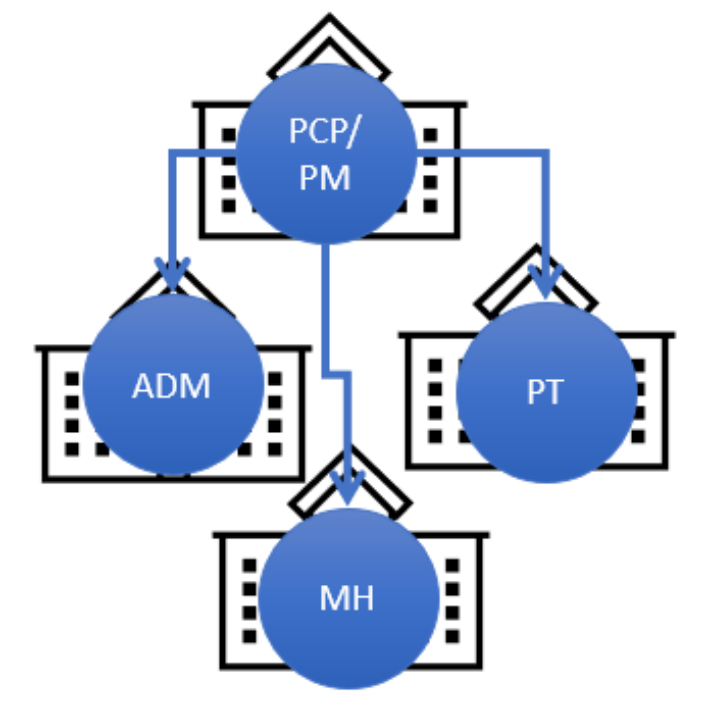
Single Discipline Practices



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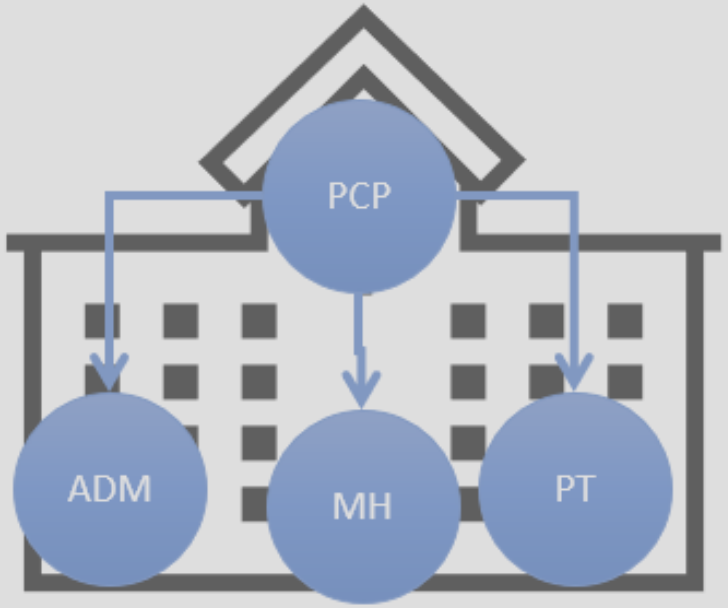

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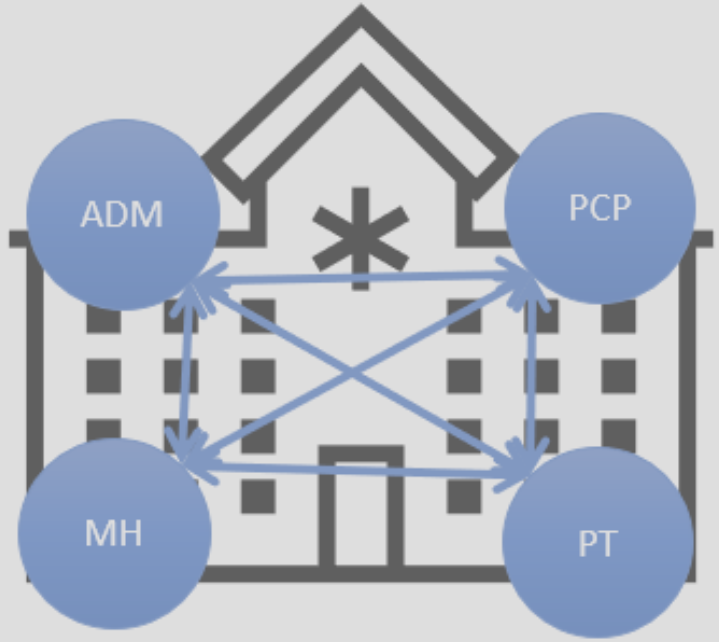

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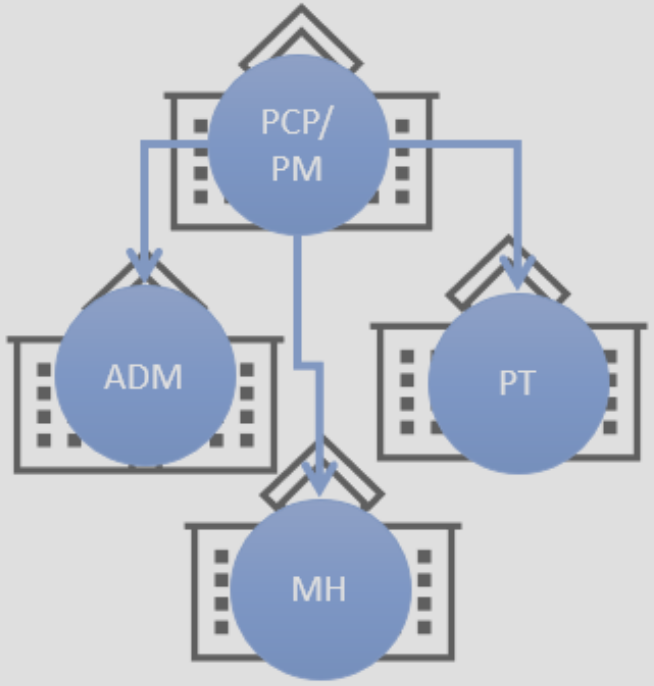

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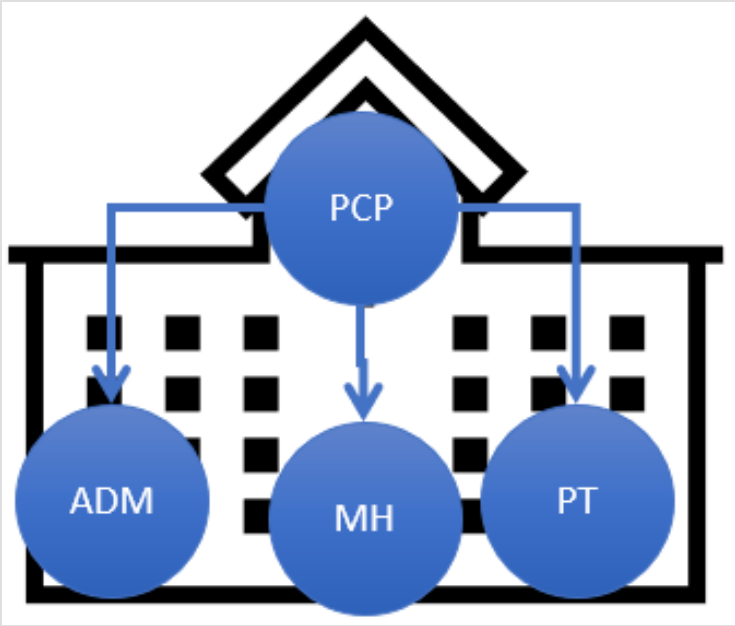

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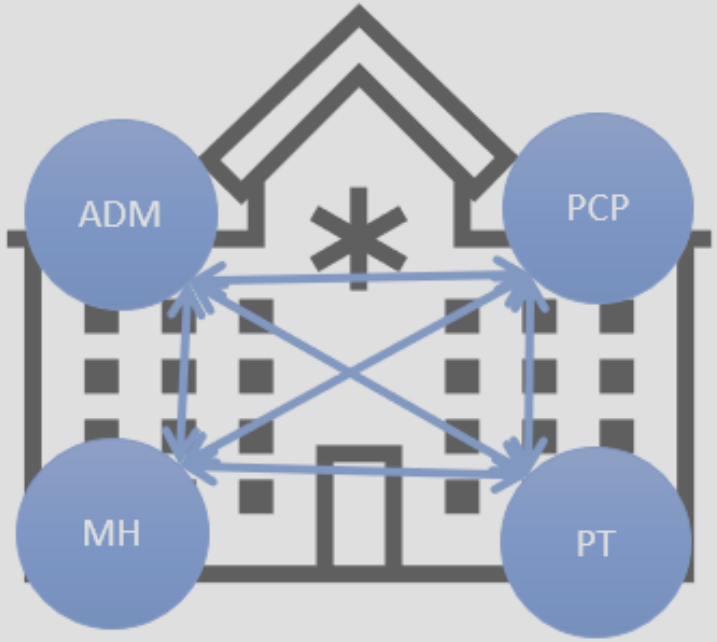
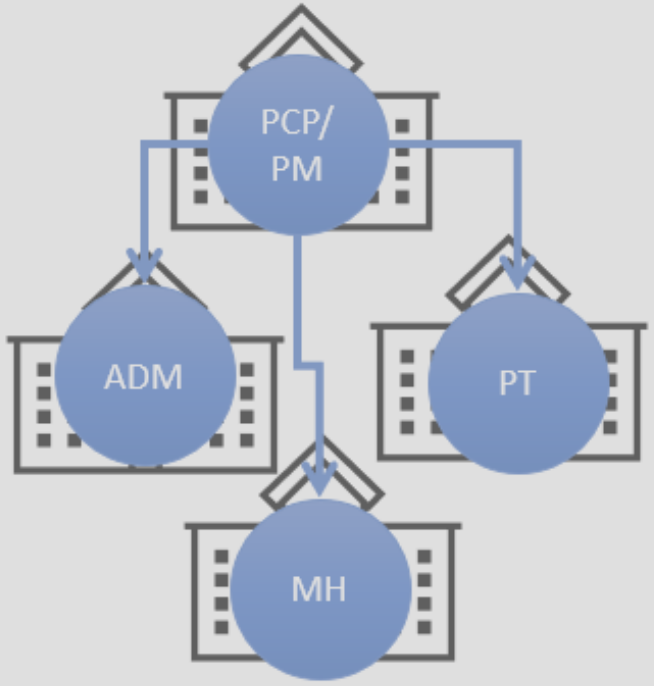


