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Psychiatry and Addictions Case Conference

UW Medicine | Psychiatry and Behavioral Sciences

Opioid: Preventing Opioid Use Disorders

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

DAVID J. TAUBEN, MD, FACP

Chief, UW Division of Pain Medicine

Hughes M & Katherine G Blake Endowed Professor

Clinical Associate Professor

Depts of Medicine And Anesthesia & Pain Medicine

University of Washington, Seattle WA

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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
- Mayday Fund: “Tele-Coaching for Optimization of Pre- and Post-Operative Pain Management.”
- NIH STRR: Optimization of Pre- and Post-Operative Pain Management.
- CDC Clinical Quality Improvement Implementation Package for Large Healthcare Systems: Activities to Support Guideline Dissemination and Implementation
- CDC RFA-CE15- 15010201SUPP16 Oregon Health Authority: UW TelePain/Oregon Implementation Proposal for the Prevention for States Prescription Drug Overdose Supplement.
- NIAMS P30 Core Centers for Clinical Research (CCR); Transforming Clinical Information for Learning (TCIL)

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UW PACC REGISTRATION

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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

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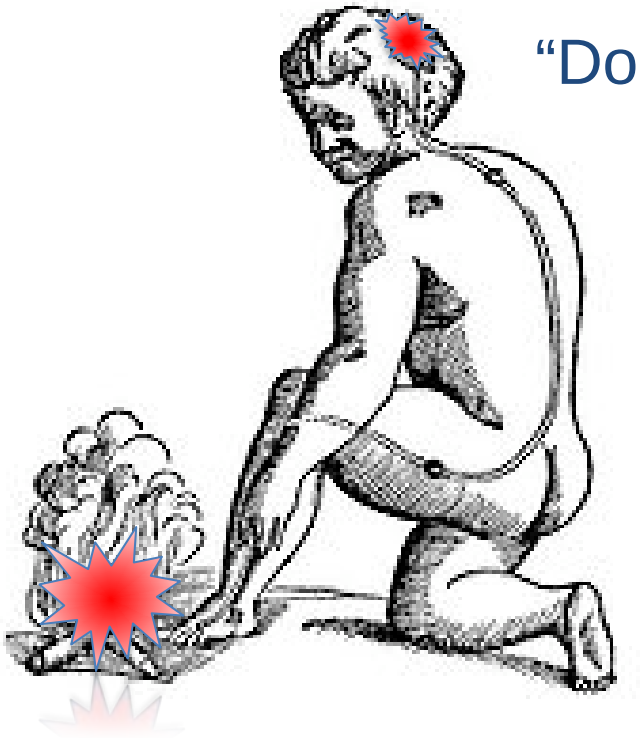
17th Century "Cartesian View" of Pain

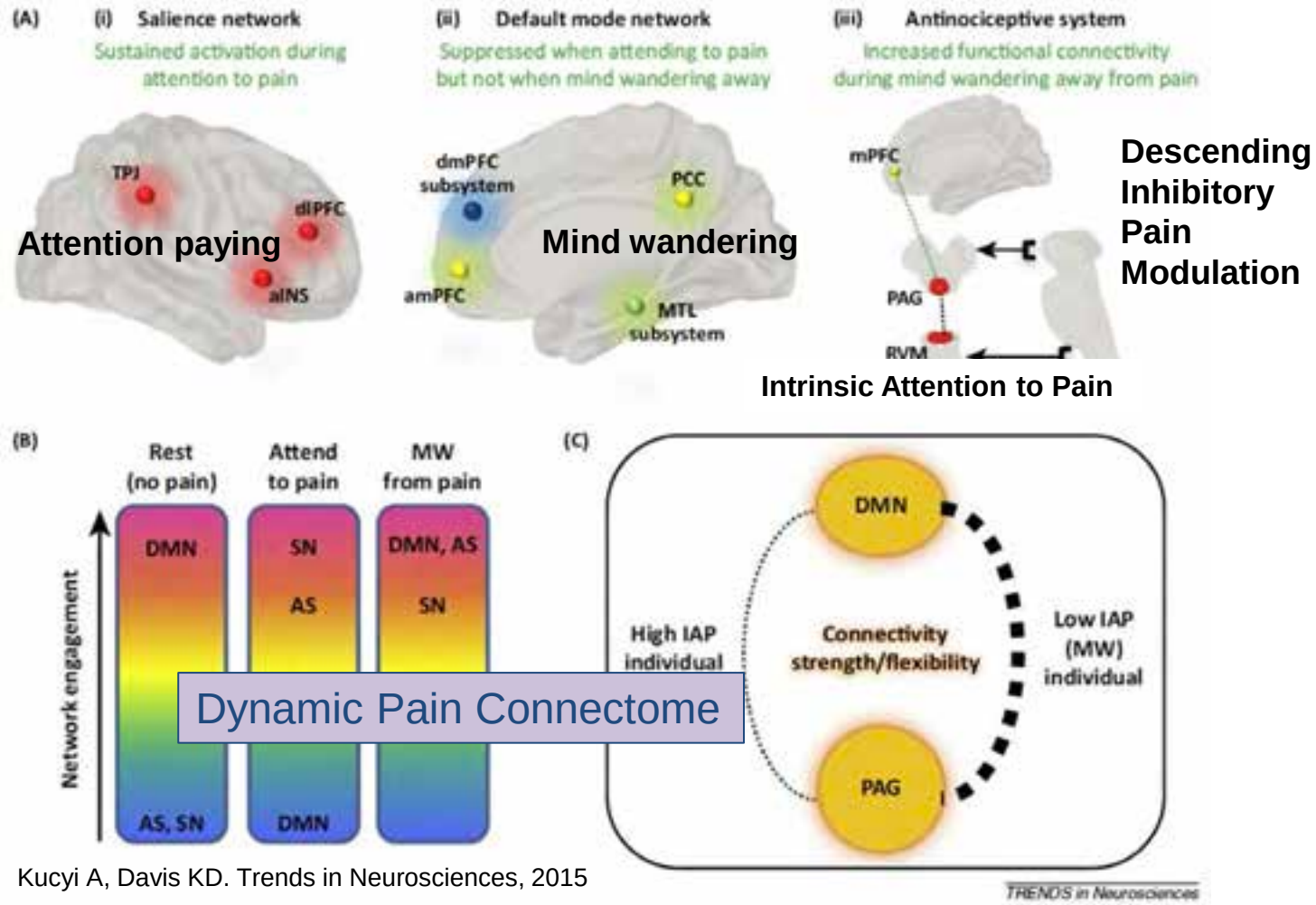
"Doleo, ergo sum" ?



