Acute and Chronic Pain Management During the AZ Opioid Epidemic

April 18, 2018

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Disclosures

- No financial conflict of interests to disclose
- The ideas discussed are my own and not those of the VA or federal government

Objectives

- Contrast the biomedical, biopsychosocial, and sociopsychobiological models of pain
- Describe a whole person approach to acute and chronic pain
- Discuss the importance of prevention, recognition, diagnosis, and management of opioid use disorder

Models of Pain Care

Biomedical

Biopsychosocial

Sociopsychobiological

Biomedical Care Model

- “Find it and Fix it” approach
- Assumes a 1:1 correlation between physical pathology and pain
- Patient is passive victim of identifiable disease and doctor is responsible for urgent and complete pain relief
- Focus on passive treatments that are done TO the patient
- 1980s-2000s
- Created a care system that is fragmented, costly, risky, and ineffective

Biomedical Model – fragmented care

Biomedical Model – Pain Medicine

Other Factors Influencing Opioid Epidemic

Industry influence

Beginning in the mid 1990s, pharmaceutical companies began aggressively marketing new opioid formulations and reassured the medical community that patients would not become addicted to opioid pain relievers

Between 1996 and 2002, Purdue Pharma funded

more than 20,000

pain-related educational programs

Kolodny A, *Annu Rev Public Health*. 2015

Original Investigation

The Changing Face of Heroin Use in the United States
A Retrospective Analysis of the Past 50 Years

Theodore J. Cicero, PhD; Matthew S. Ellis, MPE; Hilary L. Surratt, PhD; Steven P. Kurtz, PhD

JAMA Psychiatry Published online May 28, 2014

Prescription opioids as primary risk for heroin use

- 1960s – 80% of heroin users introduced to opioids with heroin
- 2000s – 75% of heroin users introduced to opioids with prescription opioids