Continuum of Team Integration

Single Discipline Practices



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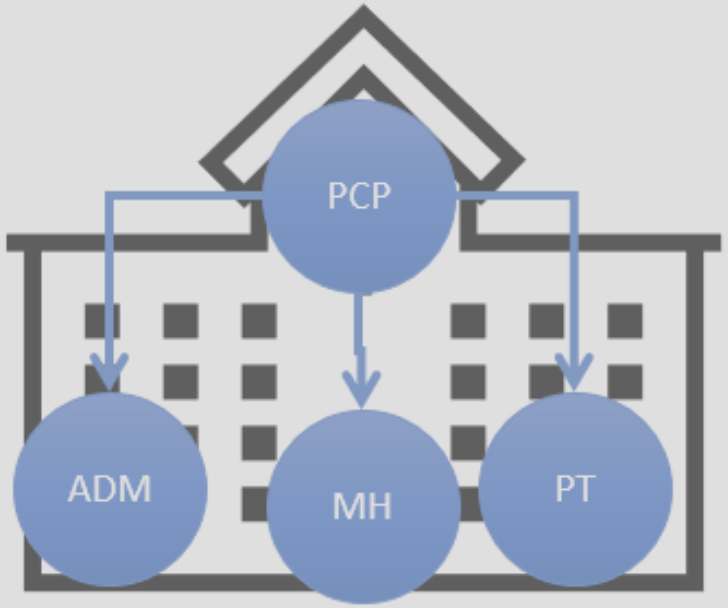
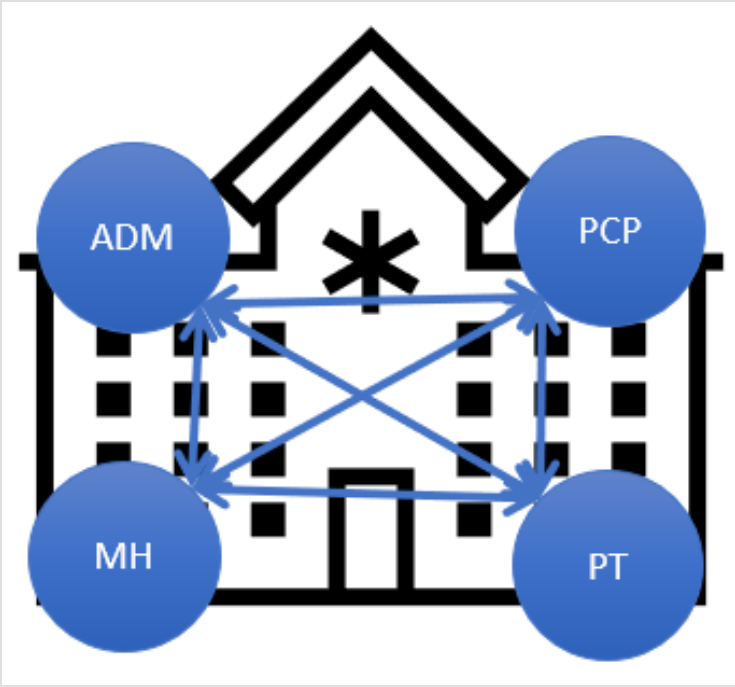
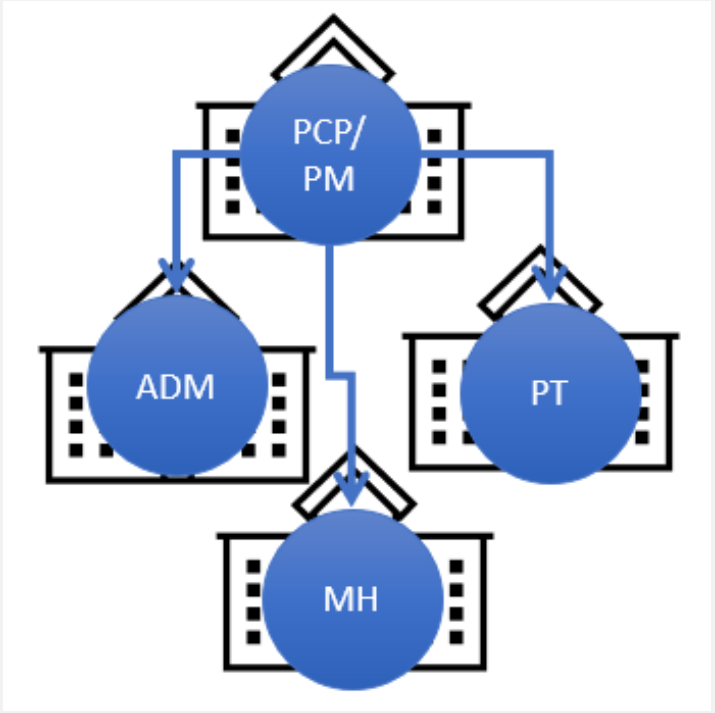


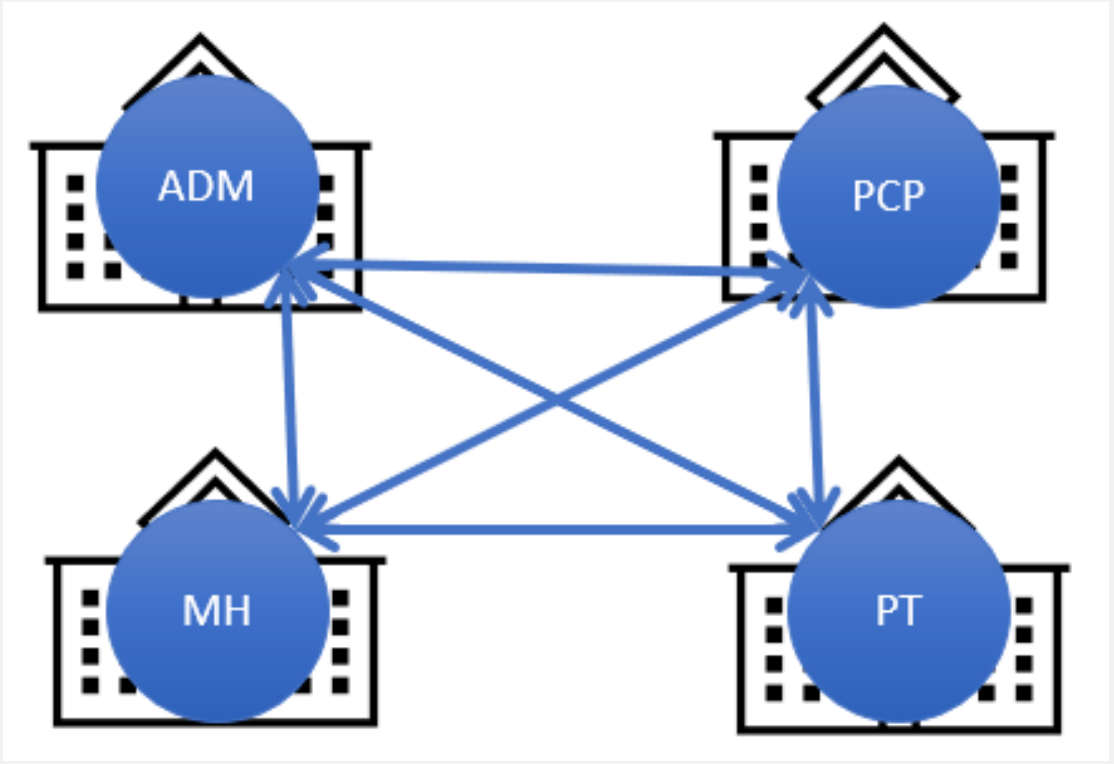
Interdisciplinary Team



Single Discipline Practices



Building the best possible **(virtual) interdisciplinary team**

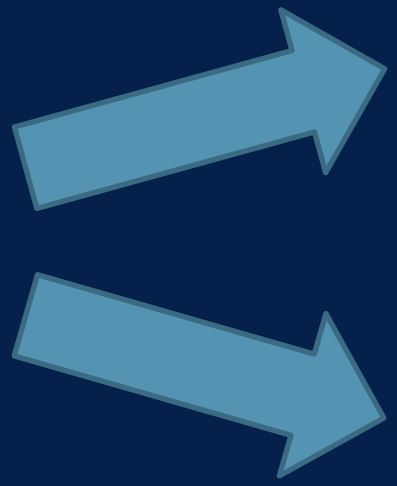


APPLY IT

Case

- Vanessa is a 57 y/o female with LBP x 30 years. She presents to your office in distress and opioid withdrawal stating that her prior PCP “is cutting her off her pain pills”
- Hx: oxycodone 30mg TID was reduced to 10mg TID 1 wk prior
- **What is your next step?**

Tapering LTOT



?Benefits:
reduce pain, improved function and QoL

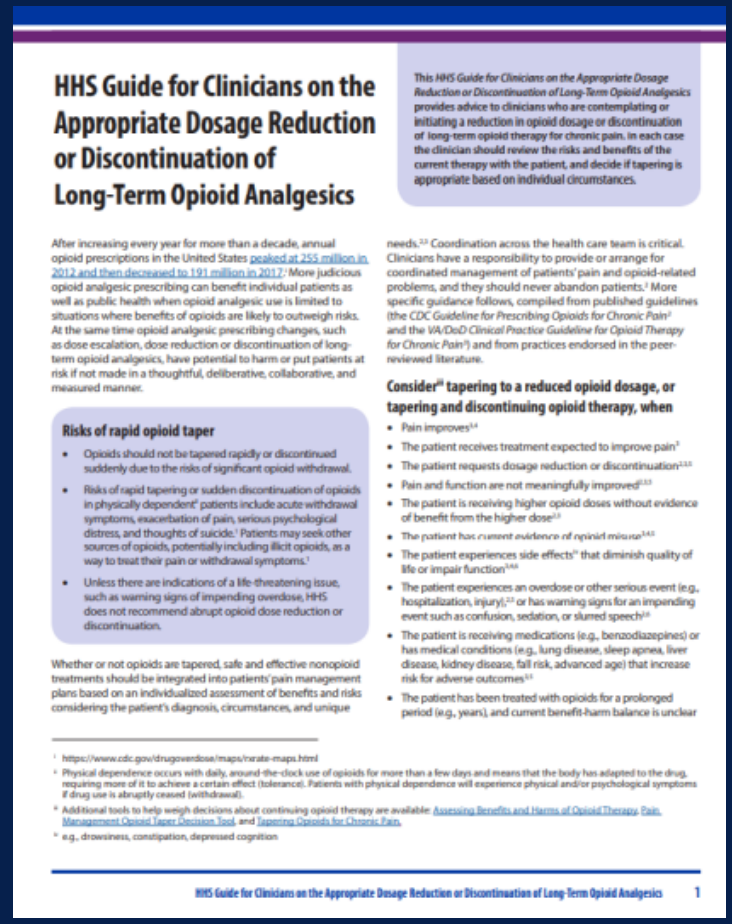
Mackey, 2020
Frank, 2017

?Harms:
increased risk of emotional crisis, overdose, death

Agnoli, 2021
Glanz, 2019
James, 2019

HHS Guide for Clinicians on the Appropriate Dosage Reduction or Discontinuation of Long-Term Opioid Analgesics

- Factors to improve tapering outcomes
  - Take time to engage patients to seek “buy-in”
  - Add behavioral support
  - Add non-pharmacologic treatments for pain
  - Taper slowly



HHS Guide for Clinicians on the Appropriate Dosage Reduction or Discontinuation of Long-Term Opioid Analgesics

This HHS Guide for Clinicians on the Appropriate Dosage Reduction or Discontinuation of Long-Term Opioid Analgesics provides advice to clinicians who are contemplating or initiating a reduction in opioid dosage or discontinuation of long-term opioid therapy for chronic pain. In each case the clinician should review the risks and benefits of the current therapy with the patient, and decide if tapering is appropriate based on individual circumstances.

After increasing every year for more than a decade, annual opioid prescriptions in the United States peaked at 255 million in 2012 and then decreased to 191 million in 2017.[1] More judicious opioid analgesic prescribing can benefit individual patients as well as public health when opioid analgesic use is limited to situations where benefits of opioids are likely to outweigh risks. At the same time opioid analgesic prescribing changes, such as dose escalation, dose reduction or discontinuation of long-term opioid analgesics, have potential to harm or put patients at risk if not made in a thoughtful, deliberative, collaborative, and measured manner.

Risks of rapid opioid taper

- Opioids should not be tapered rapidly or discontinued suddenly due to the risks of significant opioid withdrawal.
- Risks of rapid tapering or sudden discontinuation of opioids in physically dependent[a] patients include acute withdrawal symptoms, exacerbation of pain, serious psychological distress, and thoughts of suicide.[1] Patients may seek other sources of opioids, potentially including illicit opioids, as a way to treat their pain or withdrawal symptoms.[1]
- Unless there are indications of a life-threatening issue, such as warning signs of impending overdose, HHS does not recommend abrupt opioid dose reduction or discontinuation.

