How Can I Prevent My Patients From Developing An Opioid Use Disorder?

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GENERAL DISCLOSURES

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Speaker Disclosures

✓ No financial conflicts of interest

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  - NIH Pain Consortium award: UW Center of Excellence in Pain Education
  - AHRQ: Team-Based Safe Opioid Prescribing in Primary Care
  - CDC Clinical Quality Improvement Implementation Package for Large Healthcare Systems: Activities to Support Guideline Dissemination and Implementation
  - NIAMS P30 Core Centers for Clinical Research (CCR); Transforming Clinical Information for Learning (TCIL)
UW PACC REGISTRATION

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If you have not yet registered, please email uwpacc@uw.edu so we can send you a link.
Objectives
Be able to...

1. Choose opioids wisely, based on indication and risk.

2. Reduce risk of transitioning from acute to chronic opioid use patients.

3. Differentiate between pain relief-seeking behaviors from opioid misuse, abuse, and addiction behaviors.

4. Describe approach to tapering opioids, when necessary and appropriate.
Accurate Diagnosis *Precedes* Effective Treatment

“In order to treat something, we must first learn to recognize it.”  
- William Osler

1. Chronic pain is a complex condition which when assessed following a structured approach, supports diagnostic accuracy

2. Thorough assessment of the common *biopsychosocial* domains also adds important diagnoses that require treatment
17th Century “Cartesian View” of Pain

“Doleo, ergo sum”?

“Nociception”
Emerging Science: “Pain Salience”

Early 21st Century “Gate Theory” of Pain

Kucyi A, Davis KD. Trends in Neurosciences, 2015
Physical and Social Pain  Reward or Pleasure Network

Periaqueductal gray
Dorsal Anterior Cingulate
Insula
Somatosensory cortex
Thalamus

Ventral tegmental area
Ventral striatum
Ventromedial prefrontal
Amygdala

Leiberman MD, Eisenberger NI. Science 2009
Preexisting brain-states impact the experience of pain

By carefully evaluating our patients we can “observe” these behavioral “phenotypes”

Kucyi A, Davis KD. Trends in Neurosciences, 2015
History Shapes Beliefs, Behaviors, & Outcomes: Adverse Childhood Events (“ACE”)

**Significant Events**

- Recurrent physical/emotional abuse
- Contact sexual abuse
- An alcohol and/or drug abuser in the household
- An incarcerated household member
- Someone who is chronically depressed, mentally ill, institutionalized, or suicidal
- Mother is treated violently
- Emotional or physical neglect

**Robust Correlations**

- Depressed affect, suicide attempts
- Multiple sexual partners, sexually transmitted diseases
- Smoking & alcoholism
- Social, emotional, cognitive impairment
- Disease, disability & social problems
- **Chronic Pain**

Anda R., www.acestudy.org
So then, what might “10/10” Pain mean?

So for “≥12/10”: “worse than... nothing else matters.”
“When your brain is on fire
I can’t help your pain...”
Routine Assessment of Co-occurring MOOD Disorders

PHQ-9 Scoring Tally Sheet

<table>
<thead>
<tr>
<th>PHQ-9 Question</th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>GAD-7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Little interest or pleasure in doing things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Feeling down, depressed, or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Trouble falling asleep, staying asleep, or sleeping too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Feeling tired or having little energy</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Poor appetite</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Feeling fatigued</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Feeling restlessness or being agitated</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Feeling worthlessness or guilt</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Diminished interest or pleasure</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Thoughts that you would be better off dead or in some other way</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

PHQ-4

- **Anxiety**: GAD-7 (or PHQ-4)
- **Depression**: PHQ-9 (or PHQ-4)
- **PTSD**

PC-PTSD Screen

In your life, have you ever had any experience that was so frightening, horrible, or upsetting, that in the past month you:

1. Have had **nightmares** or thought about it when you did not want to?
2. Tried hard **not to think** about it or went out of your way to **avoid situations** that reminded you of it?
3. Were constantly **on guard, watchful, or easily startled**?
4. Felt **numb or detached** from others, activities, or your surroundings?
Opioids For Pain: When?