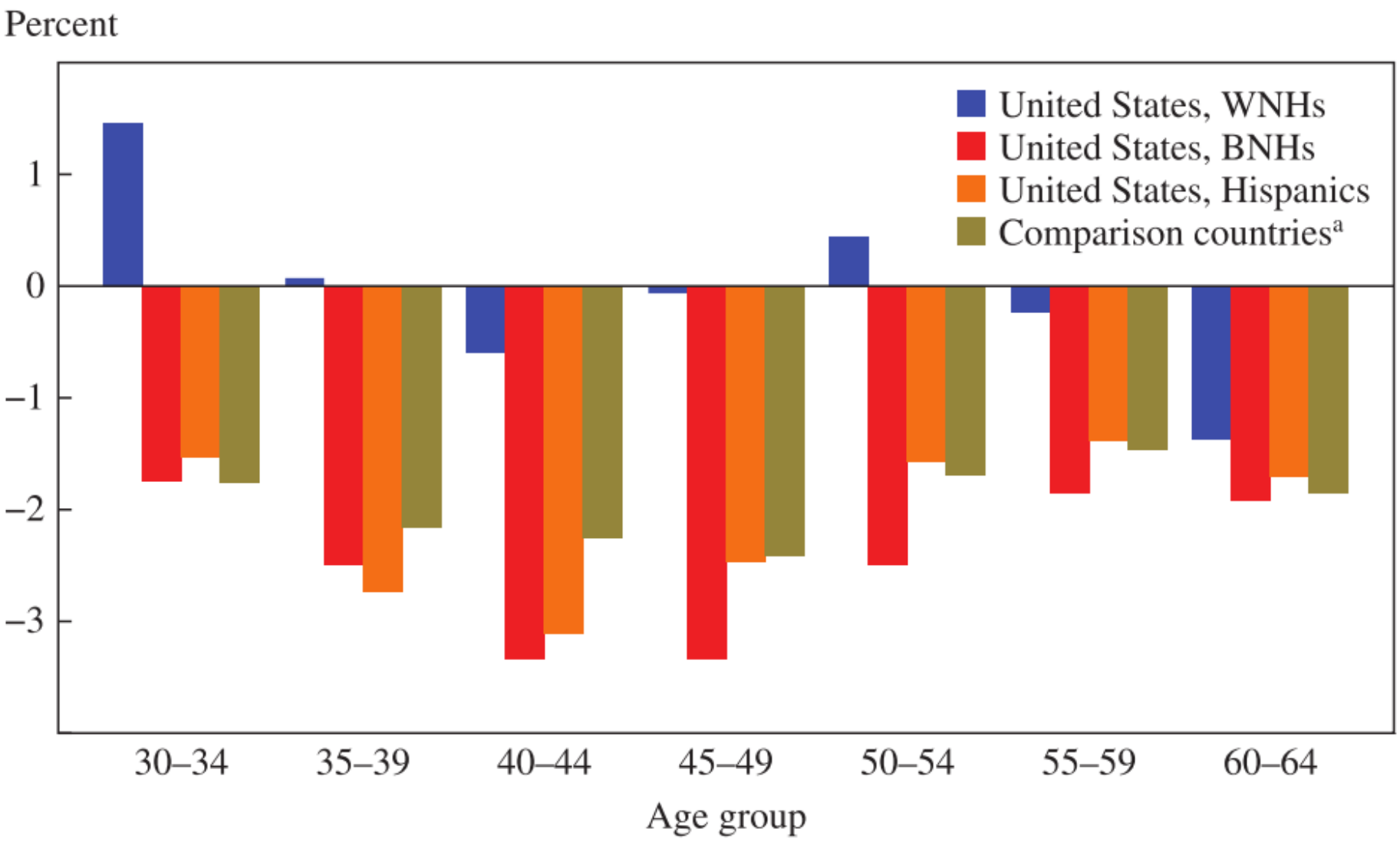
Changing Demographics

- Heroin use has shifted from an inner-city, minority-centered problem
- To one that primarily involves white men and women in their late 20s living outside of large urban areas