"Nociception"

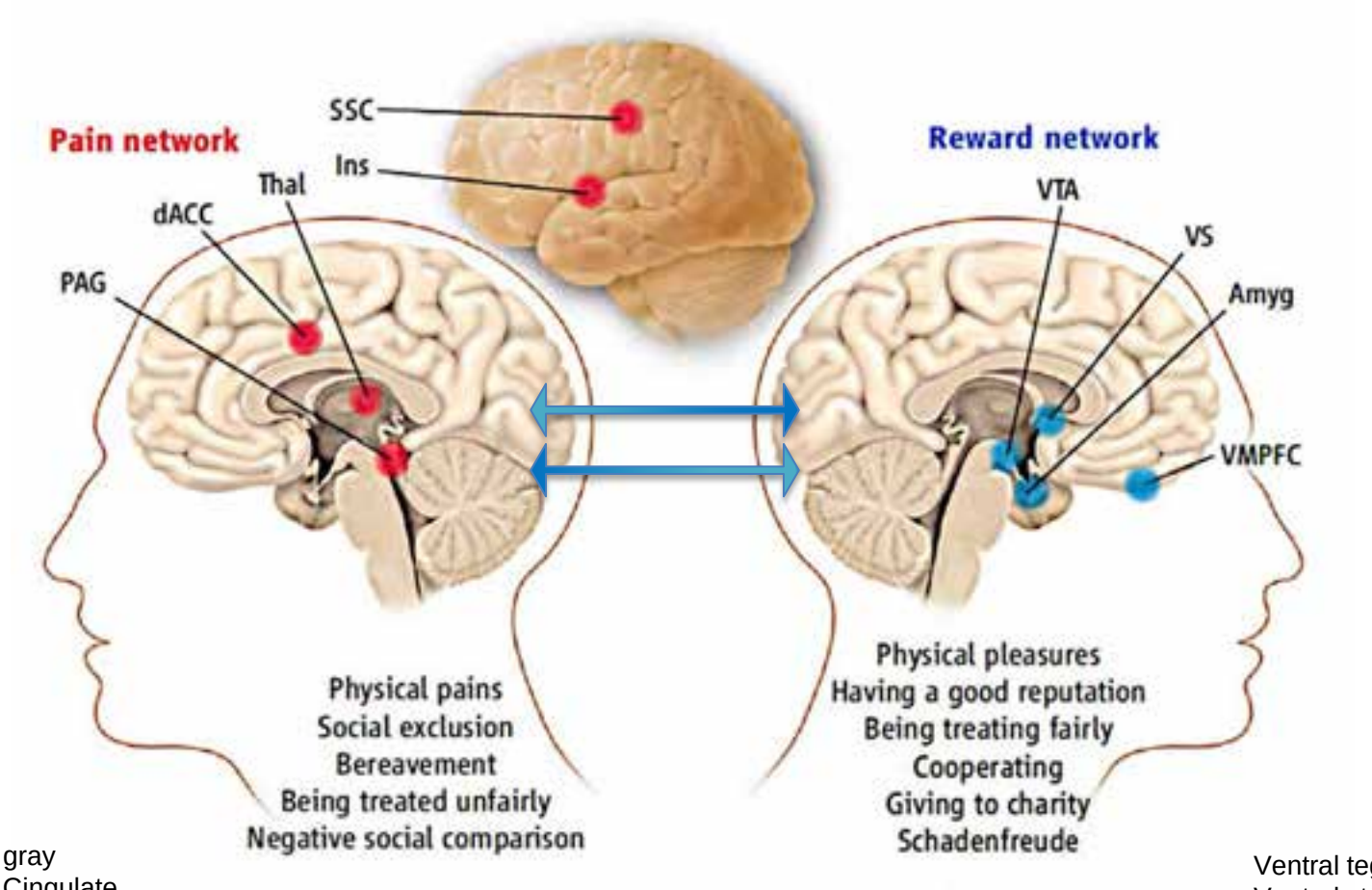
Emerging Science: "Pain Salience"

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

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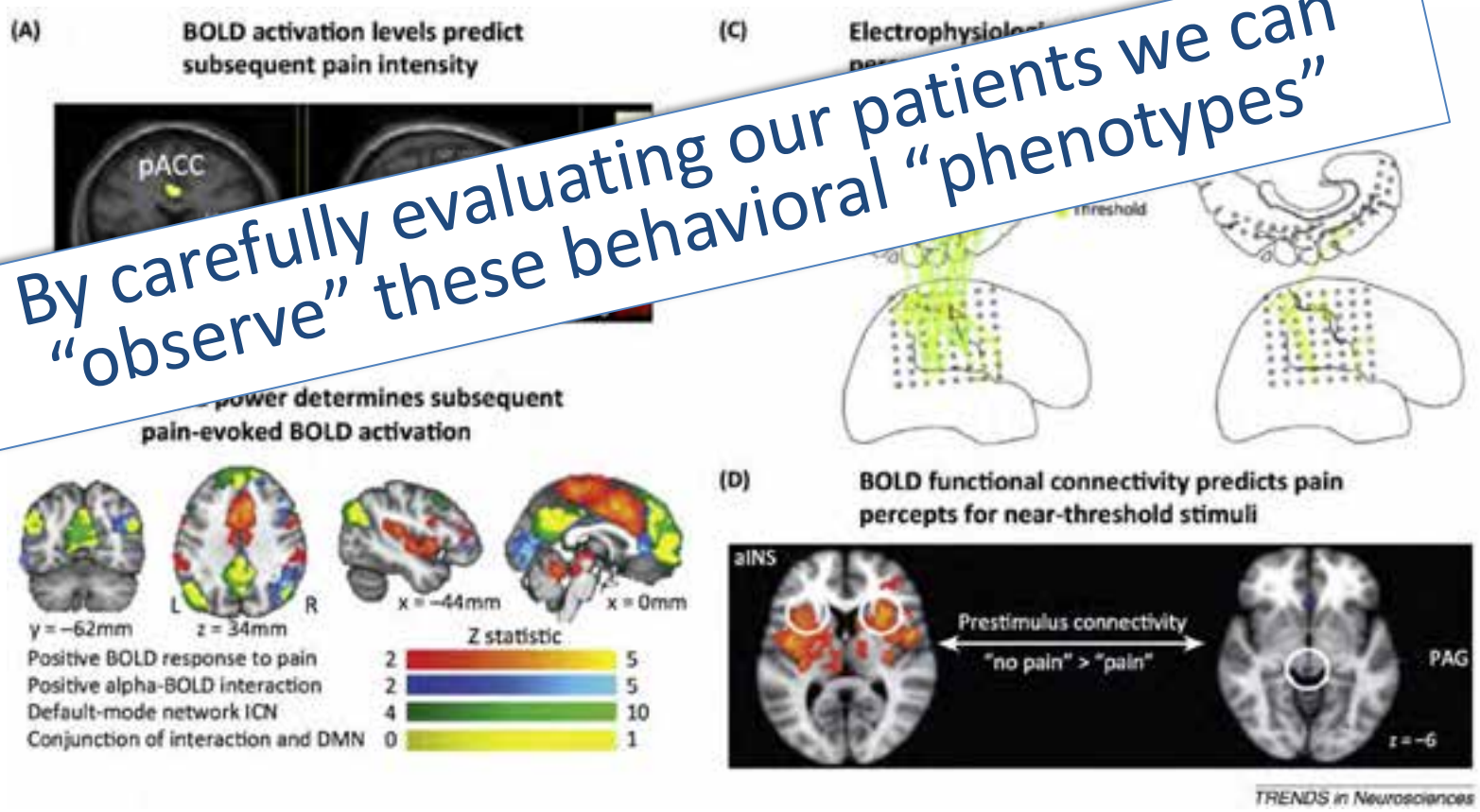
Preexisting brain-states impact the experience of pain