Whether or not opioids are tapered, safe and effective nonopioid treatments should be integrated into patients' pain management plans based on an individualized assessment of benefits and risks considering the patient's diagnosis, circumstances, and unique needs.[2,3] Coordination across the health care team is critical. Clinicians have a responsibility to provide or arrange for coordinated management of patients' pain and opioid-related problems, and they should never abandon patients.[2] More specific guidance follows, compiled from published guidelines (the *CDC Guideline for Prescribing Opioids for Chronic Pain*[2] and the *VA/DoD Clinical Practice Guideline for Opioid Therapy for Chronic Pain*[4]) and from practices endorsed in the peer-reviewed literature.

Consider[b] tapering to a reduced opioid dosage, or tapering and discontinuing opioid therapy, when

- Pain improves[3,4]
- The patient receives treatment expected to improve pain[3]
- The patient requests dosage reduction or discontinuation[2,3,5]
- Pain and function are not meaningfully improved[2,3,5]
- The patient is receiving higher opioid doses without evidence of benefit from the higher dose[2,3]
- The patient has current evidence of opioid misuse[3,4,5]
- The patient experiences side effects[c] that diminish quality of life or impair function[3,4,5]
- The patient experiences an overdose or other serious event (e.g., hospitalization, injury),[2,3] or has warning signs for an impending event such as confusion, sedation, or slurred speech[2,3]
- The patient is receiving medications (e.g., benzodiazepines) or has medical conditions (e.g., lung disease, sleep apnea, liver disease, kidney disease, fall risk, advanced age) that increase risk for adverse outcomes[2,3]
- The patient has been treated with opioids for a prolonged period (e.g., years), and current benefit-harm balance is unclear

[1] https://www.cdc.gov/drugoverdose/maps/rxrate-maps.html

[a] Physical dependence occurs with daily, around-the-clock use of opioids for more than a few days and means that the body has adapted to the drug, requiring more of it to achieve a certain effect (tolerance). Patients with physical dependence will experience physical and/or psychological symptoms if drug use is abruptly ceased (withdrawal).

[b] Additional tools to help weigh decisions about continuing opioid therapy are available: Assessing Benefits and Harms of Opioid Therapy, Pain Management Opioid Taper Decision Tool, and Tapering Opioids for Chronic Pain.

[c] e.g., drowsiness, constipation, depressed cognition

https://www.hhs.gov/opioids/sites/default/files/2019-10/Dosage_Reduction_Discontinuation.pdf

Medical Provider Tasks

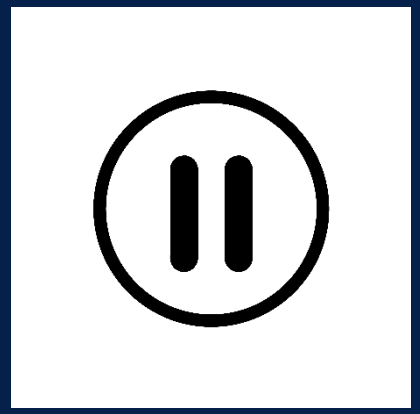
- Whole Person Assessment and set Treatment Course and Goals
  - Screen for OUD
  - Assess for Risks/Benefits of LTOT
  - Taper vs MOUD vs monitor at same opioid dose vs other
- Inquire about Vanessa's wider health goals
- Engage providers of various disciplines who are open to supporting the common treatment goals
- Maintain communication amongst care team and with patient

Case

- Collaborative plan to take over prescribing at a dose between current dose and prior dose (20mg TID), hold dose for 1-2 months and the proceed with gradual “micro-tapering”

Case

- **Gradual and individualized taper pace**
  - “Micro dose reductions” – e.g. 2.5mg reduction Q 1-2 months
  - No rush
  - Individualize plan for Vanessa and her unique life circumstances
  - Maintain flexibility during taper
  - Maximize patient choice points – timing, formulation, pace



Power of the Pause

When there is **resistance**, diagnostic or therapeutic **uncertainty,** and **NO imminent risks**

Err on the side of allowing additional time

Power of the Pause

- Allows time to **enhance buy-in**
- Allows time to **build team-based support**
- Allows time for **neurobiological changes** of opioids to adjust
- Allows time for patient to **improve self-regulation skills**
- Builds in space to **consider alternate treatment pathways**

Cochrane Library

Cochrane Database of Systematic Reviews

2021

Exercise therapy for chronic low back pain (Review)

Hayden JA, Ellis J, Ogilvie R, Malmivaara A, van Tulder MW

Noninvasive Nonpharmacological Treatment for Chronic Pain: A Systematic Review

2018

AHRQ Agency for Healthcare Research and Quality

Effective Health Care Program

Original Investigation

JAMA Internal Medicine

2016

Prevention of Low Back Pain

A Systematic Review and Meta-analysis

Daniel Steffens, PhD; Chris G. Maher, PhD; Leani S. M. Pereira, PhD; Matthew L Stevens, MScMed (Clin Epi); Vinicius C. Oliveira, PhD; Meredith Chapple, BPhty; Luci F. Teixeira-Salmela, PhD; Mark J. Hancock, PhD

ASAM

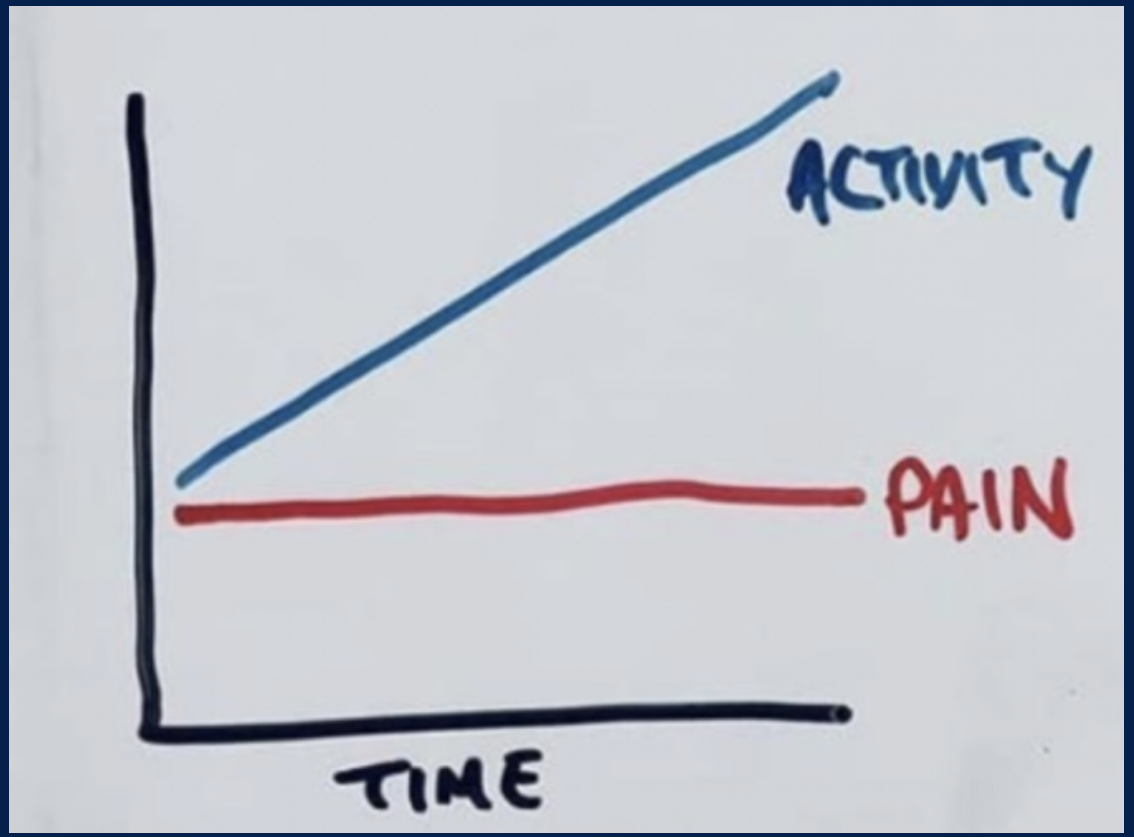
“PT made my pain worse!” Chronic Pain PT and LBP

Daniel Vilaubi PT, DPT

Conundrum

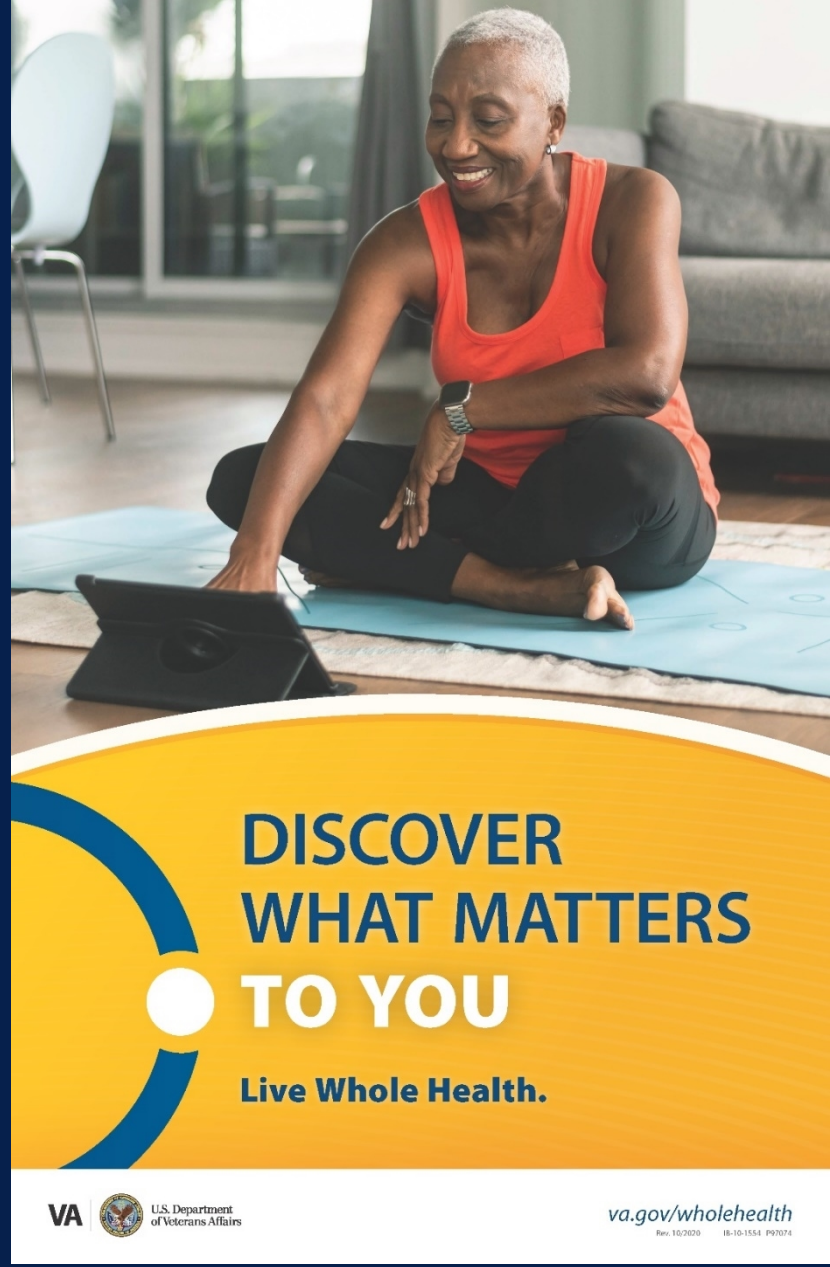
How Do We Make Sense of This?