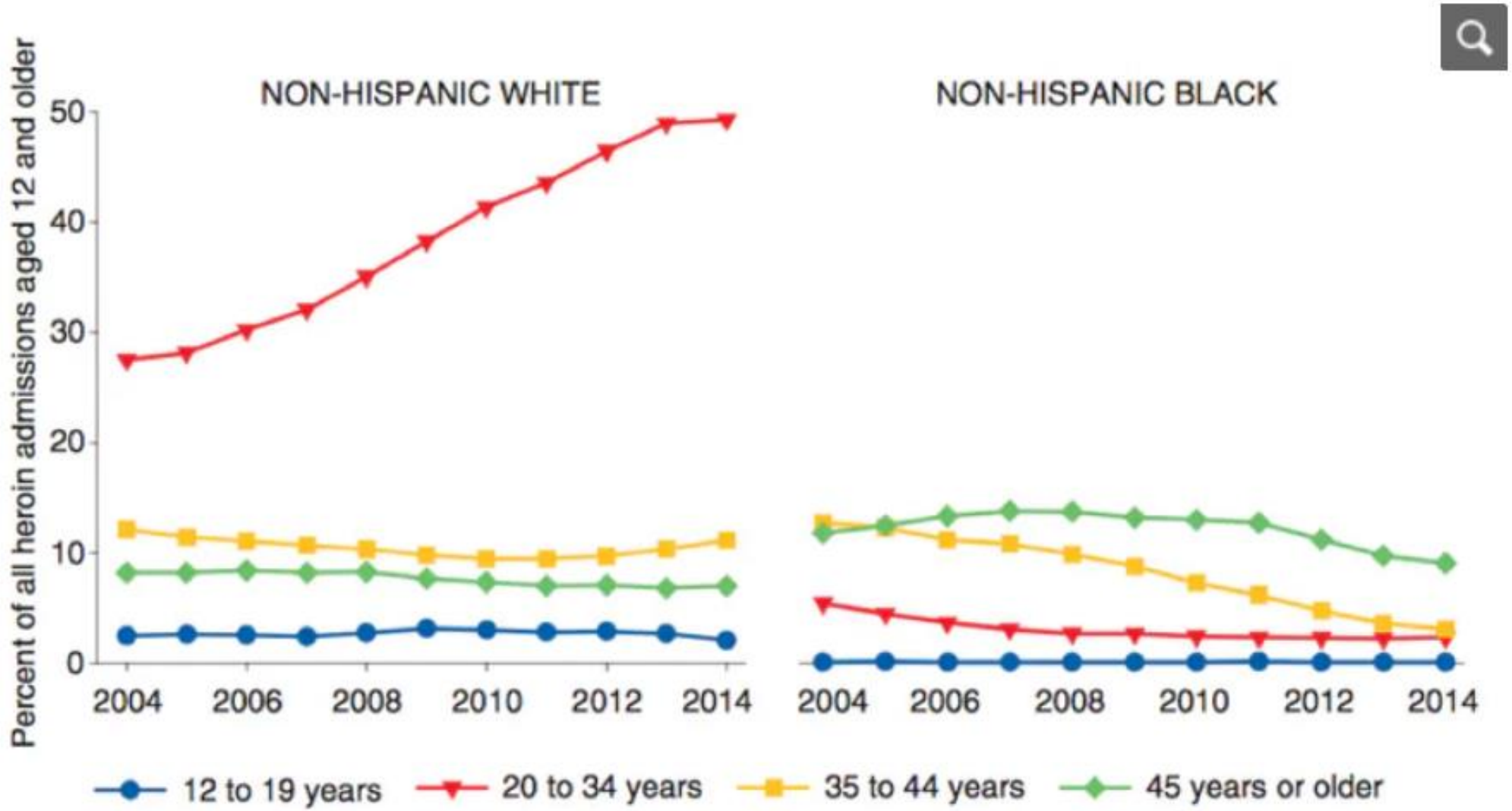
Socioeconomic Trends in US

- Crisis of meaning and identity for many white American, particularly among those with the least education
  - Mortality rates among mid-life white Americans *increased* in early 2000s
  - Attributed to "**deaths of despair**" ie deaths from alcohol, drug overdose, suicide (Case and Deaton, 2015 and 2017)