✔ Clear indications
  - **Acute** Pain: moderate severe & severe
  - “**Peri-operative**” Pain
  - **Cancer** Pain, active treatment
  - **End-of-life Palliative** Care comfort

✔ Unclear and Uncertain: **Chronic** pain

“No study of opioid therapy vs placebo, no opioid therapy, or nonopioid therapy evaluated long-term (>1 year) outcomes related to pain, function, or quality of life.”

Opioids for **Chronic Pain**

**Conclusion:** Evidence is insufficient to determine the effectiveness of long-term opioid therapy for improving chronic pain and function. Evidence supports a dose-dependent risk for serious harms.
Centralized Pain Syndromes
Not an Indication for Opioids!

Central sensitization

Fibromyalgia syndrome
Chronic fatigue syndrome
PTSD
IBS
Irritable bowel
T-T headache
Tension headache
Migraine
Temporo-mandibular disorder
MPS
Myofascial pain syndrome
PLMS
Restless legs syndrome
MCS
Primary dysmenorrhea
FUS/IC
Interstitial cystitis
Pelvic pain

Yunus 2007
"Fibromyalgianess"

Wolfe, F. Arthritis & Rheumatism. 2009

For each one point increase:
- 25% greater likelihood of NO improvement in pain after hip or knee replacement surgery
- 9 mg greater oral morphine requirements during acute hospitalization

Symptom Intensity scale

Clauw, D. JAMA 2014
Mixed pain conditions with multiple pain pathophysologies such as chronic low back pain

Adapted from: Stanos et al. Rethinking chronic pain in a primary care setting. Postgraduate Medicine 2016
If Not Opioids, What Then?

1. Patient education
2. Non-drug *multimodal analgesia*
   1. Exercise (of all kinds)
   2. Sleep hygiene
   3. CBT, MBSR
   4. Acupuncture
   5. OMT, chiropractic
3. Non-opioid *multimodal analgesia*
   - APAP, NSAIDs, TCAs, SNRIs, ACDs...
Effectiveness of Chronic Pain Treatments

- Opioids: No Quality Evidence
- Adjuvants (Tricyclics/SNRIs/Anticonvulsants): 30%
- Cannabis: 10-30%
- Acupuncture: 10+%
- Patient education: 15%
- CBT/Mindfulness: 30-50%
- Physical fitness: “moderate”
- Sleep restoration: 40-50%

Evidence of CHANGE in some “PAIN” Measure
(“intensity” mostly, sometimes includes function, mood, QoL)

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 hospital 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

A Flood of Opioids, a Rising Tide of Deaths
Susan Okie, M.D.

2015: 3rd Largest Epidemic In America
HIV (1981-2005: 550,000)
Influenza Pandemic (1918: 500,000)
Prescription Opioid ODs (1999-2014: 165,000, & counting)
“Opioid Flood Waters”

Source where pain relievers were obtained for most recent nonmedical use (age ≥12): 2011-2012

samhsa.gov
Opioids for Acute Pain: Too Many Pills? (Adults)
Washington State Department of Health

Table 6: Number of pills by specialty: Means, medians, and selected quantiles of the number of tablets dispensed per prescription to adults age 20 and older with acute opioid prescriptions between July 1 and December 31, 2015 (N = 445,799).