- Function Vs Pain
- Pain Anatomy Vs Whole Person



Case

- Patient expectations of this visit & of physical therapy
- What are the patient's specific goal(s)?
- Ask questions:
  - What matters to you? What is important to you in life?
  - What excites you?
  - What is your understanding of why you hurt?
- Does the patient feel that I understand their situation?

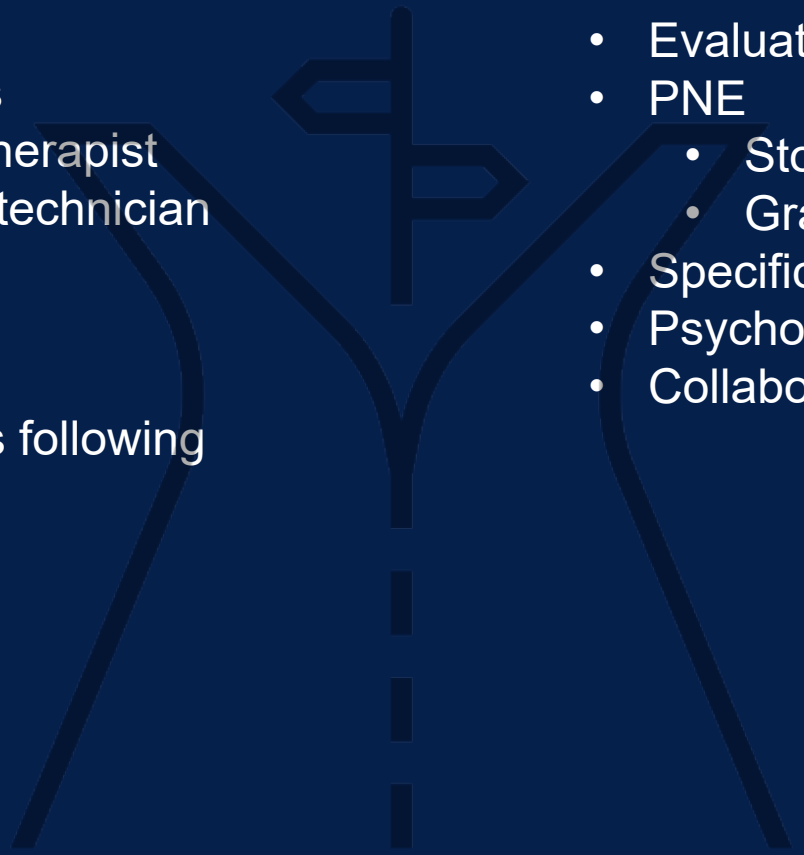


Vanessa's previous experience with PT

Previous Experience

- Evaluation – "Special" Tests
- Exercise bike for 20 minutes
- 15 minutes with a physical therapist
- Exercises completed with a technician
  - "cookie cutter"
- Heat/ice & Stimulation

- Stopped doing the exercises following discharge

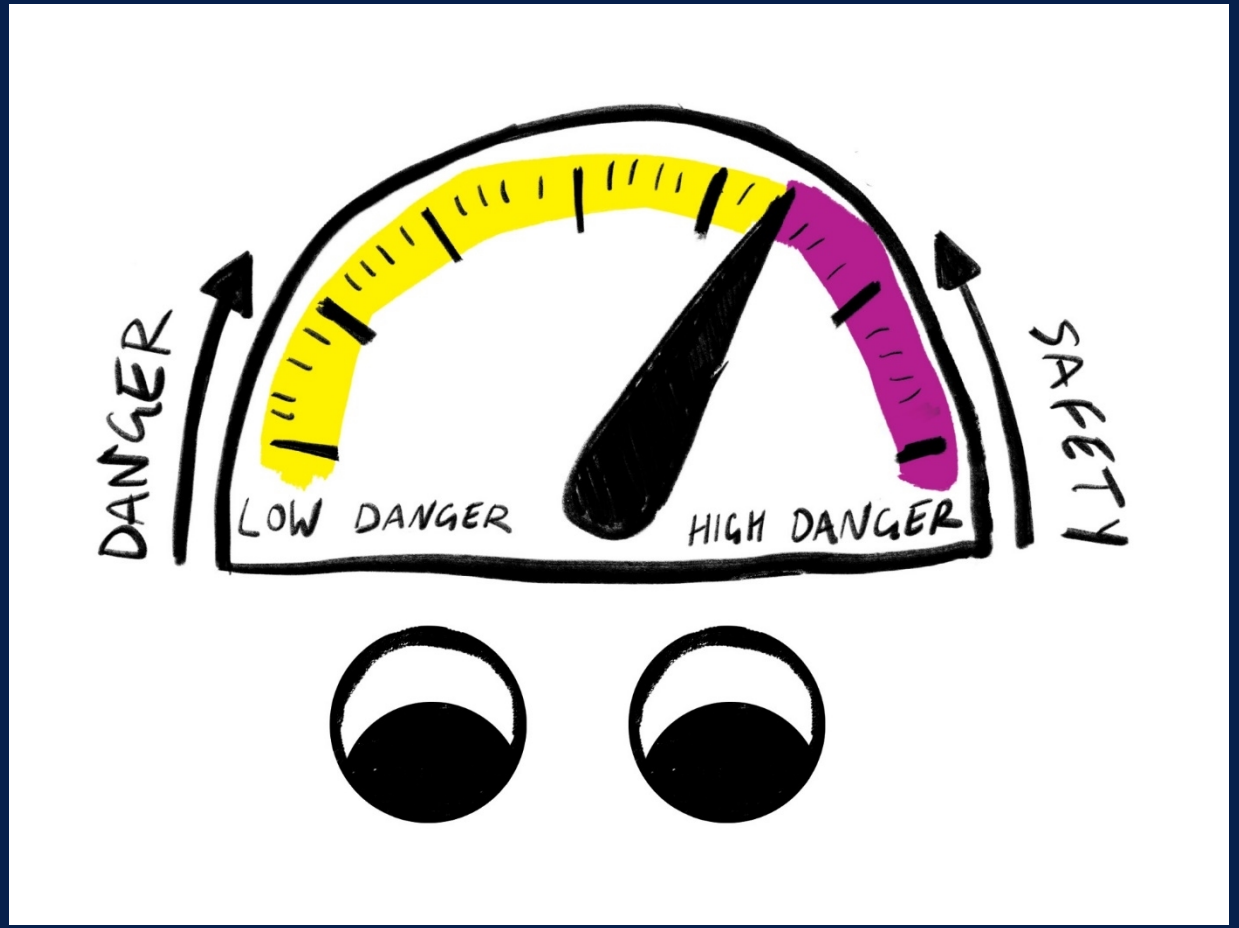


Pain PT Rehabilitation

- Evaluation – Listening, Functional Testing
- PNE
  - Stories
  - Graded Motor Imagery
- Specific functional exercises
- Psychologically Informed PT
- Collaboration

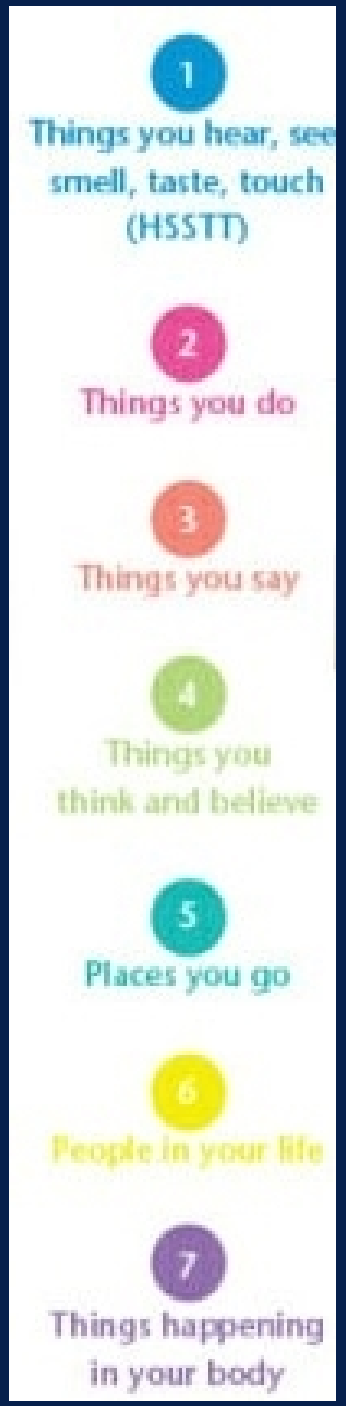
The Protectometer

- You will have pain when your brain concludes that there is more credible evidence of ***danger*** related to your body than there is credible evidence of ***safety*** related to your body.



DIMs

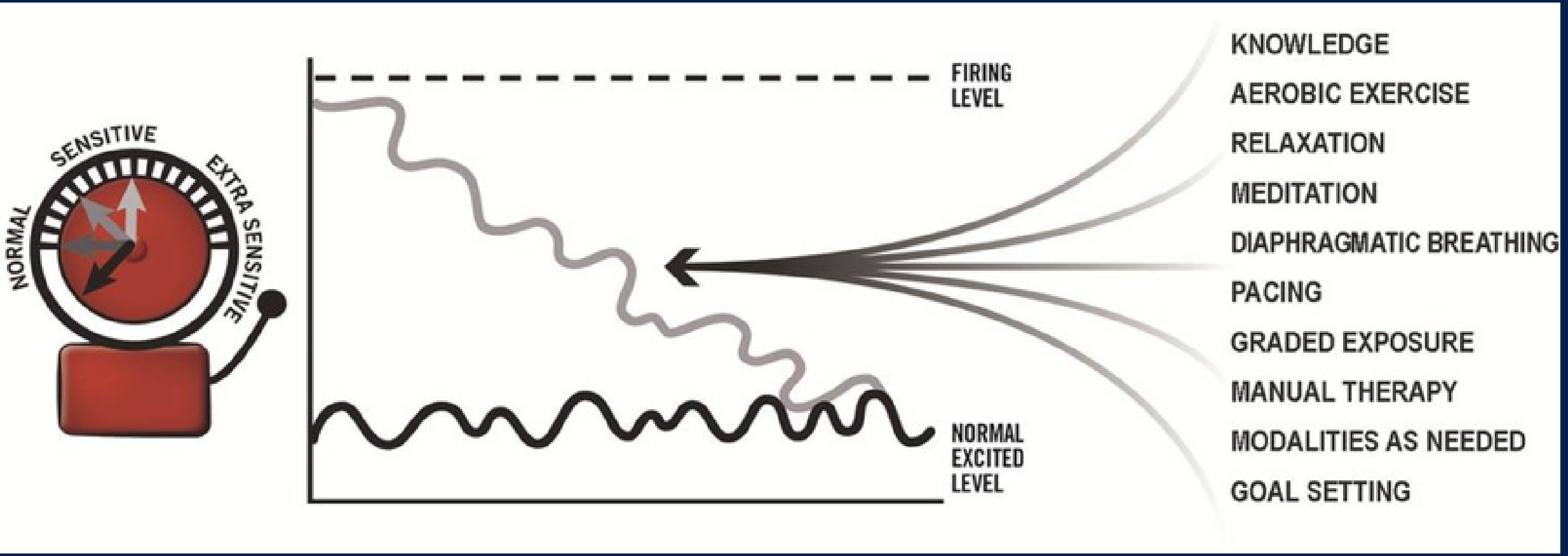
- Imaging:
  - Laundry list of items
  - MRI doesn't show anything
- Stay at home all the time



SIMs

- Imaging:
  - All clear
  - Your image is a picture in time
- Going to a dance class with my best friend