Figure 4. Mortality Trends by Five-Year Age Group, 2000–14

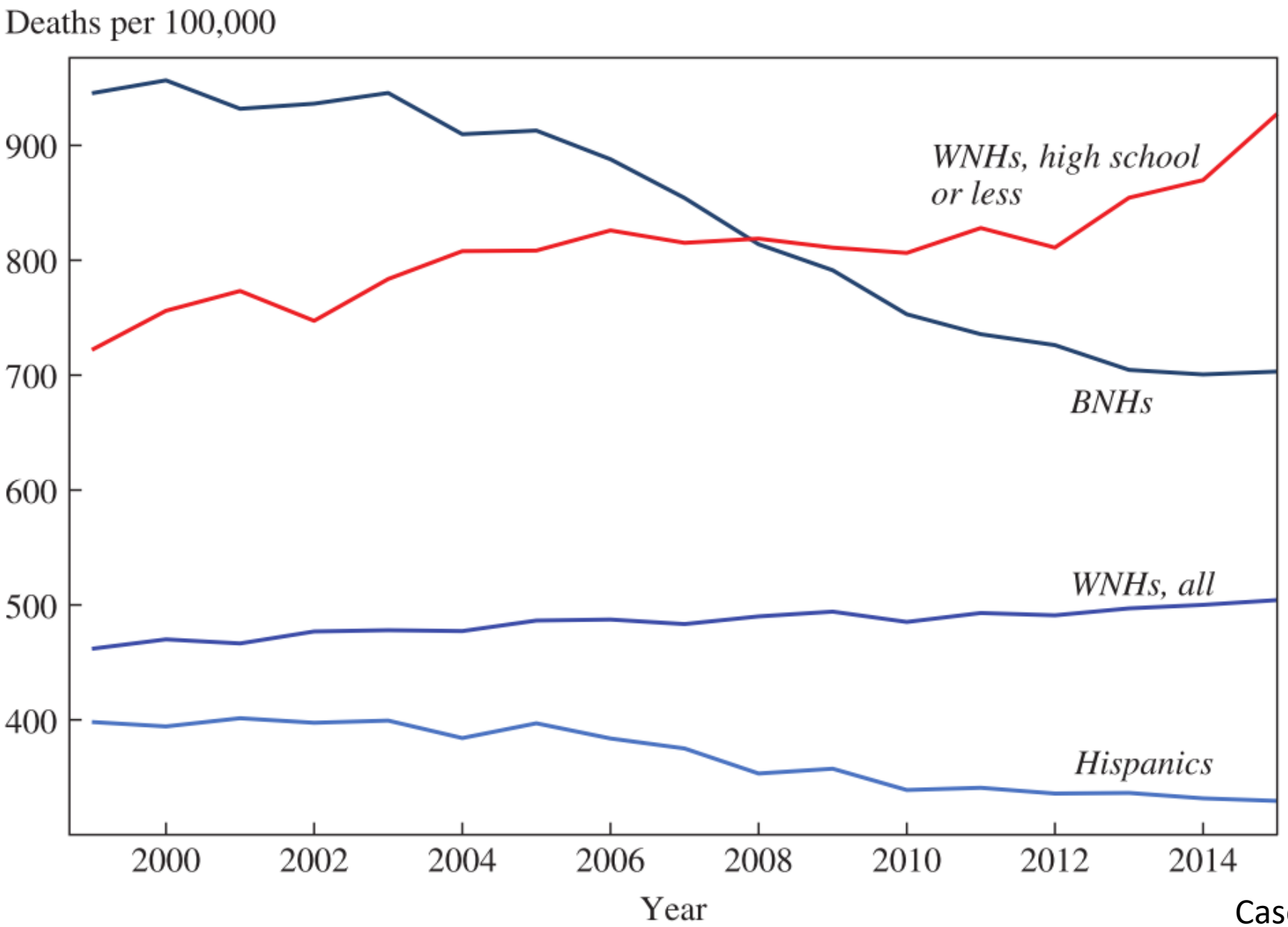


Sources: CDC WONDER; Human Mortality Database; WHO Mortality Database; authors' calculations.
a. The comparison countries are Australia, Canada, France, Germany, Sweden, and the United Kingdom.



SOURCE: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Treatment Episode Data Set (TEDS). Data received through 02.01.16.