<table>
<thead>
<tr>
<th>Provider specialty</th>
<th>N</th>
<th>mean</th>
<th>median</th>
<th>75th %tile</th>
<th>90th %tile</th>
<th>99th %tile</th>
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<tr>
<td>State Total</td>
<td>445,799</td>
<td>29.7</td>
<td>20.0</td>
<td>30.0</td>
<td>60.0</td>
<td>144.0</td>
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<tr>
<td>Dentist</td>
<td>84,136</td>
<td>17.6</td>
<td>16.0</td>
<td>20.0</td>
<td>25.0</td>
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<td>Dermatology</td>
<td>2,472</td>
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<td>20.0</td>
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<td>Emergency Medicine</td>
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<td>16.7</td>
<td>15.0</td>
<td>20.0</td>
<td>21.0</td>
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<td>Family Medicine</td>
<td>52,543</td>
<td>38.9</td>
<td>30.0</td>
<td>40.0</td>
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<td>Internal Medicine</td>
<td>23,304</td>
<td>52.7</td>
<td>30.0</td>
<td>60.0</td>
<td>100.0</td>
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<td>Obstetrics &amp; Gynecology</td>
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<td>40.0</td>
<td>50.0</td>
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<td>Ophthalmology</td>
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<td>25.0</td>
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<td>Oral &amp; Maxillofacial Surgery</td>
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<td>25.5</td>
<td>28.0</td>
<td>30.0</td>
<td>30.0</td>
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<td>60.0</td>
<td>80.0</td>
<td>150.0</td>
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<td>Otolaryngology</td>
<td>4,591</td>
<td>34.1</td>
<td>30.0</td>
<td>40.0</td>
<td>50.0</td>
<td>100.0</td>
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<td>Plastic Surgery</td>
<td>2,650</td>
<td>34.1</td>
<td>30.0</td>
<td>40.0</td>
<td>50.0</td>
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<td>Podiatrist</td>
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<td>90.0</td>
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<td>Specialist</td>
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<td>39.6</td>
<td>30.0</td>
<td>45.0</td>
<td>64.0</td>
<td>180.0</td>
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<td>Student</td>
<td>4,617</td>
<td>29.9</td>
<td>20.0</td>
<td>30.0</td>
<td>60.0</td>
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<tr>
<td>Surgery</td>
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<td>34.7</td>
<td>30.0</td>
<td>40.0</td>
<td>50.0</td>
<td>80.0</td>
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<tr>
<td>Urology</td>
<td>5,106</td>
<td>25.9</td>
<td>30.0</td>
<td>30.0</td>
<td>40.0</td>
<td>60.0</td>
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<tr>
<td>other</td>
<td>10,369</td>
<td>41.9</td>
<td>30.0</td>
<td>60.0</td>
<td>90.0</td>
<td>224.3</td>
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<td>unknown</td>
<td>153,352</td>
<td>29.1</td>
<td>20.0</td>
<td>30.0</td>
<td>60.0</td>
<td>128.5</td>
</tr>
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</table>

Data courtesy of Jennifer Sabel, WA State DOH
Acute Pain, by the numbers...
Washington State Department of Health

What is the average pill count for a new prescription for 14-19 year kids with no other prior opioid prescriptions?

23.7 Tablets!
Opioid \( R_x \) After Surgery Can Lead to Long-term Use

Retrospective studies 1-year post surgery\(^1\):

- Approximately one-third of all patients were still using opioids
- 18% of patients who did not use opioids before surgery were still using opioids
- Older patients (>65 years of age) undergoing low-risk surgery and receiving an opioid prescription\(^2\):
  - 10.3% were still taking opioids a year later
  - There was a 44% increase in likelihood that they would become long-term opioid users, compared to patients not receiving a prescription

“...initiation of short-term opioid therapy may lead to their longer-term use”\(^3\)

CONCLUSIONS: Over half of persons receiving 90 days of continuous opioid therapy remain on opioids years later. Factors most strongly associated with continuation were intermittent prior opioid exposure, daily opioid dose ≥120 mg MED, and possible opioid misuse. Since high dose and opioid misuse have been shown to increase the risk of adverse outcomes special caution is warranted when prescribing more than 90 days of opioid therapy in these patients.
Prescription limits

Preventing opioid use disorder: On November 1, 2017, a new Health Care Authority (HCA) clinical policy pertaining to opioid prescriptions takes effect for Apple Health (Medicaid), both fee-for-service and managed care.

Policy implementation date moved to November 1, 2017. Read more about it. Review information from the opioid policy webinar.