Decreasing Sensitivity



APPLY IT

Exercise – Brain & Body

- Glute Activation

Fire Hydrant

Clamshell

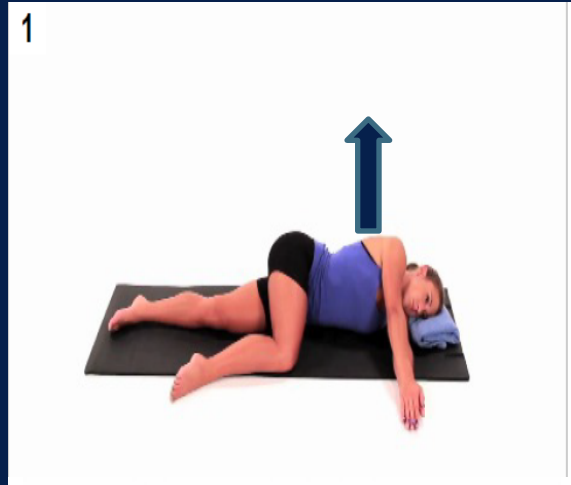
Sidelying Hip Abduction

APPLY IT

Movement

- Gentle Movement
  - Okay to “Nudge” Symptoms
  - “Sore but Safe”
  - “Hurt Does *Not* Equal Harm”
- Trial
  - 3 times per day, 10 repetitions
  - Isometric – two 60-second hold

Sidelying Thoracic Rotation



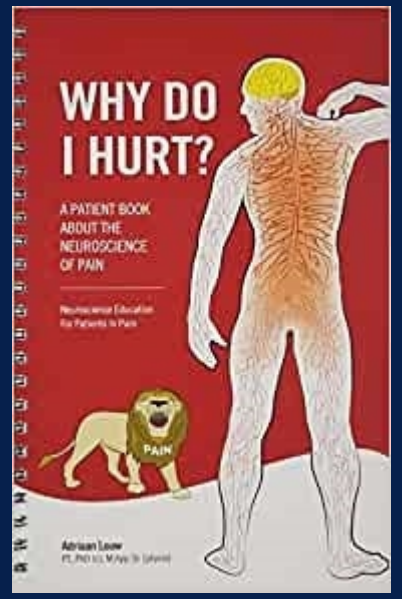
Lower Trunk Rotation

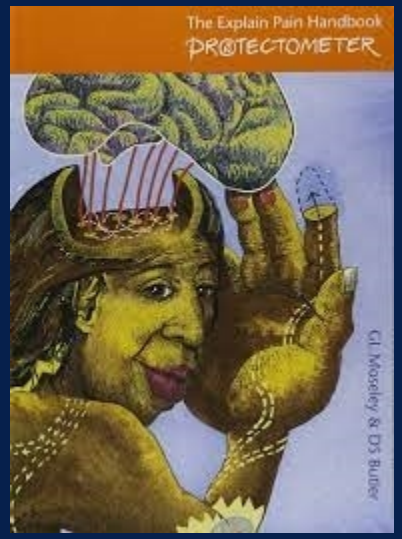
Seated Hip Abduction Isometric

APPLY IT

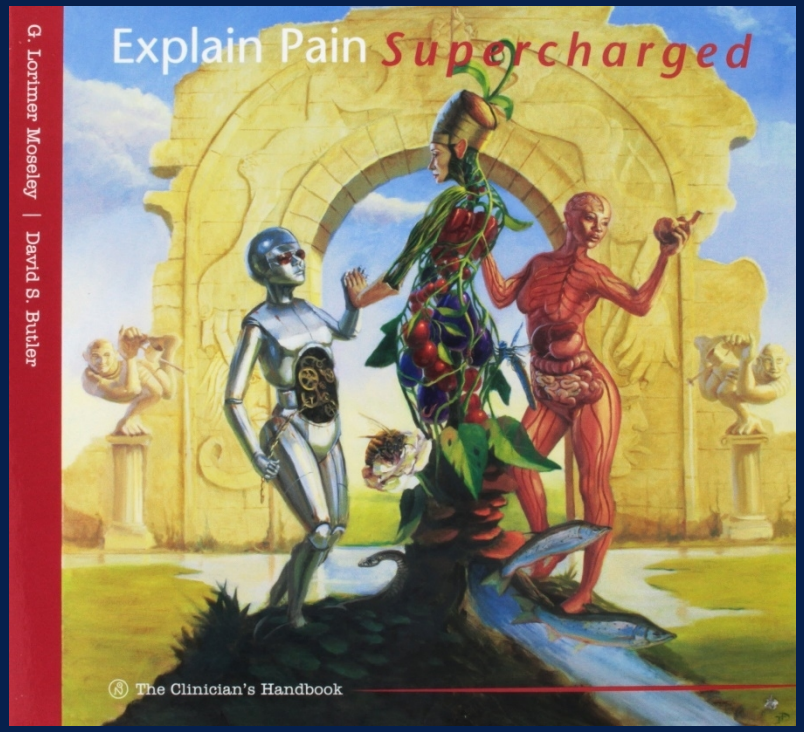
Resources

- For Patients:





- For Providers:



Cochrane Library

Cochrane Database of Systematic Reviews

2020

Psychological therapies for the management of chronic pain (excluding headache) in adults (Review)

Williams ACDC, Eccleston C, Morley S

Noninvasive Nonpharmacological Treatment for Chronic Pain: A Systematic Review

2018

2022

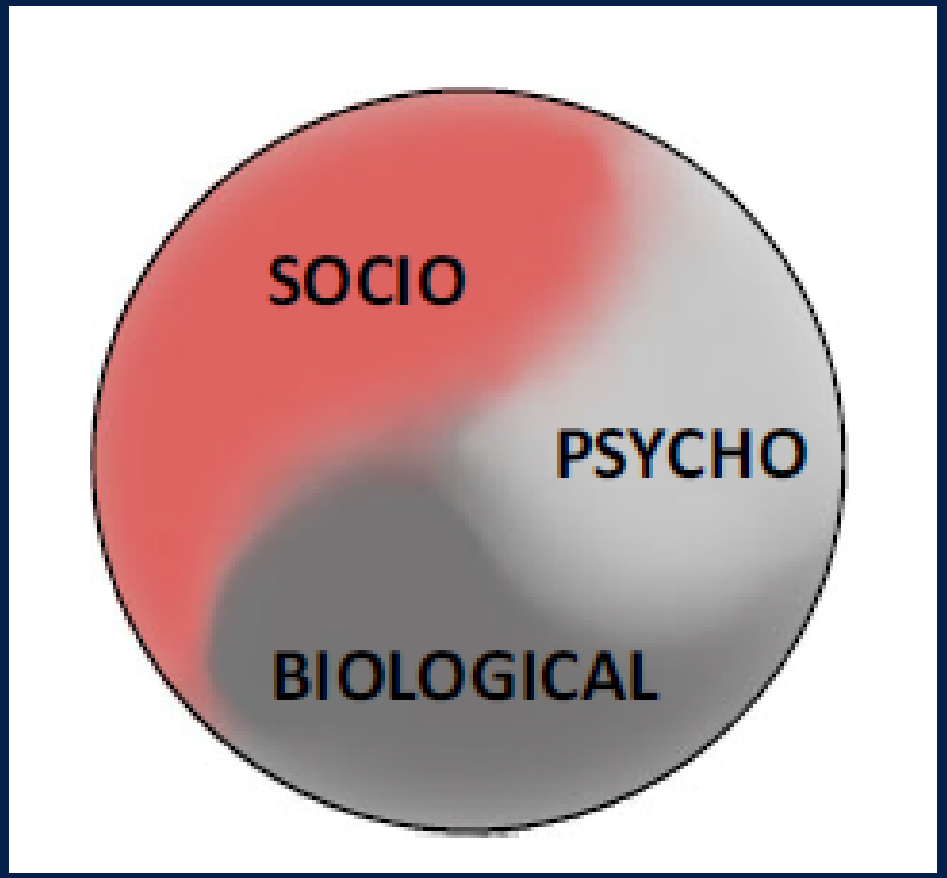
VA/DoD CLINICAL PRACTICE GUIDELINE FOR THE DIAGNOSIS AND TREATMENT OF LOW BACK PAIN

Skillz with the Pillz

Eric Hanson, PhD

(Re)Assess

- Hippocrates: It is more important to know what kind of person has a disease than what kind of disease a person has.
- What are we treating?
- What are realistic expectations that are measurable in the long term?
  - Quality of Life
  - Physical Function



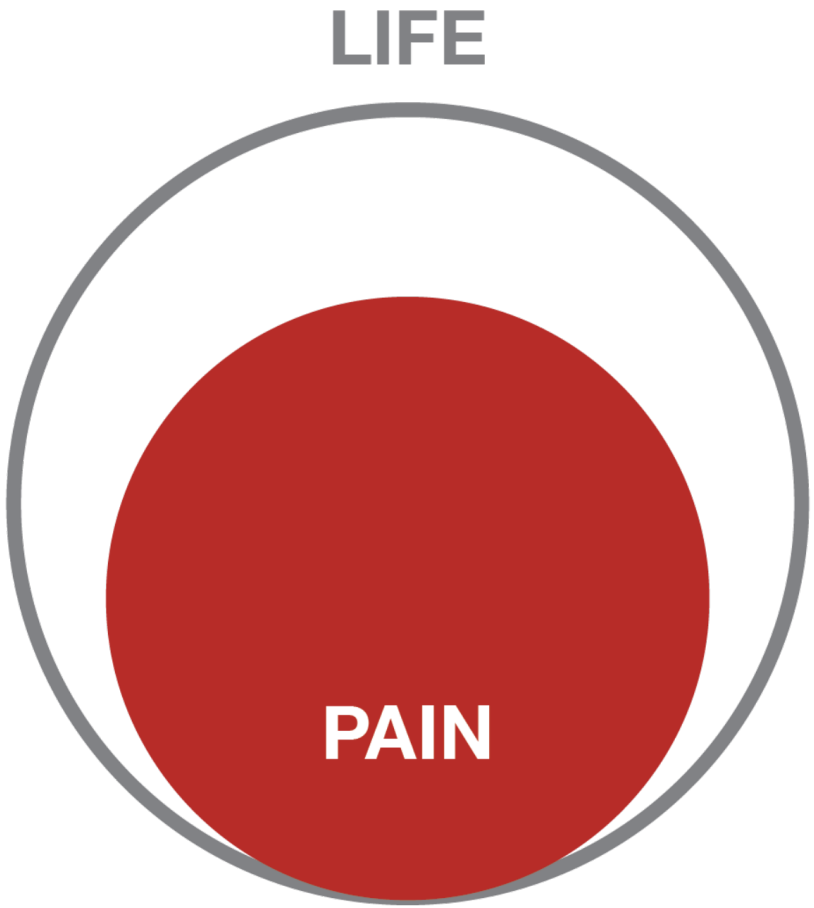
Mardian, et al. (2020)