Figure 1. All-Cause Mortality by Race and Ethnicity for Age 50–54, 1999–2015



Case and Deaton, 2017

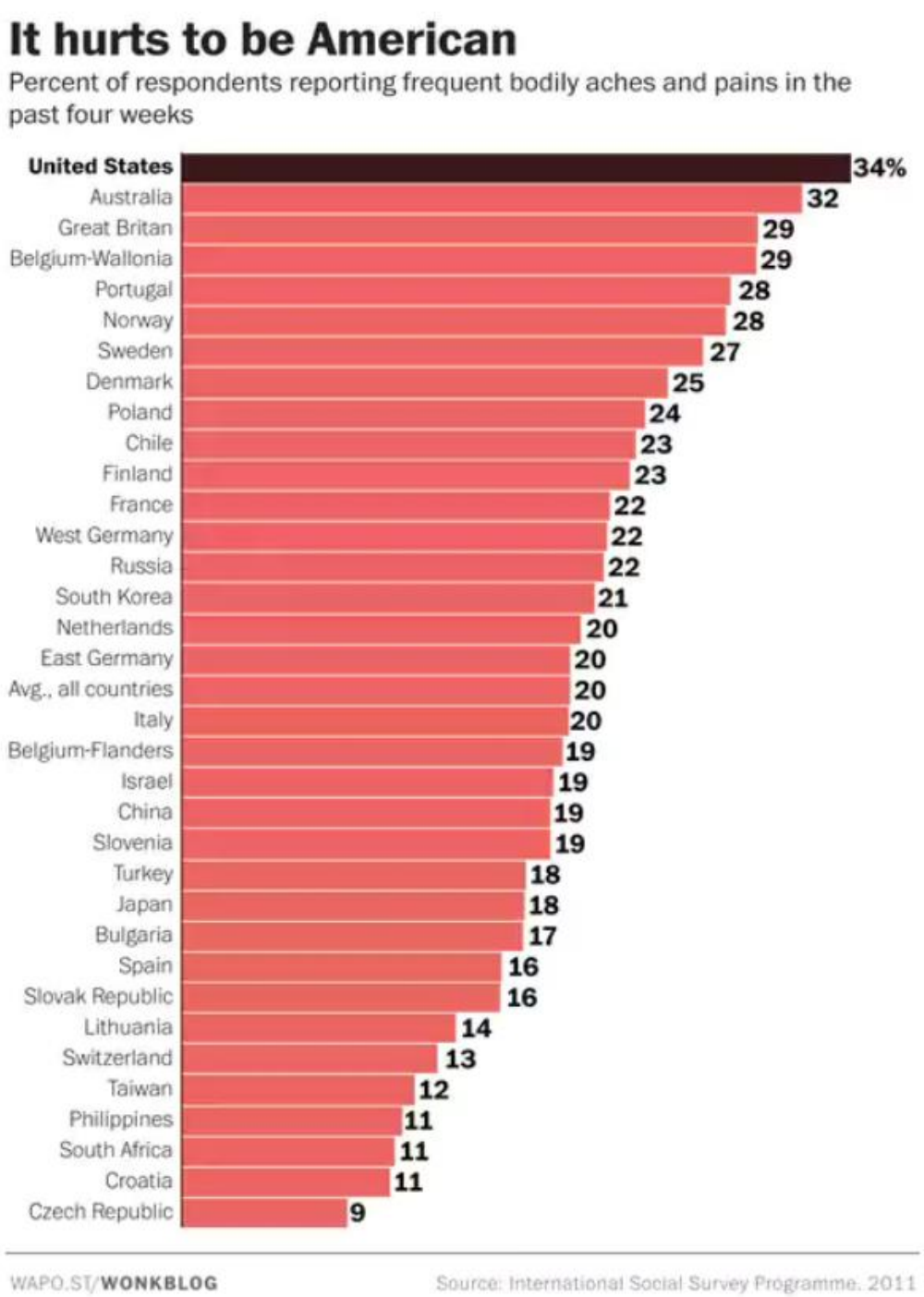
UNHAPPINESS AND PAIN IN MODERN AMERICA:
A REVIEW ESSAY, AND FURTHER EVIDENCE, ON CAROL GRAHAM'S HAPPINESS FOR ALL?

November 2017

David G. Blanchflower
Andrew Oswald

NATIONAL BUREAU OF ECONOMIC RESEARCH

- White Americans report declining happiness and optimism
- Happiness of black Americans has increased strongly since the 1970s (now almost equal to that of white Americans)
- Compared to the rich, those who are poor in the USA have higher levels of stress, pain, and lower life satisfaction
- Mortality and Happiness declines particularly striking among least educated and poorest white Americans



Americans report more pain than citizens of 30 other countries

Impact of the Opioid Epidemic

- Mortality: Opioid Overdose Deaths
- Morbidity: Addiction
- Economic Costs
- Disability

Nationally in the US:

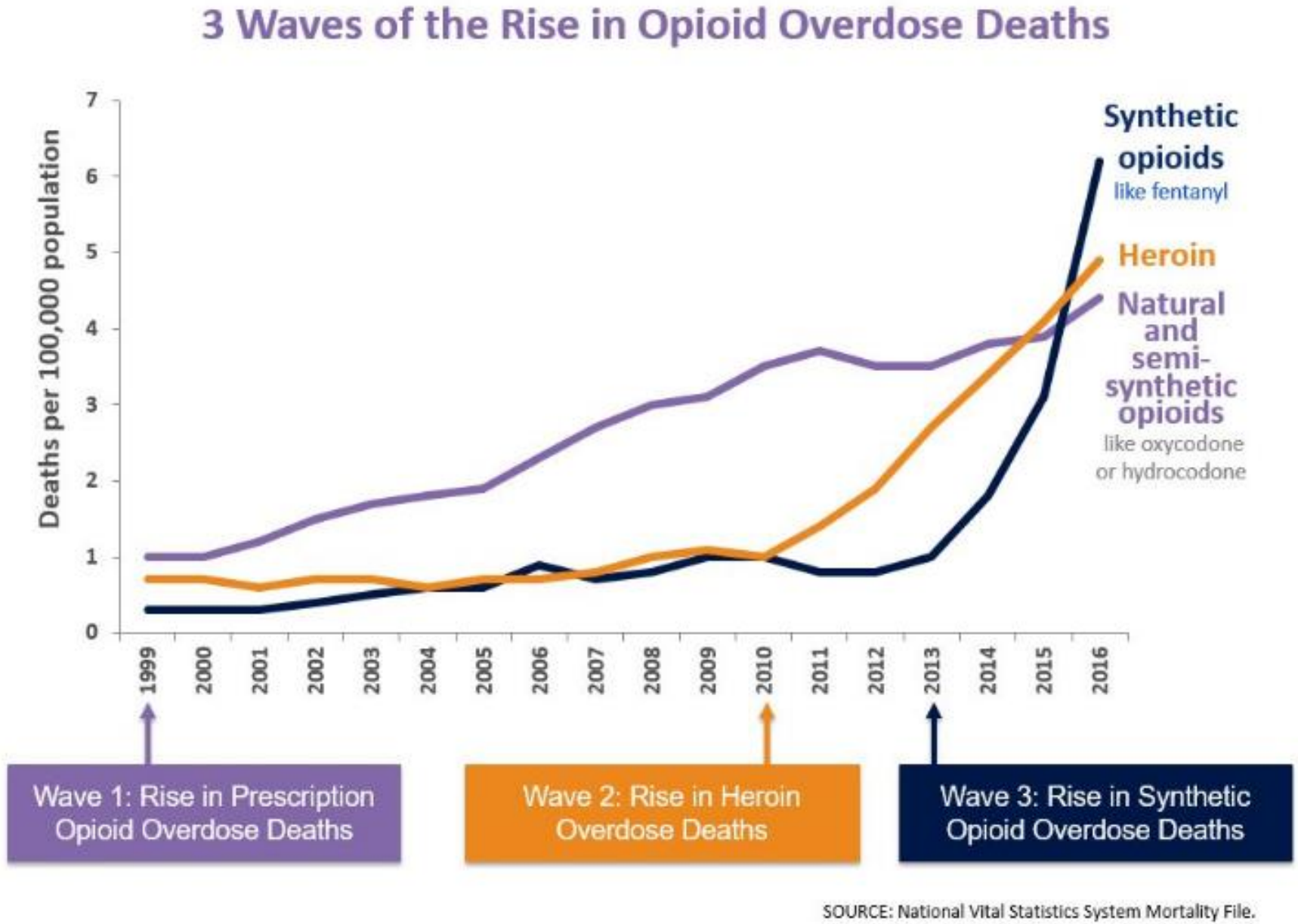
From 1999 - 2016 there have been more than

350,000

deaths from prescription and illicit opioids in the US

Opioid overdose caused **42,249 DEATHS** nationwide in 2016— this exceeded the # caused by motor vehicle crashes.[4,5]

opioid overdose deaths were **5x higher** in 2016 than in 1999



https://www.cdc.gov/drugoverdose/epidemic/index.html accessed 4/3/18

VA | U.S. Department of Veterans Affairs
Veterans Health Administration
PBM Academic Detailing Service

Fentanyl & Carfentanil

One time could be the LAST time

What are Fentanyl and Carfentanil?

Fentanyl is a synthetic opioid that works like morphine. It may be used to treat severe pain after surgeries and for pain at the end of life in patients with cancer. Carfentanil is another synthetic opioid. It is used as a tranquilizer for very large animals like elephants.

Opioid overdoses are on the rise. Fentanyl and carfentanil may be deadly if they are injected. They are so strong that even touching or inhaling them can be lethal.

Why are We Concerned?

Fentanyl and carfentanil are very inexpensive to make. They have been added to illicit drugs like heroin and cocaine and counterfeit opioid pills.