Blood-
Oxygen-
Level
Deper
contra

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**

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Anda R., www.acestudy.org

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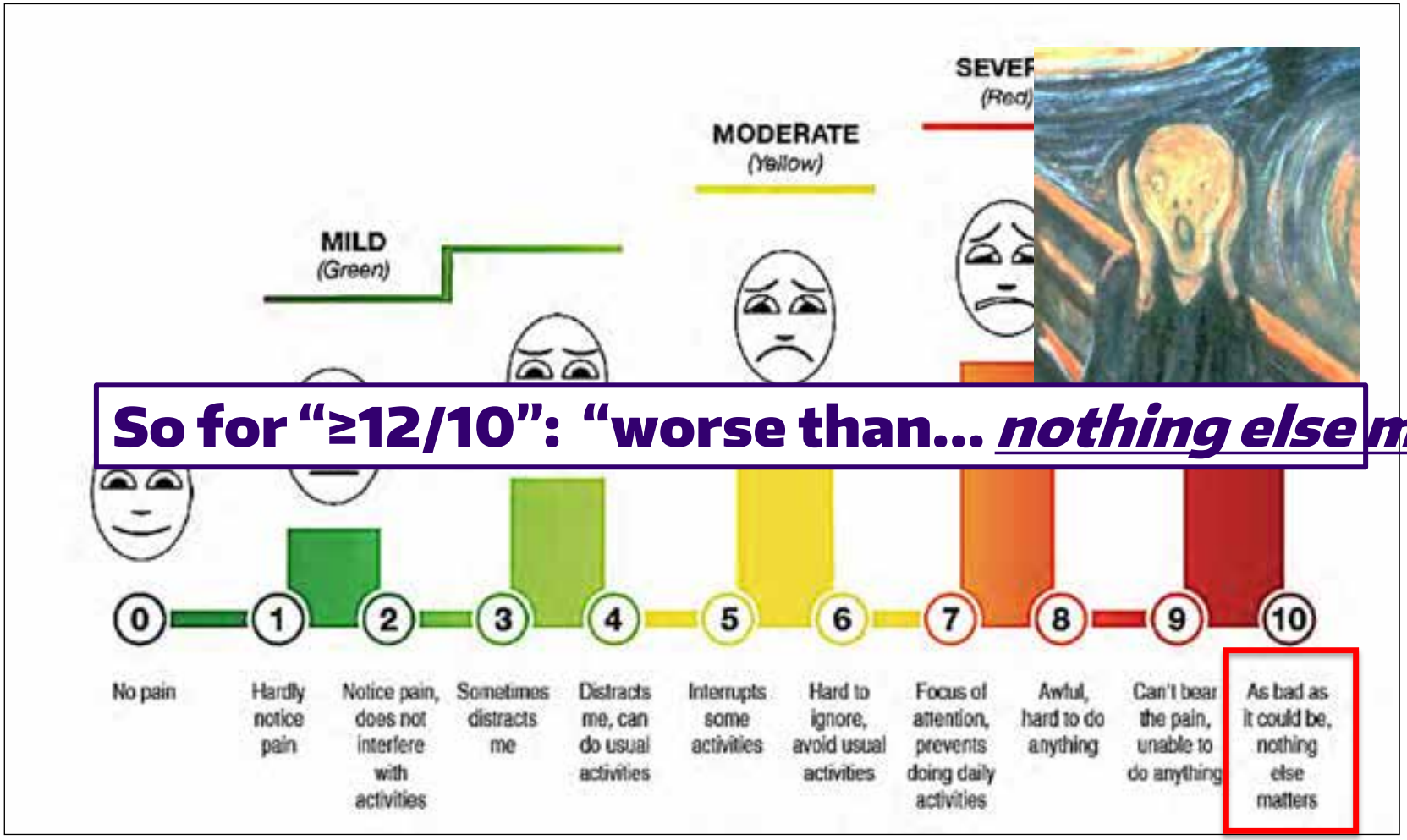
So then, what might *"10/10" Pain mean*?



“When your brain is on fire I can’t help your pain…”

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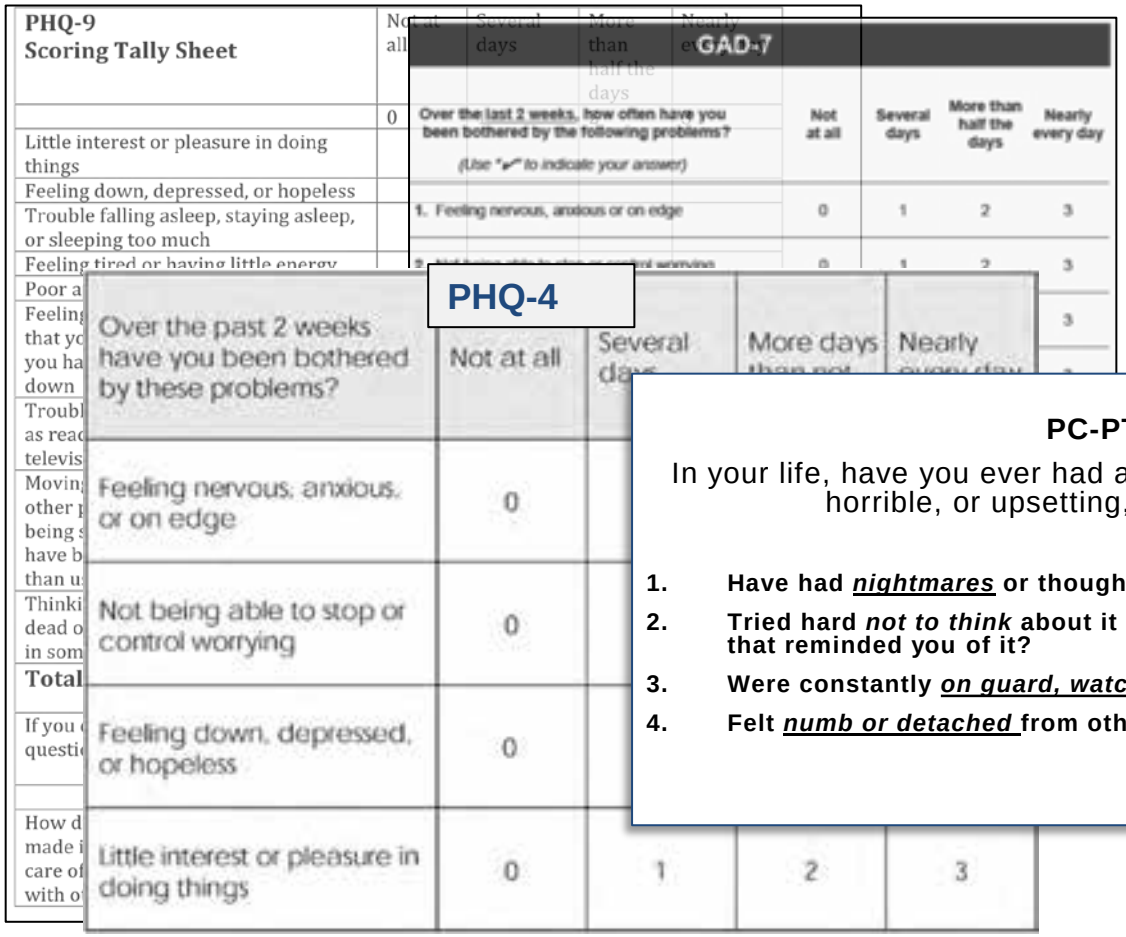
Routine Assessment of Co-occurring *MOOD* Disorders