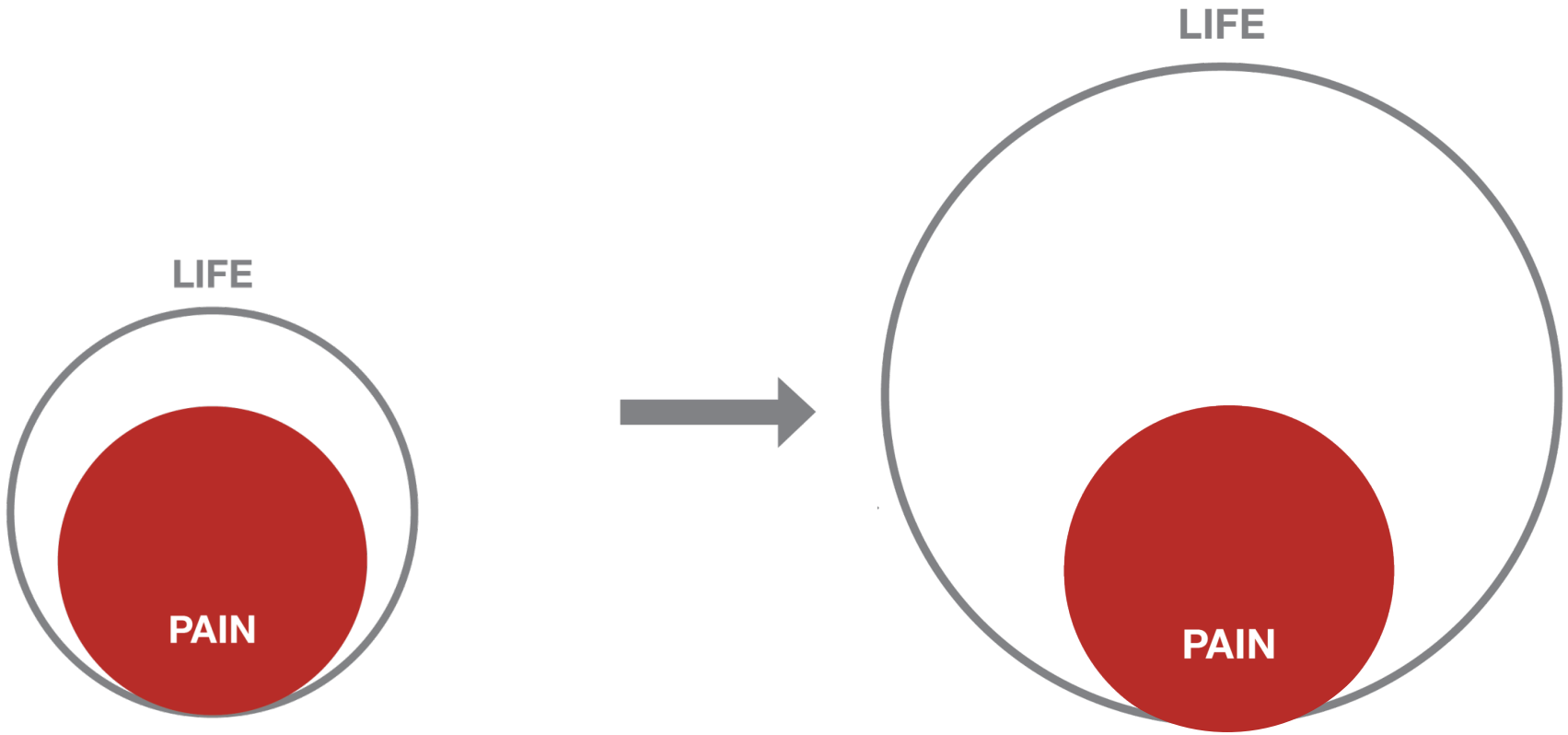
Case – Functional Assessment

- Who is Vanessa?
  - Grandmother
  - Former Athlete
    - Not exercising
  - No Hobbies
  - Depressed with transient thoughts of death
    - Cognitions focused on pain and opioids
  - Low Social Support
  - Overusing Distraction

Building Pain/Addiction Management Skills

- Teaching Cognitive Behavioral Skills
  - Social
  - Psychological
  - Physical
  - (Spiritual)
  - Medical Adherence


LIFE
PAIN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APPLY IT

Increasing Pleasant Activities

- Ask about hobbies and enjoyable activities
  - May need to ask what these were prior to having chronic pain
- If unable to do previous hobbies without injury, encourage finding new ways to re-engage
  - E.g. Vanessa enjoyed playing basketball in the past. Could she coach for her son or grandson's team?
  - E.g. Vanessa enjoyed going on long overnight fishing trips with her friends. Could she join a weekly nature walking group?
- Focus on the underlying value of the activity (e.g. time in nature, time with friends)
- Prioritize activities with social component

Time-Based Pacing

- Time based pacing is a key skill for individuals with chronic pain
- Time based pacing means planning activity and breaks/rest at predetermined time intervals with a goal of keeping pain within acceptable levels
  - Contrasted to pain-based pacing which involves engaging in activities until the pain is unbearable and then taking a break
- Challenges:
  - Unhelpful cognitions
  - Learning a new way to engage with tasks
  - Often can allow patients to return to higher level of functioning

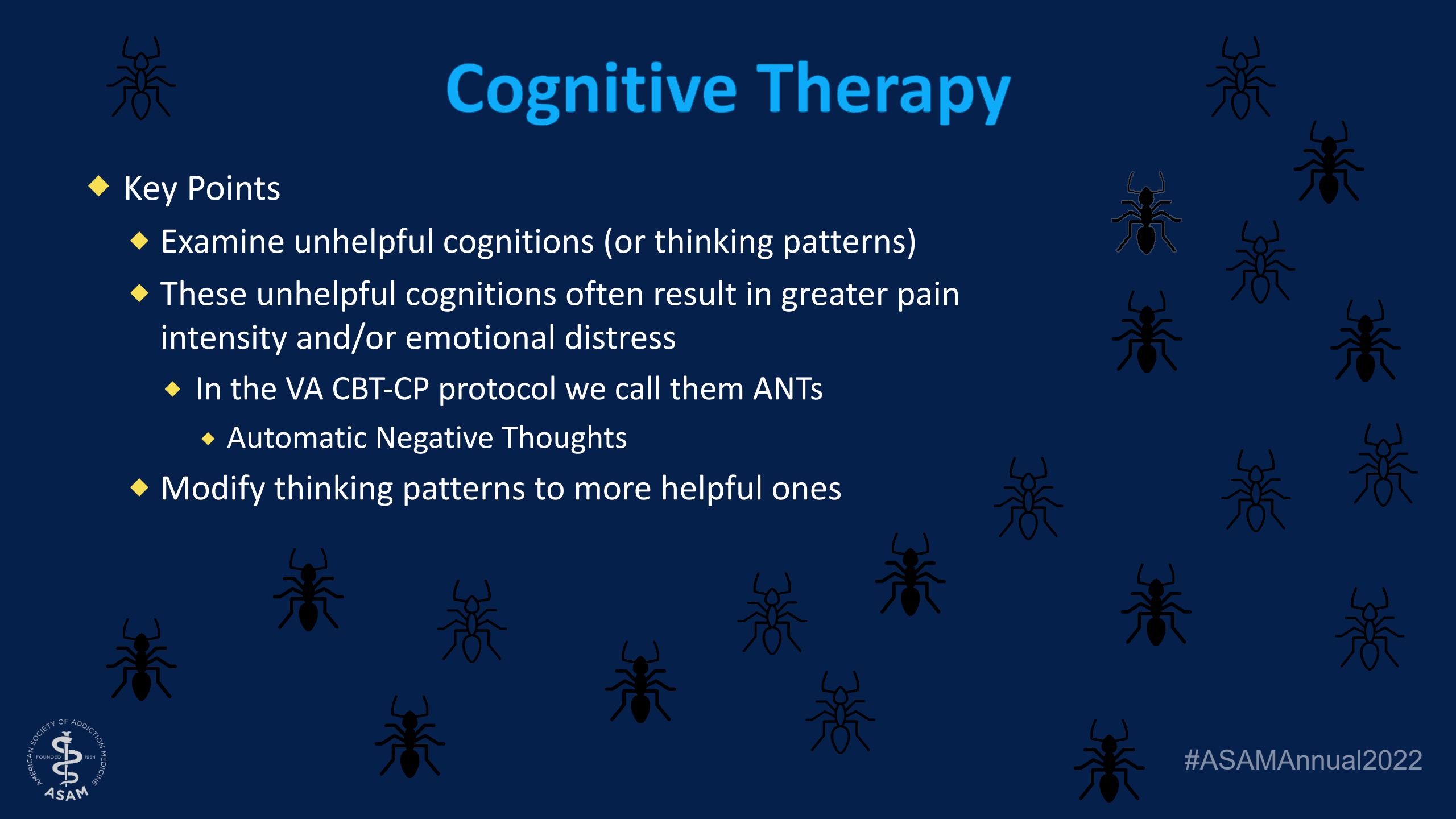
APPLY IT

Time Based Pacing

- Vanessa: “The dishes pile up because the pain is terrible if I stand more than 15 minutes”
- Response: “~~Have you tried using paper plates?~~”
- Better Response: “I hear that the cleanliness of your household is important to you and doing things in the same ways that you used to is not working well. Would you be interested in trying a new approach to doing the dishes that has helped with many of my other patients? Let’s try an experiment of planning to wash dishes only for the amount of time that is comfortable for you and then taking a break before returning for another comfortable period of washing.”

Cognitive Therapy

- Key Points
  - Examine unhelpful cognitions (or thinking patterns)
  - These unhelpful cognitions often result in greater pain intensity and/or emotional distress
    - In the VA CBT-CP protocol we call them ANTs
      - Automatic Negative Thoughts
  - Modify thinking patterns to more helpful ones



APPLY IT

Listen for ANTs in your patients

- Example 1: **Vanessa says:** “I can’t exercise because my knees are bone on bone and exercise will make it worse”
- **Response:** “I hear that you want your knees to be healthy and I hear you are concerned that exercise might harm them. Would you be interested in knowing more about how exercise might help improve the physical health of your knees?”

APPLY IT

Listen for ANTs in your patients

- Example 2: **Vanessa says:** “My spine is disintegrating”
- **Response:** “I hear you’re concerned about the physical state of your spine. Reviewing your MRI, I see that you have age related changes that are very common, but I don’t see anything dangerous or concerning. Let’s talk about some of the best treatments for this.”

Language Rubric

- VEMA – Helpful mnemonic for scripting
  - Validate – pain experiences or diagnosis
  - Educate – best practices & realistic expectations
  - Motivate – patient taking an active role
  - Activate – goal setting and action plan

- VEMA comes from Anthony J. Mariano, PhD Clinical Psychologist, Pain Service VA Puget Sound Health Care System

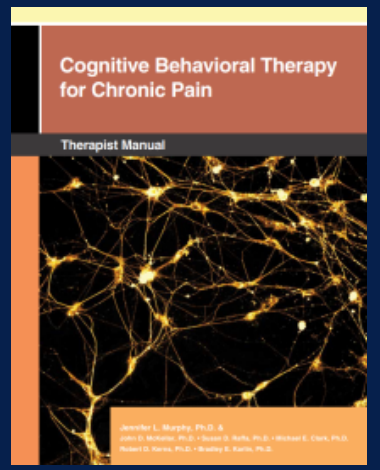
APPLY IT

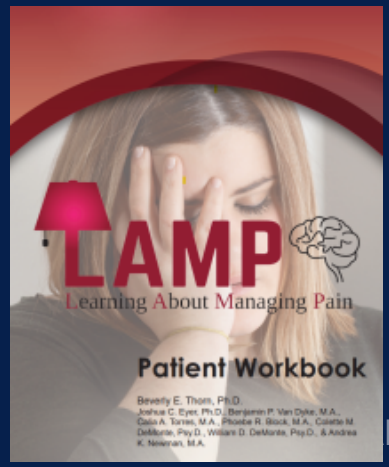
Example Script for Vanessa

- VEMA
  - **Validate**: “Vanessa, I *know* your pain is real. AND I am concerned about all the stress you are under. It seems like there are many things in your life are contributing to your stress (list from your psychosocial assessment).
  - **Educate**: Thank you for completing this measure before our appointment, I see that you have some anxiety and depression symptoms. You have told me how stress and these negative emotions are worsening your pain. AND we know that stress, anxiety, and depression will often worsen the pain experience.
  - **Motivate**: I would like you to see a colleague of mine. Dr. Hanson is a psychologist that specializes in how reducing stress, anxiety, and depression can help you feel better by increase your quality of life and function.
  - **Activate**: Dr. Hanson has a similar philosophy to mine regarding pain. Here is their number. When during the next week do you think that you could call to set up an appointment? I would really like it if you saw them before your next appointment with me.