The policy limits the quantity of opioids that can be prescribed to opiate naïve patients for non-cancer pain. The limits for new opioid prescriptions will be:

- No more than 18 doses (approximately a 3-day supply) for patients age 20 or younger.
- No more than 42 doses (approximately a 7-day supply) for patients age 21 or older.

You can override these limits if you feel this is medically necessary, by typing “Exempt” in the text of the prescription.

Exemptions

- Patients who are undergoing active cancer treatment or who are in hospice, palliative care, or end-of-life care are exempt from these restrictions.
- Patients who have filled 90 days of opioids in the last 120 days will be grandfathered under the policy, and do not require attestation/prior authorization.
“Adverse Selection”
Patients on ER opioids 35% co-administered psychiatric medications

*Odds ratios adjusted for pain severity and patient characteristics

Highest Risk Patients* Receive Highest Opioid Dose

26.8% 38.5% 51.7% 61.4%

1.0 1.4 2.1 2.6

*Co-occurring psychiatric and addiction disorders

Merrill et al. 2011
Sullivan et al 2012
## Assessing Opioid Misuse Risk

**Mark each box that applies**

<table>
<thead>
<tr>
<th>1. Family history of substance abuse</th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>[ ] 1</td>
<td>[ ] 3</td>
</tr>
<tr>
<td>Illegal drugs</td>
<td>[ ] 2</td>
<td>[ ] 3</td>
</tr>
<tr>
<td>Prescription drugs</td>
<td>[ ] 4</td>
<td>[ ] 4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. Personal history of substance abuse</th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>[ ] 3</td>
<td>[ ] 3</td>
</tr>
<tr>
<td>Illegal drugs</td>
<td>[ ] 4</td>
<td>[ ] 4</td>
</tr>
<tr>
<td>Prescription drugs</td>
<td>[ ] 5</td>
<td>[ ] 5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3. Age (mark box if 16-45 years)</th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>[ ] 1</td>
<td>[ ] 1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4. History of preadolescent sexual abuse</th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>[ ] 3</td>
<td>[ ] 0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5. Psychological disease</th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attention-deficit/hyperactivity disorder, obsessive-compulsive disorder, bipolar disorder, schizophrenia</td>
<td>[ ] 2</td>
<td>[ ] 2</td>
</tr>
<tr>
<td>Depression</td>
<td>[ ] 1</td>
<td>[ ] 1</td>
</tr>
</tbody>
</table>

**Scoring**

- **Low (0-3)**
- **Moderate (4-7)**
- **High (≥8)**

**Scoring totals**

*Administration*

- **On initial visit?**
- **Prior to Chronic Opioid Therapy**

*Scoring*

- **0-3: low risk (6%)**
- **> 8: high risk (> 90%)**

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“Opioid Risk Tool” Webster & Webster 2005
Treatment Adherence Monitoring

Prescription Drug Monitoring Program

• 49 of 50 States capture all scheduled medication *dispensed*, even mail order or cash purchased
• Requires prescriber registration; can delegate proxy access to any number of licensed health care assistants
• Can seek registration from neighboring states
• Possible error with name entered by pharmacists:
  • call to verify when unexpected result
• VA/DoD, Tribal, and methadone programs don’t report (coming soon)

https://wapmp-provreg.hidinc.com
Often hard to distinguish between drug seeking and “pain relief” seeking

- For the patient with pain
  - Continuous opioid therapy may prevent opioid seeking
  - Even if the opioid seeking appears as seeking pain relief, it becomes an adaptation that is difficult to reverse
  - Often hard to distinguish between drug seeking and relief seeking


Slide adapted from Jane Ballantyne
1. **Assess** for opioid use disorder using DSM-5 criteria, or **refer** for a consultation with an addiction specialist if a patient demonstrates aberrant behaviors suggestive of substance use disorder.

2. Patients diagnosed with **opioid use disorder** should receive a combination of medication-assisted treatment* and behavioral therapies.