PHQ-9 Scoring Tally Sheet

	Not at all	Several days	More than half the days	Nearly every day
	0			
Little interest or pleasure in doing things				
Feeling down, depressed, or hopeless				
Trouble falling asleep, staying asleep, or sleeping too much				
Feeling tired or having little energy				
Poor a				
Feelin that yo you ha down				
Troubl as read televis				
Movin other p being s have b than u				
Thinki dead o in som				
Total				
If you questi				
How d made i care of with o				

GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems? (Use "✔" to indicate your answer)	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3

PHQ-4

Over the past 2 weeks have you been bothered by these problems?	Not at all	Several days	More days than not	Nearly every day
Feeling nervous, anxious, or on edge	0			
Not being able to stop or control worrying	0			
Feeling down, depressed, or hopeless	0			
Little interest or pleasure in doing things	0	1	2	3

- ✓ **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?**

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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."

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Chou R, et al. Ann Intern Med. 2015

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Opioids for *Chronic Pain*

REVIEW

Annals of Internal Medicine

The Effectiveness and Risks of Long-Term Opioid Therapy for Chronic Pain: A Systematic Review for a National Institutes of Health Pathways to Prevention Workshop

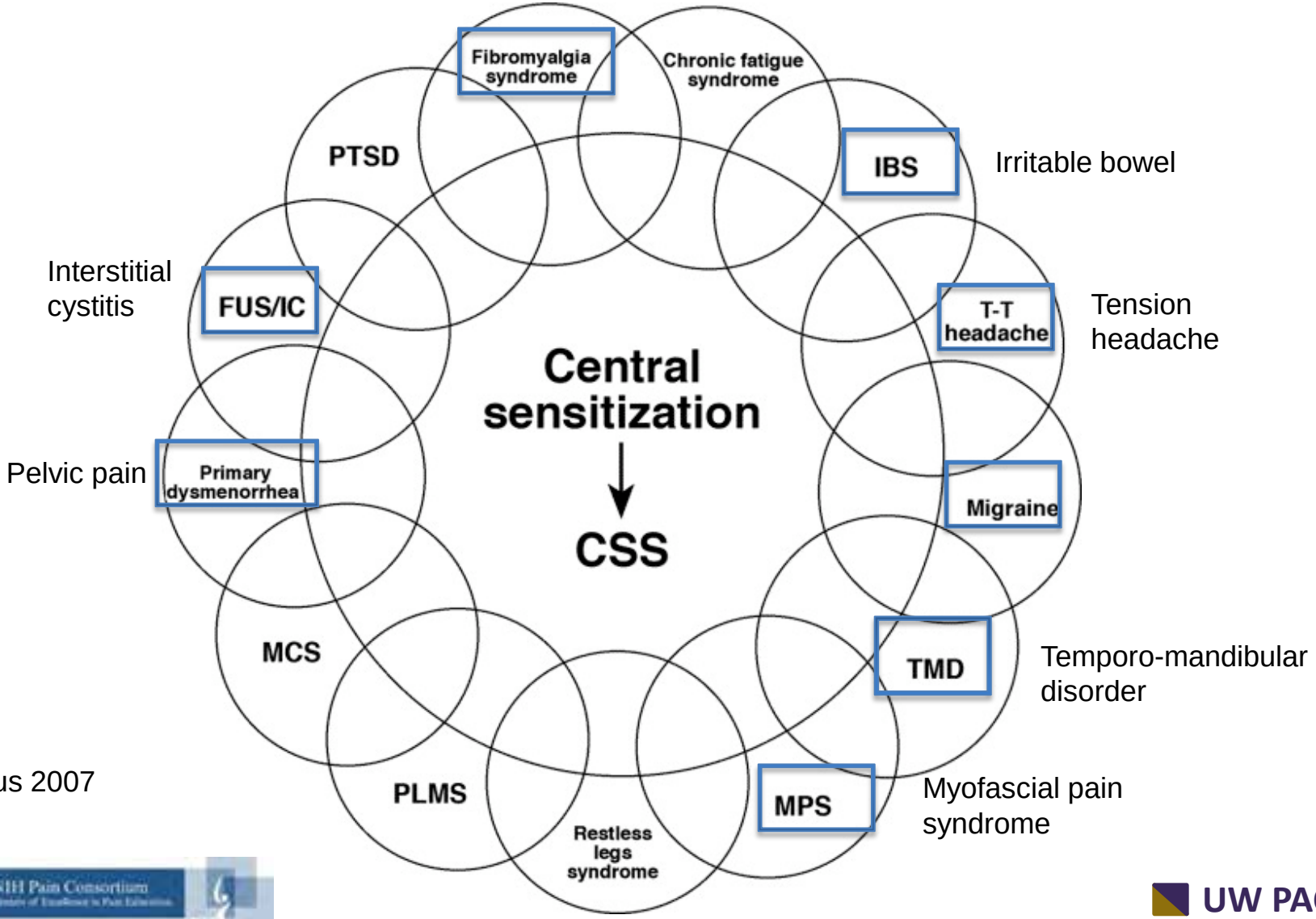
Roger Chou, MD; Judith A. Turner, PhD; Emily B. Devine, PharmD, PhD, MBA; Ryan N. Hansen, PharmD, PhD; Sean D. Sullivan, PhD; Ian Blazina, MPH; Tracy Dana, MLS; Christina Bougatsos, MPH; and Richard A. Deyo, MD, MPH

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.

Annals of Internal Medicine • Vol. 162 No. 4 • 17 February 2015

Centralized Pain Syndromes

Not an Indication for Opioids!