They look just like prescription opioid pills and can cause death within seconds.

How Strong is Carfentanil?

Carfentanil is 10,000 times more potent than morphine and 100 times more potent than fentanyl.

2mg dose will knock out an average size elephant...

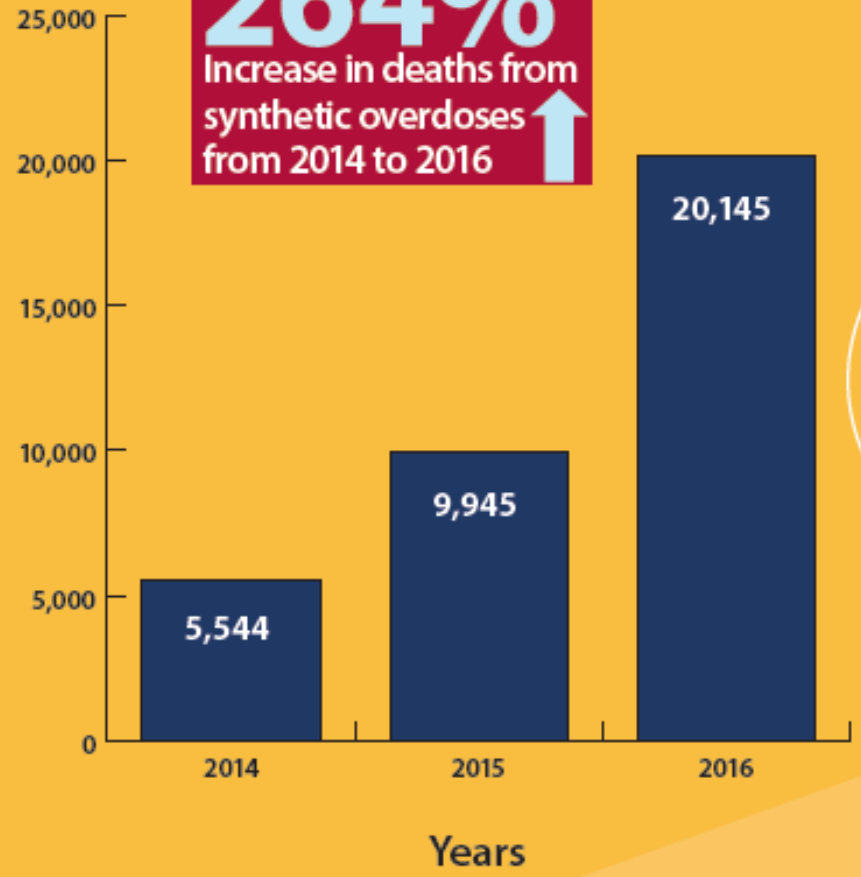
How Strong is Fentanyl?

Fentanyl is **50–100** times more potent than morphine.

...and is enough to kill about **50 people**

Deaths from Synthetic Opioids like Fentanyl and Carfentanil Skyrocket

264%
Increase in deaths from synthetic overdoses from 2014 to 2016



What Can You Do?

There are treatments that work to help you stop using opioids. These are called "medication assisted treatments" and include buprenorphine/naloxone (Suboxone®), methadone and naltrexone. Talk to your VA provider to get started if you are:

- Using street drugs
- Unable to control how much opioid pain medication you use

NALOXONE is a medication that is sprayed in the nose or injected and can reverse an opioid overdose. It is a life-saving treatment that you can get from the VA.

Ask your healthcare team for naloxone if you are taking opioids.