Resources

- Pain Management - Cognitive Behavioral Therapy for Chronic Pain (CBT-CP) - VHA Pain Management (va.gov)
- VA CBT-CP Therapist Manual
- Dr. Beverly Thorne CBT-CP resources





Clinical Pharmacists Can Share the Load!

Bethany Dipaula, PharmD, BCPP, FASHP

Pharmacist Scope of Practice/Responsibilities

- May vary from state to state/ between practice settings
- Key roles
  - Dispensing, compounding medication
  - Medication profile review
  - Administration of vaccines and long acting injectables
  - Management of drug therapy
  - Order medication pursuant to practice agreement

Pharmacy Specialization

Board of Pharmacy Specialties (BPS)

- Ambulatory Care
- Cardiology
- Compounded/Sterile Prep
- Critical Care
- Emergency Medicine
- Geriatrics
- Infectious Disease
- Nuclear
- Nutrition Support
- Oncology
- Pediatric
- Pharmacotherapy
- Psychiatric
- Solid Organ Transplantation

Multidisciplinary

- Anticoagulation
- Asthma
- Depression
- Diabetes
- HIV/AIDS
- Pain Management*
- Poison Information
- Substance Use Disorders
- Toxicology

https://www.bpsweb.org/bps-specialties/

Diverse Practice Settings

- Patient population: indigent, underserved
- Setting: Urban/Suburban, Inpatient/Ambulatory
- FQHC-7 clinics in high poverty areas of Baltimore
- County Health Department-Substance Abuse Bureau
- Integrated Primary Care Center-Baltimore City

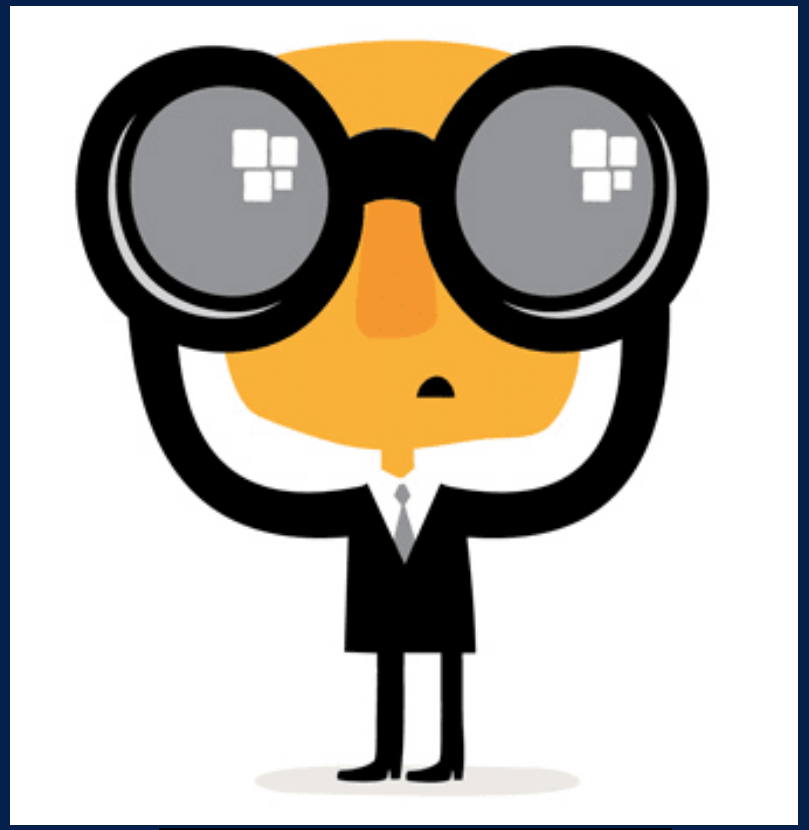
Clinical Pharmacist Role for Vanessa?

- Person centered care! It takes a village
- Physician extender-collaborative team-based care
- Disease-state monitoring and medication management
  - Medication history
  - Dose monitoring (efficacy, side effects, adherence)
  - Laboratory tests orders (urine toxicology screens)
  - Drug interaction monitoring
  - Comorbidity monitoring (SUD)
- Diversion monitoring (PDMP, local pharmacies)
- Insurance follow up (PA, cost-goodrx)

APPLY IT

How can I find a clinical pharmacist?

- Common practice settings
  - Universities
  - VA
  - Medical groups (Kaiser Permanente)
  - Project ECHO (Extension for Community Healthcare Outcomes)
    - https://hsc.unm.edu/echo/become-a-partner/#findanexistingecho
- Board of Pharmacy Specialties (BPS)
  - http://www.bpsweb.org/find-a-board-certified-pharmacist/
- National or State Pharmacy Organizations
  - College of Psychiatric and Neurologic Pharmacists (CPNP) www.cpnp.org



Resources

- Patient
  - Prescribe To Prevent: materials/training on opioid safety and naloxone
    - https://prescribetoprevent.org/patient-education/materials/
  - Opioid Checklist: education on safe use of opioid medications
    - https://generationrx.org/wp-content/uploads/2017/09/checkopioids2021_07_13.pdf
  - Safe Opioid Disposal
    - https://www.fda.gov/drugs/safe-disposal-medicines/safe-opioid-disposal-remove-risk-outreach-toolkit

- Pharmacist/Other Healthcare Professionals
  - ASHP Pain Management Toolkit
    - https://www.ashp.org/pharmacy-practice/resource-centers/pain-management-toolkit?loginreturnUrl=SSOCheckOnly
  - Toolkits (including buprenorphine initiation/dosing)
    - https://cpnp.org/ed/oud

“I’m not an addict, I have real pain!” – An addiction psychiatrist wades into the grey zone

Anita Karnik, MD

Case

- Vanessa improves after stabilizing her opioid dose at oxycodone 20mg TID
- The medical team initiated “micro-tapering” with 2.5mg dose reductions every other month while optimizing whole person team-based care
- Vanessa is doing well with function and following with the opioid taper plan but presented with high anxiety and distress during various appointments that she associated with taper.

Addressing Real Clinical Challenges That Can Lead to Barriers

Distress Surrounding Opioid Taper

Potential for Challenges in the Patient-Clinician Relationship

Pitfalls can occur on both sides

- When pain is the patient's the central concern it is quite possible that the identified need for SUD services may be **only** clinician driven.

Patient related pitfalls	Addiction specialist related pitfalls
May feel a complete disconnect from SUD specialty services	DSM5 criteria for OUD may not capture full picture
May feel abandoned or stigmatized and hide what they are experiencing	May not feel fully knowledgeable about pain conditions expected levels of treatment.
Patient may not identify with any negative consequences of use – see opioids as bringing value and function	If no immediate action needed (ex: No MAT immediately indicated) treatment planning may prematurely end.
May medicalize entire appointment in an effort to prove their pain	ADM specialist network of services may not fit the patient. Example CBT SUD referral may not fit.

Integrated SUD Evaluation

- Chronic Pain team to start language of incorporating SUD evaluation early in the plan using non stigmatizing language

- At SUD intake starting with knowledge of plan from chronic pain team and using shared language of patient identified successes and barriers

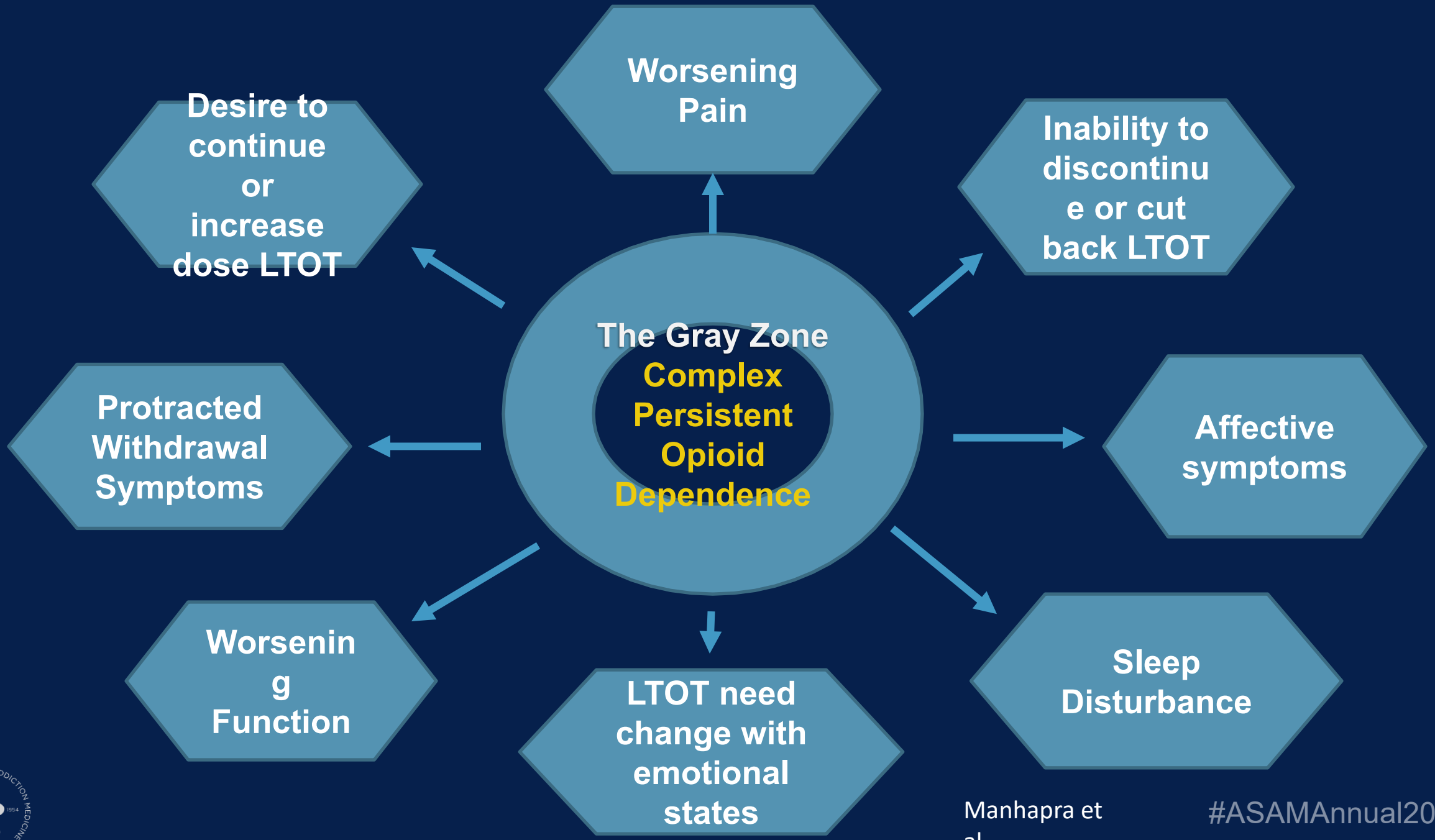
Choi, et al

Vanessa's Journey

- Vanessa met with addiction medicine physician early on in her treatment plan for chronic pain. She did not meet criteria for OUD. Addiction Medicine specialist continued to follow Vanessa as she worked with her medical provider to taper opioids.

- After 8 months, Vanessa is taking 55mg of oxycodone daily and reports that she is doing worse (waking up more frequently at night, feeling irritable and achy during the day- these symptoms have not improved despite being on the same opioid dose for 3 months.)

- Despite slow changes she reached a point she "could not continue her opioid taper any further."



Manhapra et al

#ASAMAnnual2022

Vanessa's Journey

Its not about the opioids-Its about pain!

I think of pain around the clock and that is the reason I do not do anything fun.

I know an opioid would help some; If there was another medication that would help with pain, I would gladly take that.