Yunus 2007

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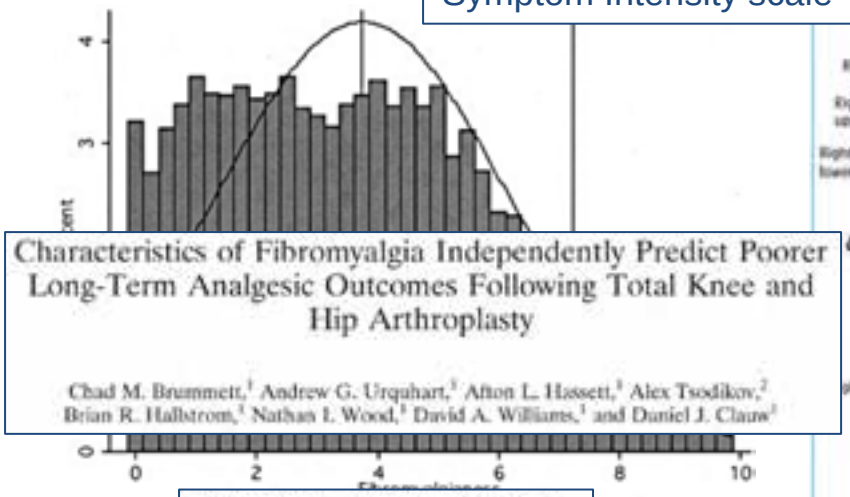
"Fibromyalgianess"

Clauw, D. JAMA 2014

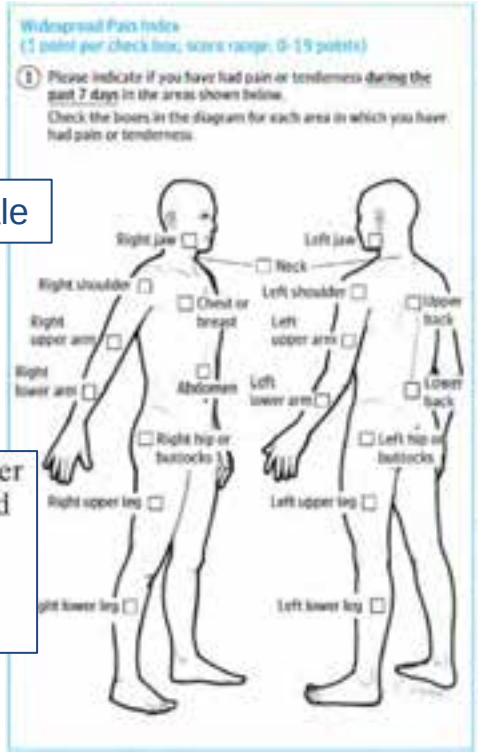
Symptom Intensity scale

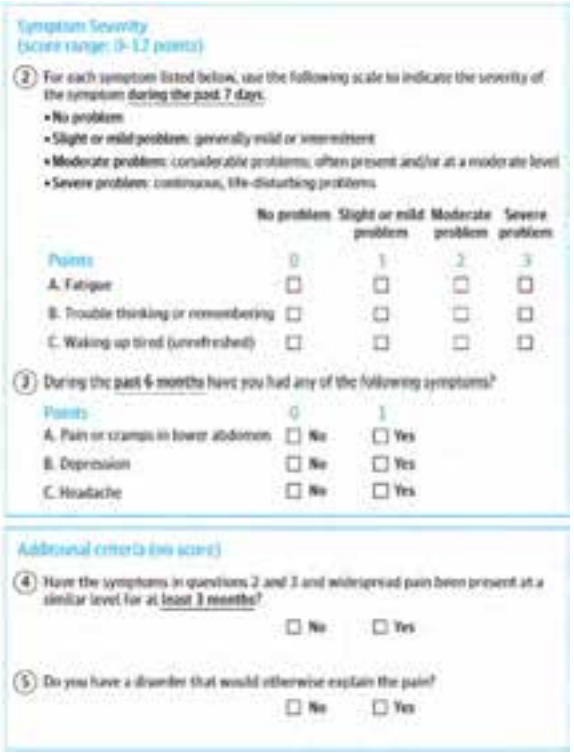


Characteristics of Fibromyalgia Independently Predict Poorer Long-Term Analgesic Outcomes Following Total Knee and Hip Arthroplasty

Chad M. Brummett,[1] Andrew G. Urquhart,[1] Afton L. Hassett,[1] Alex Tsodikov,[2] Brian R. Hallstrom,[1] Nathan I. Wood,[1] David A. Williams,[1] and Daniel J. Clauw[1]

ARTHRITIS & RHEUMATOLOGY
Vol. 67, No. 5, May 2015, pp 1386–1394





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

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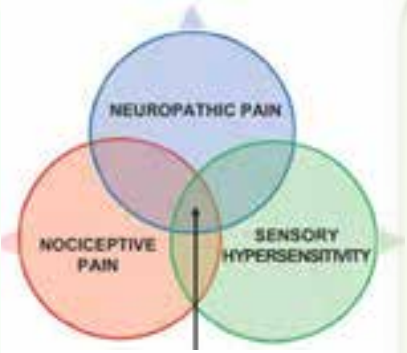
PREDOMINANTLY NEUROPATHIC

- PHN
- pDPN
- Lumbar or cervical radiculopathy
- Stenosis
- Tumor-related neuropathy
- Chemotherapy-induced neuropathy
- Small fiber neuropathy
- Persistent postoperative pain
- Multiple sclerosis pain
- Post-stroke pain
- Pain associated with spinal cord injury

PREDOMINANTLY NOCICEPTIVE

- Osteoarthritis
- Rheumatoid arthritis
- Tendonitis, bursitis
- Ankylosing spondylitis
- Gout
- Neck and back pain with structural pathology
- Tumor-related nociceptive pain
- Sickle-cell disease
- Inflammatory bowel disease



Mixed pain conditions with multiple pain pathophysiologies such as chronic low back pain

PREDOMINANTLY SENSORY HYPERSENSITIVITY

- Fibromyalgia
- Irritable bowel syndrome
- Tension-type headaches
- Interstitial cystitis/pelvic pain syndrome
- Tempo-mandibular joint disorder
- Chronic fatigue syndrome
- Restless leg syndrome
- Neck and back pain without structural pathology

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

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

• 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%

Chou R, et al. Ann Intern Med. 2015; Turk, D. et al. Lancet 2011; Davies KA, et al. Rheum. 2008; Kroenke K. et al. Gen Hosp Psych. 2009; Morley S Pain 2011; Moore R, et al. Cochrane 2012; Cherkin D et al. JAMA 2016

Porter J, Jick H. [letter]. N Engl J Med. 1980;302:123.