3. Consider prescribing naloxone as a preventive rescue medication for patients with opioid use disorder.

*Medication Assisted Treatment: Methadone Maintenance or “Suboxone®”*
Opioid Exit Strategies:
*Tapering is HARD! (...mostly for the patient)*

• Discuss goals of taper
  • Reiterate the “why”
  • Delineate the “how” (dose target and time frame)

• Describe potential withdrawal symptoms
  • Temporary increase in pain: “withdrawal hyperalgesia”

• Regularly scheduled office follow-ups to support (or nurse check-ins)

• Do not retreat!

• When possible: add behavioral health support

• Identify at least one self-management goal
• “...tapering opioids can be especially challenging after years on high dosages because of physical and psychological dependence.”

• Offer in a “nonjudgmental manner”... “the opportunity to re-evaluate their continued use of opioids at high dosages in light of recent evidence regarding the association of opioid dosage and overdose risk.”

• “empathically review benefits and risks of continued high-dosage opioid therapy” and “offer to work with the patient to taper opioids to safer dosages”

• “very slow opioid tapers as well as pauses in the taper to allow gradual accommodation to lower opioid dosages.”

• Be aware that anxiety, depression, and opioid use disorder “might be unmasked by an opioid taper”
Tapering / Discontinuing Chronic Opioids

Analgesic Treatments

• Sequential tapers when on both chronic benzos and opioids
  – Taper off opioids first, then the benzodiazepines.

• Do not use ultra-rapid detoxification or antagonist-induced withdrawal under heavy sedation or anesthesia.

• Rate of taper based on safety:
  – Immediate discontinuation: diversion or non-medical use.
  – Rapid taper (≤ 3 week period) if a severe adverse outcome such as overdose or substance use disorder
  – Slow taper when no acute safety concerns: ≤ 10% per week; variably adjusted per patient response

  **Do not reverse taper**

• MAY PRECIPITATE MENTAL HEALTH DISORDERS; be alert for need of expert help
<table>
<thead>
<tr>
<th>Issue</th>
<th>Recommended Length of Taper</th>
<th>Degree of Shared Decision Making about Opioid Taper</th>
<th>Intervention/Setting</th>
</tr>
</thead>
</table>
| Substance Use Disorder              | No taper, immediate referral | None – provider choice alone                         | **Intervention:** Detoxification with medication assisted treatment (buprenorphine or methadone), Naloxone rescue kit  
**Setting:** Inpatient or Outpatient Buprenorphine (OBOT) |
| Diversion                           | No taper*                   | None – provider choice alone                         | Determine need based on actual use of opioids, if any                                 |
| At risk for immediate harms         | Weeks to months             | Moderate – provider led & patient views sought       | **Intervention:** Supportive care  
Naloxone rescue kit  
**Setting:** Outpatient opioid taper |
| Therapeutic failure                  | Months                      | Moderate – provider led & patient views sought       | **Intervention:** Supportive care  
Naloxone rescue kit  
**Setting:** Outpatient opioid taper  
**Option:** Buprenorphine (OBOT) |
| At risk for future harms            | Months to Years             | Moderate – provider led & patient views sought       | **Intervention:** Supportive care  
Naloxone rescue kit  
**Setting:** Outpatient opioid taper  
**Option:** Buprenorphine (OBOT) |

Courtesy: Melissa Weimer, MD
Free Resources

UW Medicine
Pain and Opioid Consult Hotline for Clinicians
1-844-520-PAIN (7246)

UW Medicine pain pharmacists and physicians are available Monday through Friday, 8:30 a.m. to 4:30 p.m. (excluding holidays) to provide clinical advice at no charge to you.