Vanessa's Journey

- Vanessa's specific risks outweighed benefits of opioid therapy and the decision was made to move to buprenphine/naloxone for complex persistent opioid dependence.
- Vanessa was very anxious about losing her opioid.
- Vanessa's pain medical provider and addiction medicine clinician worked with Vanessa to move to buprenorphine/nx by initiating a microinduction to buprenorphine/nx.

Low Dose Initiation of Buprenorphine: A Narrative Review and Practical Approach

Shawn M. Cohen, MD, Melissa B. Weimer, DO, MCR, Ximena A. Levander, MD, Alyssa M. Peckham, PharmD, BCPP, Jeanette M. Tetrault, MD, and Kenneth L. Morford, MD

JOURNAL OF Addiction Medicine
The Official Journal of the American Society of Addiction Medicine
2021 Epub

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Buprenorphine dose	0.5mg daily	0.5mg BID	1mg BID	2mg BID	4mg BID	4mg TID	8mg BID
Film size	2mg	2mg	2mg	2mg	2mg	2mg	8mg
Morning dose							
Afternoon Dose							
Night dose							
Full agonist	Continue	Continue	Continue	Continue	Continue	Continue	STOP

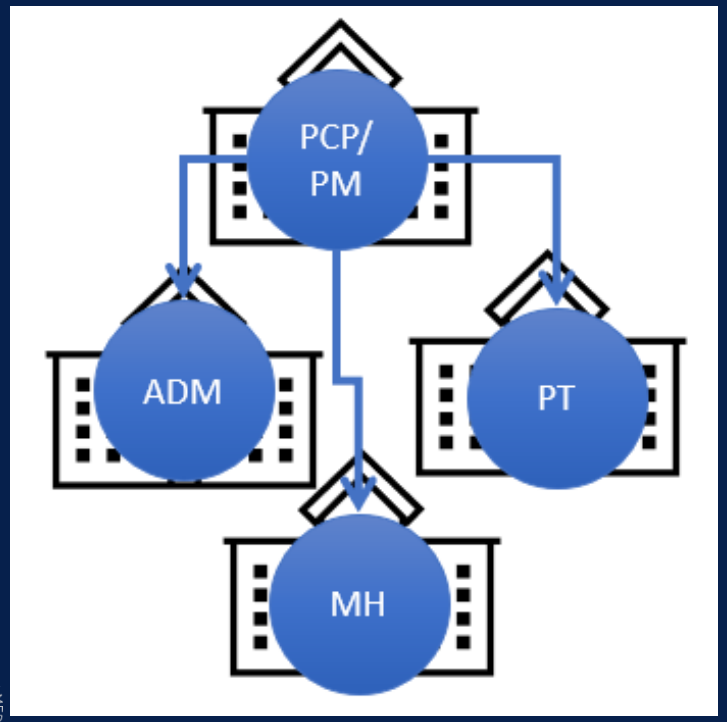
APPLY IT

Microinduction to Bup/Naloxone

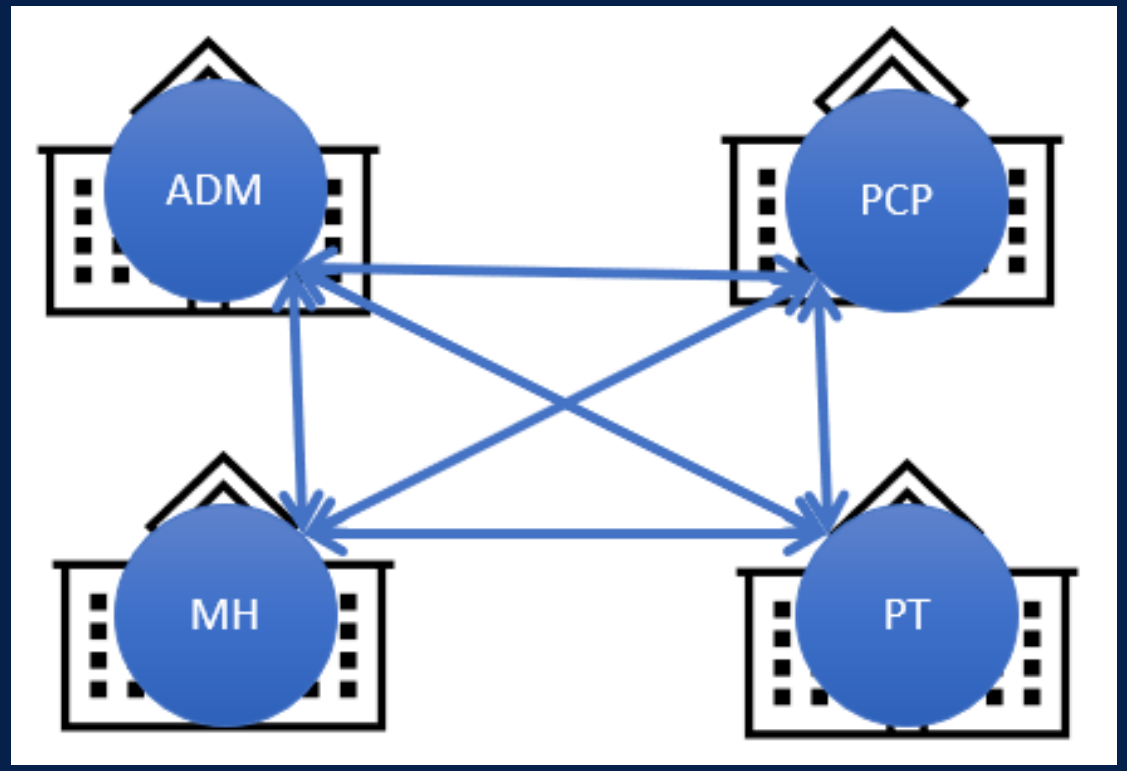
- The traditional induction to Bup/naloxone can be a barrier
- Buprenorphine/naloxone microinduction is an effective strategy
  - Helps patient ease into medication and helps to avoid panic about withdrawal
  - More receptiveness to this approach as do not give up their opioids on a certain day before knowing experience on buprenorphine/naloxone
  - For patients in geriatric age group, this has led to less concern of instability of patients undergoing withdrawal when trying to do inductions.

Continuum of Team Integration

Single Discipline Practices



Building the best possible (virtual) interdisciplinary team



Thank you

Summary

- Team based care supports patients and providers
- Interdisciplinary care can be adapted to diverse settings
  - Try building a team with diverse disciplines that are available in your setting
- All providers can incorporate key behavioral strategies when treating patients with chronic pain and addiction
  - Try incorporating time-based pacing, identification of ANTs, and guiding your patients to engage in pleasant activities
- Partner with your patients and team members to individualize a gradual taper when risks of LTOT outweigh benefits
- Consider a buprenorphine microinduction when transitioning from prescribed opioids for chronic pain to buprenorphine for OUD

References

1. Agnoli, A.; Xing, G.; Tancredi, D.J.; Magnan, E.; Jerant, A.; Fenton, J.J. Association of Dose Tapering With Overdose or Mental Health Crisis Among Patients Prescribed Long-term Opioids. JAMA 2021, 326, 411, doi:10.1001/jama.2021.11013.
2. Carroll KM, Weiss RD. The Role of Behavioral Interventions in Buprenorphine Maintenance Treatment: A Review. Am J Psychiatry. 2017 Aug 1;174(8):738-747. doi: 10.1176/appi.ajp.2016.16070792. Epub 2016 Dec 16. PMID: 27978771; PMCID: PMC5474206.
3. Choi BC, Pak AW. Multidisciplinarity, interdisciplinarity and transdisciplinarity in health research, services, education and policy: 1. Definitions, objectives, and evidence of effectiveness. *Clin Invest Med* 2006;29:351–364
4. De Aquino JP, Parida S, Sofuoglu M. The Pharmacology of Buprenorphine Microinduction for Opioid Use Disorder. *Clin Drug Investig*. 2021;41(5):425-436. doi:10.1007/s40261-021-01032-7
5. Ehde, D. M., Dillworth, T. M., & Turner, J. A. (2014). Cognitive-behavioral therapy for individuals with chronic pain: Efficacy, innovations, and directions for research. *American Psychologist, 69*(2), 153–166. https://doi.org/10.1037/a0035747
6. Frank, J.W.; Lovejoy, T.I.; Becker, W.C.; Morasco, B.J.; Koenig, C.J.; Hoffecker, L.; Dischinger, H.R.; Dobscha, S.K.; Krebs, E.E. Patient Outcomes in Dose Reduction or Discontinuation of Long-Term Opioid Therapy. Ann. Intern. Med. 2017, 165, 245–52, doi:10.7326/M17-0598.
7. Glanz, J.M.; Binswanger, I.A.; Shetterly, S.M.; Narwaney, K.J.; Xu, S. Association Between Opioid Dose Variability and Opioid Overdose Among Adults Prescribed Long-term Opioid Therapy. *JAMA Netw. Open* **2019**, *2*, e192613, doi:10.1001/jamanetworkopen.2019.2613.
8. Hayden, J.A.; Ellis, J.; Ogilvie, R.; Malmivaara, A.; van Tulder, M.W. Exercise therapy for chronic low back pain. *Cochrane Database Syst. Rev.* **2021**, *2021*, doi:10.1002/14651858.CD009790.pub2.

References

1. HHS Guide for Clinicians on the Appropriate Dosage Reduction or Discontinuation of Long-Term Opioid Analgesics
2. James, J.R.; Scott, J.A.M.; Klein, J.W.; Jackson, S.; McKinney, C.; Novack, M.; Chew, L.; Merrill, J.O. Mortality After Discontinuation of Primary Care–Based Chronic Opioid Therapy for Pain: a Retrospective Cohort Study. J. Gen. Intern. Med. 2019, 34, 2749–2755, doi:10.1007/s11606-019-05301-2.
3. Mackey, K.; Anderson, J.; Bourne, D.; Chen, E.; Peterson, K. Benefits and Harms of Long-term Opioid Dose Reduction or Discontinuation in Patients with Chronic Pain: a Rapid Review. J. Gen. Intern. Med. 2020, 35, 935–944, doi:10.1007/s11606-020-06253-8.
4. Manhapra A, Arias AJ, Ballantyne JC. The conundrum of opioid tapering in long-term opioid therapy for chronic pain: A commentary. *Subst Abus*. 2018;39(2):152-161. doi:10.1080/08897077.2017.1381663
5. Mardian AS, Hanson ER, Villarroel L, Karnik AD, Sollenberger JG, Okvat HA, Dhanjal-Reddy A, Rehman S. Flipping the Pain Care Model: A Sociopsychobiological Approach to High-Value Chronic Pain Care. Pain Med. 2020 Jun 1;21(6):1168-1180. doi: 10.1093/pm/pnz336. PMID: 31909793.
6. National Academies of Sciences, Engineering, and Medicine 2019. Medications for Opioid Use Disorder Save Lives. Washington, DC: The National Academies Press. https://doi.org/10.17226/25310.
7. Skelly AC, Chou R, Dettori JR, Turner JA, Friedly JL, Rundell SD, Fu R, Brodt ED, Wasson N, Winter C, Ferguson AJR. Noninvasive Nonpharmacological Treatment for Chronic Pain: A Systematic Review. Comparative Effectiveness Review No. 209. (Prepared by the Pacific Northwest Evidence-based Practice Center under Contract No. 290-2015-00009-I.) AHRQ Publication No 18-EHC013-EF. Rockville, MD: Agency for Healthcare Research and Quality; June 2018. DOI: https://doi.org/10.23970/AHRQEPCCER209
8. Steffens, D.; Maher, C.G.; Pereira, L.S.M.; Stevens, M.L.; Epi, M.C.; Oliveira, V.C.; Chapple, M.; Teixeira-salmela, L.F.; Hancock, M.J. Prevention of Low Back Pain. **2016**, *2000*, 1–10, doi:10.1001/jamainternmed.2015.7431.