The NEW ENGLAND JOURNAL of MEDICINE

ADDICTION RARE IN PATIENTS TREATED WITH NARCOTICS

To the Editor: Recently, we examined our current files to d
mine the incidence of narcotic addiction in 39,946 hospita
medical patients[1] who were monitored consecutively. Alth
there were 11,882 patients who received at least one narcotic p
aration, there were only four cases of reasonably well docume
addiction in patients who had no history of addiction. The a
tion was considered major in only one instance. The drugs
plicated were meperidine in two patients,[2] Percodan in one,
hydromorphone in one. We conclude that despite widespread u
narcotic drugs in hospitals, the development of addiction is ra
medical patients with no history of addiction.

JANE PORTER
HERSHEL JICK, M.D.
Boston Collaborative Drug
Surveillance Program
Waltham, MA 02154 Boston University Medical Center

1. Jick H, Miettinen OS, Shapiro S, Lewis GP, Siskind Y, Slone D. Comprehensive drug surveillance. JAMA. 1970; 213:1455-60.
2. Miller RR, Jick H. Clinical effects of meperidine in hospitalized medical patients. J Clin Pharmacol. 1978; 18:180-8.

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The NEW ENGLAND JOURNAL of MEDICINE

Perspective

NOVEMBER 18, 2010

A Flood of Opioids, a Rising Tide of Deaths

Susan Okie, M.D.

2015: 3rd Largest Epidemic In America

HIV *(1981-2005: 550,000)*

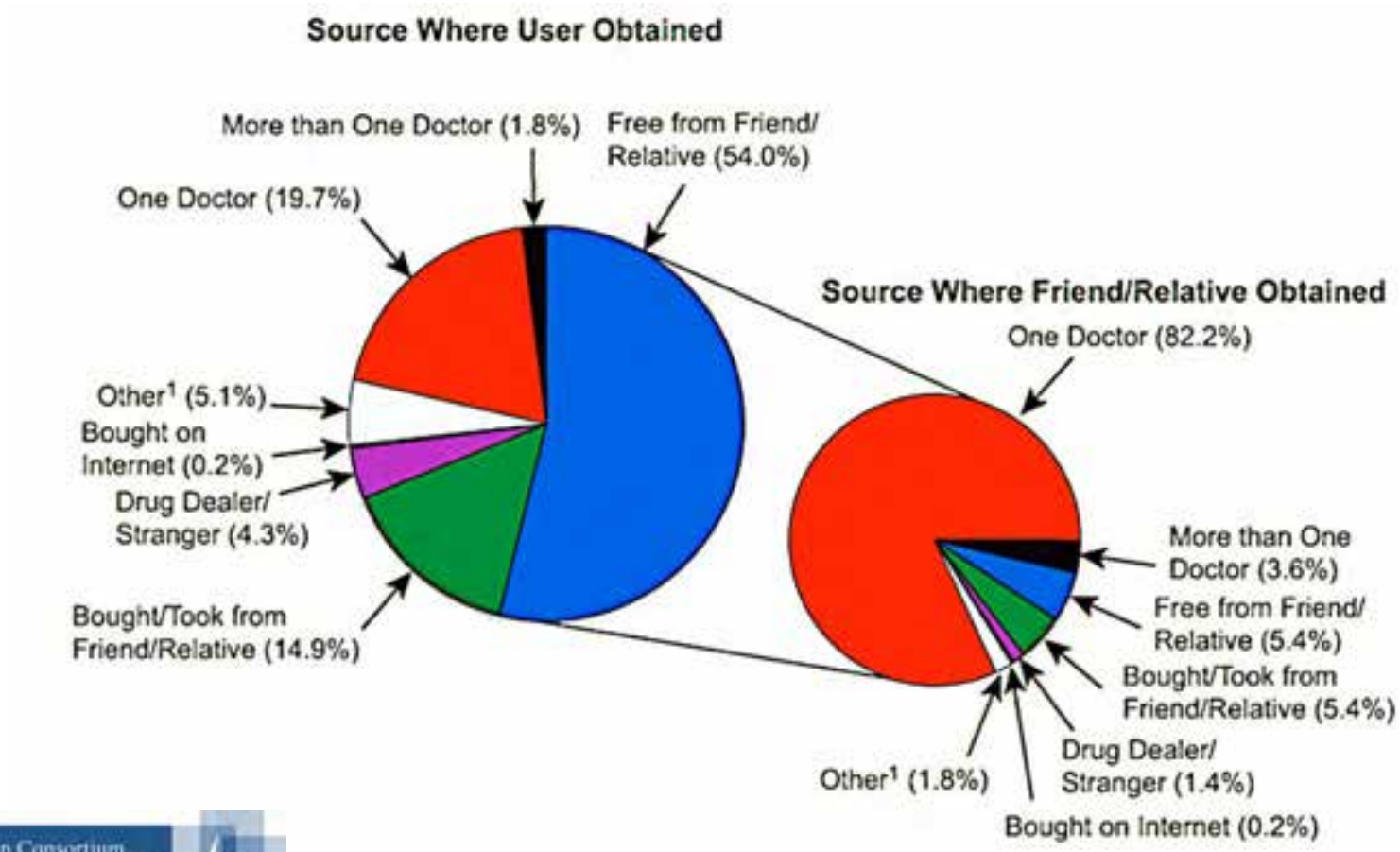
Influenza Pandemic *(1918: 500,000)*

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 ($N = 445{,}799$).

Provider specialty	N	mean	median	75th %tile	90th %tile	99th %tile
State Total	445,799	29.7	20.0	30.0	60.0	144.0
Dentist	84,136	17.6	16.0	20.0	25.0	35.0
Dermatology	2,472	17.8	15.0	20.0	25.0	42.0
Emergency Medicine	35,946	16.7	15.0	20.0	21.0	45.0
Family Medicine	52,543	38.9	30.0	40.0	84.0	210.0
Internal Medicine	23,304	52.3	30.0	60.0	100.0	360.0
Obstetrics & Gynecology	19,531	29.6	30.0	40.0	50.0	80.0
Ophthalmology	2,098	18.7	20.0	25.0	30.0	56.0
Oral & Maxillofacial Surgery	2,048	25.5	28.0	30.0	30.0	60.0
Orthopaedic Surgery	15,622	49.5	40.0	60.0	80.0	150.0
Otolaryngology	4,591	34.1	30.0	40.0	50.0	100.0
Plastic Surgery	2,650	34.1	30.0	40.0	50.0	70.0
Podiatrist	4,660	35.7	30.0	40.0	60.0	90.0
Specialist	6,885	39.6	30.0	45.0	64.0	180.0
Student	4,617	29.9	20.0	30.0	60.0	120.0
Surgery	15,869	34.7	30.0	40.0	50.0	80.0
Urology	5,106	25.9	30.0	30.0	40.0	60.0
other	10,369	41.9	30.0	60.0	90.0	224.3
unknown	153,352	29.1	20.0	30.0	60.0	128.5

Data courtesy of Jennifer Sabel, WA State DOH

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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!