Consultations for clinicians treating patients with complex pain medication regimens, particularly high dose opioids:

- Interpret Washington State Prescription Monitoring Program record to guide you on dosing
- Individualized opioid taper plans
- Systematic management of withdrawal syndrome
- Evaluate/recommend non-opioid/adjunct analgesic treatment
- Triage and risk screening
- Individualized case consultation for client care and medication management
- Explain/Review Center for Disease Control and Prevention (CDC) opioid guidelines: https://www.cdc.gov/mmwr/volumes/65/mmrr6501e1.htm

- Will help identify and refer to other resources:
  - Evaluation of Substance Use Disorder, Washington Recovery Help Line 1-866-789-1511
  - Local pain clinics for patient referrals: www.doh.wa.gov/Emergencies/PainClinicClosures/PainClinicAvailability
  - UW TelePain Services: Available Wednesdays noon to 1:30 p.m. http://depts.washington.edu/anesthes/care/pain/telepain

UW TelePain
A service for community-practice providers to increase knowledge and skills in chronic pain management

UW TelePain sessions are collegial, audio/video-based conferences that include:

1. Didactic presentations from the UW Pain Medicine curriculum for primary care providers.
2. Case presentations from community clinicians.
3. Interactive consultations for providers with a multi-disciplinary panel of specialists.
4. Education in use of guideline-recommended measurement-based clinical tools to improve diagnosis and treatment effectiveness.
5. Follow-up case presentations to track outcomes and optimize treatments for ongoing care of your patients.

UW TelePain sessions for community health care providers are held each Wednesday, noon to 1:30 p.m.

You are invited to present your difficult chronic pain cases or ask questions, even if you don’t present a case.

The expertise of the UW TelePain Panel spans pain medicine, internal medicine, anesthesiology, rehabilitation medicine, psychiatry, addiction medicine, and nursing care coordination.

Learn more about these sessions on the UW TelePain website
http://depts.washington.edu/anesthes/care/pain/telepain/

Questions?
telepain@uw.edu

To register:
Download and complete the registration form and fax it to 206-221-8259. Form location http://depts.washington.edu/anesthes/care/pain/telepain/TelPain-Participant-Reg-Form.pdf
10th Annual John D. Loeser Pain Conference:
Updates on Essential Issues
October 27 - 28, 2017

Friday - Saturday
October 27-28, 2017
Shoreline Conference Center
18560 1st Avenue NE
Shoreline, WA

Sponsored by UW School of Medicine
Department of Anesthesiology & Pain Medicine
Office of Continuing Medical Education

Credit Designation
The University of Washington School of Medicine designates this live activity for a maximum of 12.0 AMA PRA Category 1 Credits™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

COURSE DESCRIPTION
The John D. Loeser Pain conference provides cogent, evidence-based and useful information for primary care providers of all kinds. Chronic pain is a very common complaint, and many providers find treatment challenging with or without opioid prescribing. The lectures will cover many topics, including safer approaches to opioid prescribing, the use of buprenorphine in pain and addiction, the use of complementary medicine in pain, and special topics including abdominal pain, nerve pain, and using technology in pain treatment.

COURSE OBJECTIVES
Upon completion of this activity, attendees should be able to:

- Evaluate spinal pain in an efficient and clear manner.
- Educate patients about managing pain while staying on schedule.
- Develop a sound non-opioid pain treatment plan.
- Describe the pharmacology and use of buprenorphine for chronic pain.
- Help patients with pain-related disability negotiate the disability system.
- Understand the uses of antidepressants in pain treatment.
- Apply complementary medicine options to common pain issues.
- Evaluate and know when to refer for abdominal pain, pelvic pain, and headache.
- Appreciate the regulatory environment around pain care and opioid prescribing and describe best practices for this.

COURSE FEES

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<tbody>
<tr>
<td>MD/DO/PhD</td>
<td>$299</td>
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<tr>
<td>Allied Health</td>
<td>$249</td>
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<tr>
<td>Resident/Fellow</td>
<td>$125</td>
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VISIT THE COURSE WEBSITE FOR SPECIFIC DETAILS AND REGISTRATION
Register Online: uwcmo.org
UW School of Medicine | Continuing Medical Education
Email: cme@uw.edu | Phone: 206.543.1050

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