Slide courtesy of G. Franklin

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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]

1. Wang M et al. *Spine J.* 2013;13:S6-S7. 2. Alam A et al. *Arch Intern Med*. 2012;172:425-430. 3. Katz MH. *Arch Intern Med*. 2012;172:430.

Courtesy Ivan Lesnik, MD

Chronic Prescribed Opioid Exposure

…Most are hooked for Life

Long-Term Chronic Opioid Therapy Discontinuation Rates from the TROUP Study

Bradley C. Martin, PharmD, PhD[1], Ming-Yu Fan, PhD[2], Mark J. Edlund, MD, PhD[3], Andrea DeVries, PhD[4], Jennifer Brennan Braden, MD, MPH[2], and Mark D. Sullivan, MD, PhD[2]

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.

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Washington State Health Care Authority

www.hca.wa.gov/billers-providers/programs-and-services/opioids

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.

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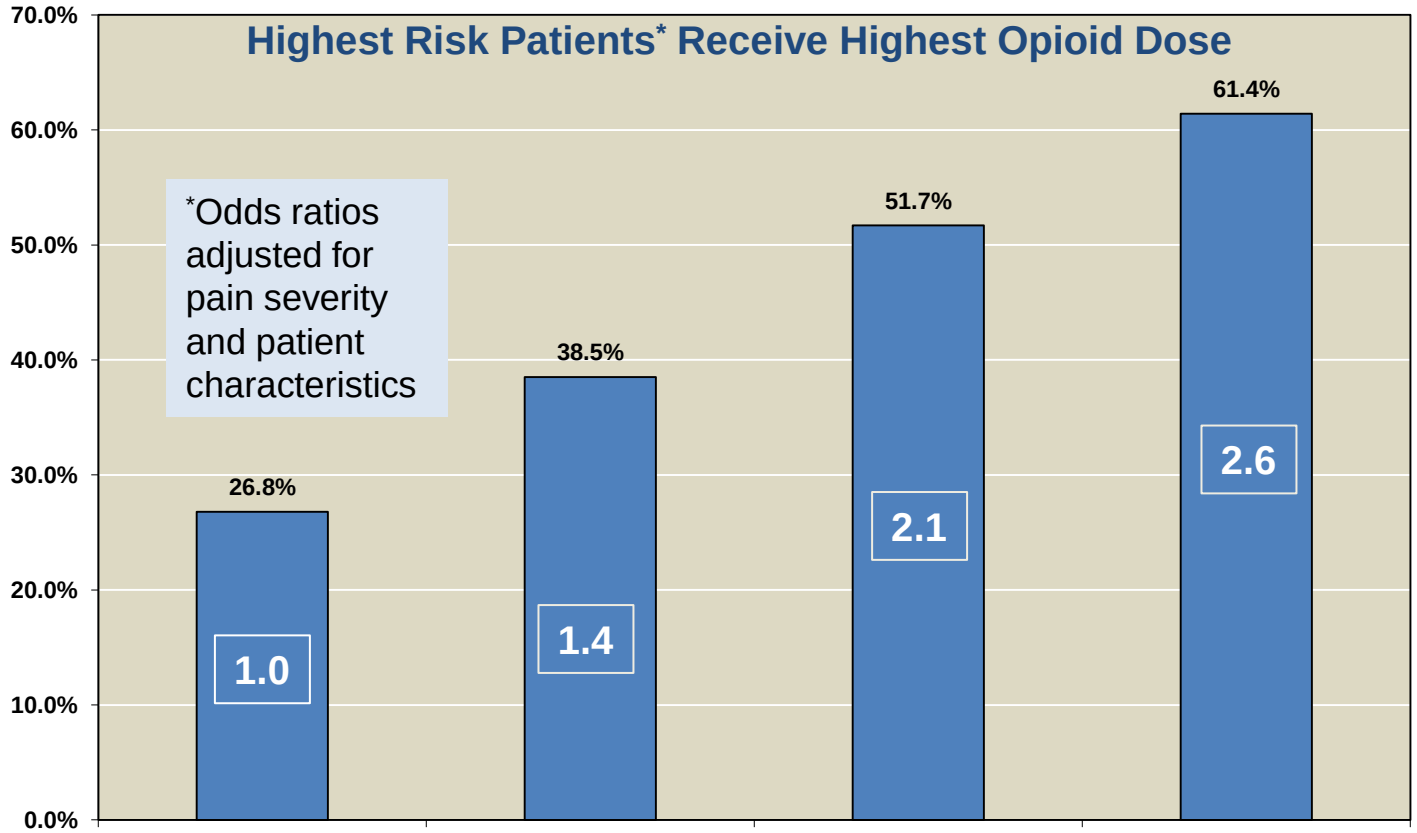
“Adverse Selection”

Patients on ER opioids 35% co-administered psychiatric medications

*Co-occurring psychiatric and addiction disorders



Merrill et al. 2011
Sullivan et al 2012
Gustavsson A, et al. 2012

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Assessing Opioid Misuse Risk

Mark each box that applies		Female	Male
1. Family history of substance abuse	▪ Alcohol ▪ Illegal drugs ▪ Prescription drugs	[ ] **1** [ ] **2** [ ] **4**	[ ] **3** [ ] **3** [ ] **4**
2. Personal history of substance abuse	▪ Alcohol ▪ Illegal drugs ▪ Prescription drugs	[ ] **3** [ ] **4** [ ] **5**	[ ] **3** [ ] **4** [ ] **5**
3. Age (mark box if 16-45 years)		[ ] **1**	[ ] **1**
4. History of preadolescent sexual abuse		[ ] **3**	[ ] **0**
5. Psychological disease	▪ Attention-deficit/ hyperactivity disorder, obsessive-compulsive disorder, bipolar disorder, schizophrenia ▪ Depression	[ ] **2** [ ] **1**	[ ] **2** [ ] **1**
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%)**

"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

Ballantyne JC, et al. New addiction criteria: Diagnostic challenges persist in treatment pain with opioids. IASP: Pain Clinical updates, Dec 2013.

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Slide adapted from Jane Ballantyne

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Recognizing and Treating

Opioid Use Disorder

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

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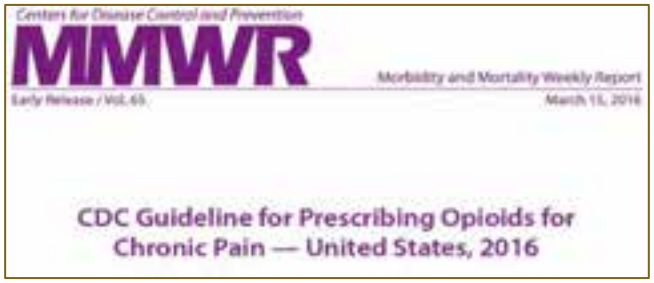


Centers for Disease Control and Prevention
MMWR March 15, 2016; 65:p23

- "…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

NIH Pain Consortium
Center of Excellence in Pain Education
CoEPE

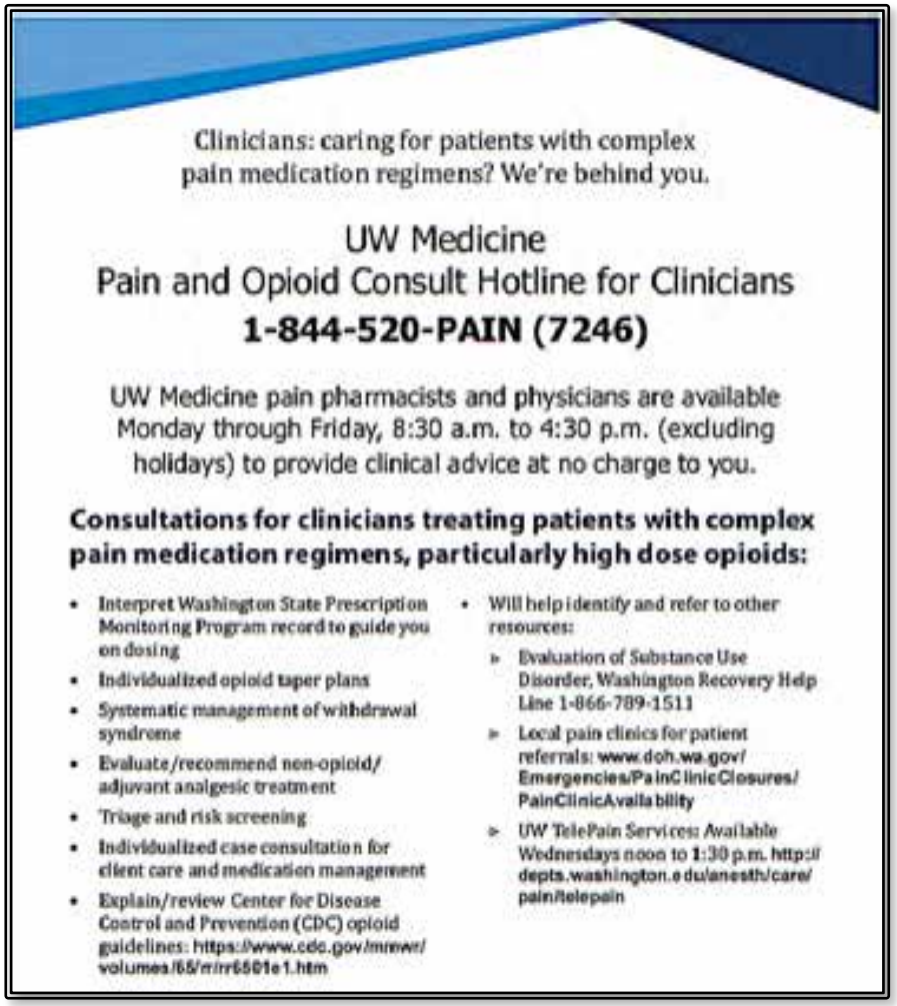
UW PACC

HOW TO APPROACH AN OPIOID TAPER/CESSATION

Issue	Recommended Length of Taper	Degree of Shared Decision Making about Opioid Taper	Intervention/Setting
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



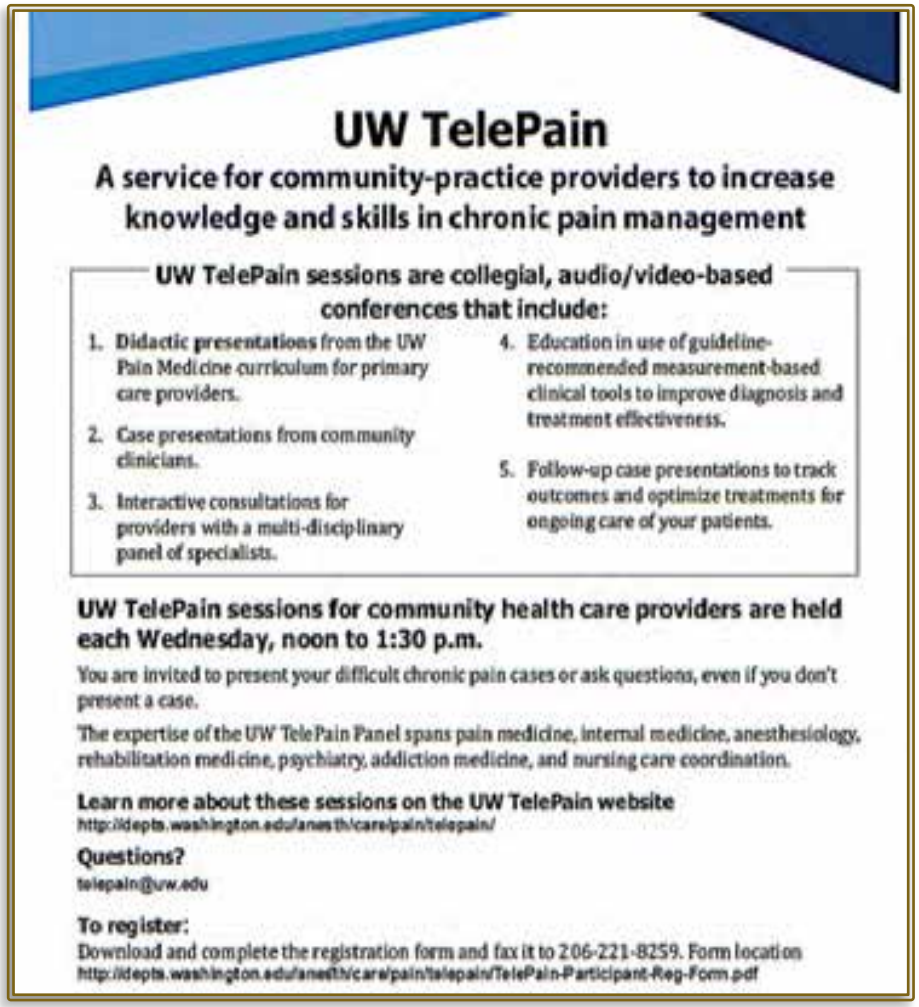
Clinicians: caring for patients with complex pain medication regimens? We're behind you.

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/adjuvant 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/rr/rr6501e1.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/anesth/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/anesth/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/anesth/care/pain/telepain/TelePain-Participant-Reg-Form.pdf

Washington State Health Care Authority

UW PACC

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 FEES	
MD/DO/PhD	$299
Allied Health	$249
Resident/Fellow	$125

VISIT THE COURSE WEBSITE FOR SPECIFIC DETAILS AND REGISTRATION
Register Online: uwcme.org
UW School of Medicine | Continuing Medical Education
Email: cme@uw.edu | Phone: 206.543.1050

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.

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