- Always have naloxone with you and know how to use it
- Make sure your family and friends know when and how to use it

NALOXONE SAVES LIVES

In Arizona, Since June 15, 2017:

Real Time Opioid Data

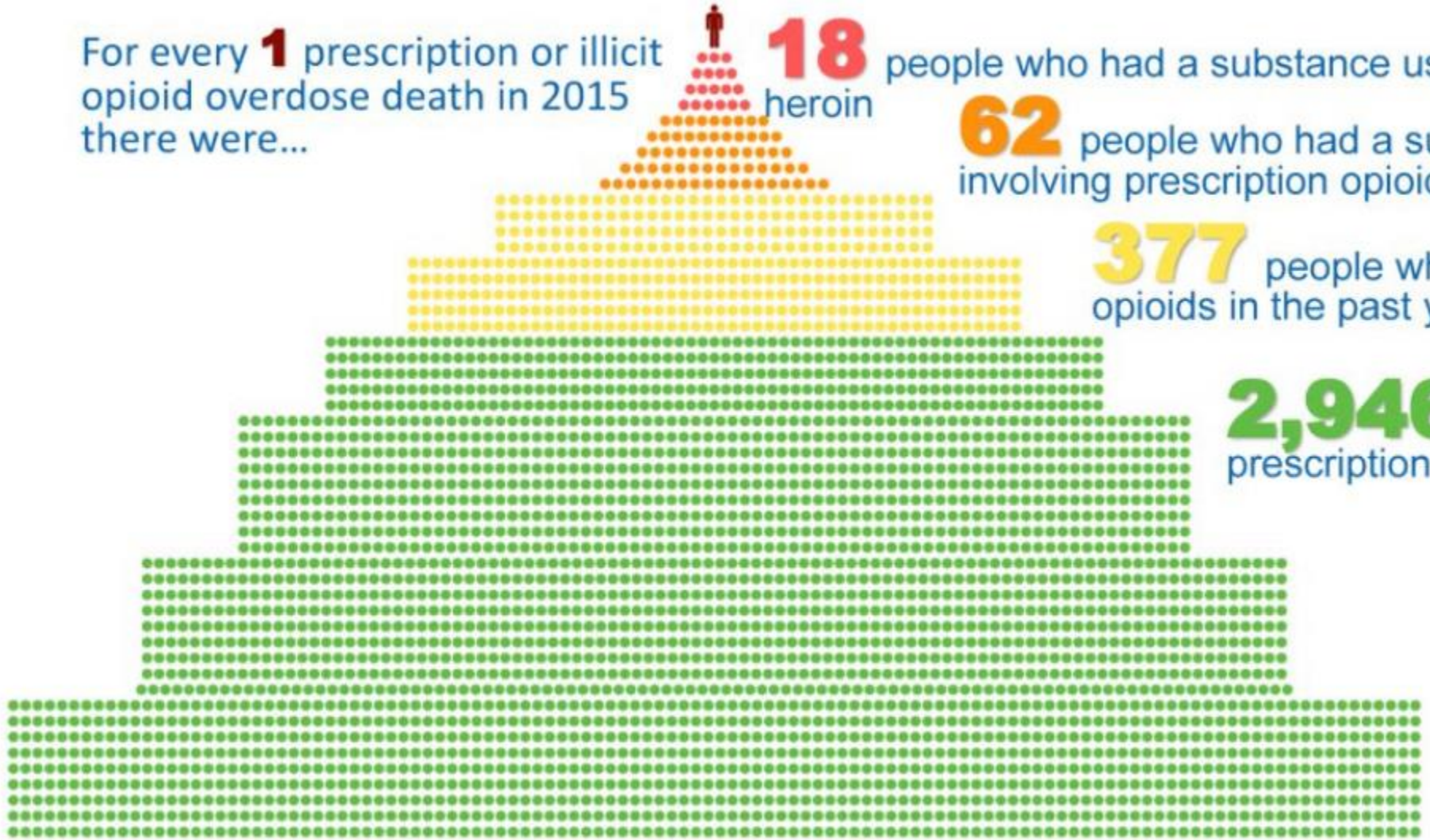
For the first time, statewide opioid data is available in real time. Check out the details of the five categories of data we are now collecting.

1,133	7,144	687	12,406	4,720
suspect opioid deaths	suspect opioid overdoses	neonatal abstinence syndrome	naloxone doses dispensed	naloxone doses administered

http://azdhs.org/opioid accessed 4/16/18 - data through 4/12/18

Overdose Deaths are the Tip of the Iceberg

For every **1** prescription or illicit opioid overdose death in 2015 there were…



18 people who had a substance use disorder involving heroin

62 people who had a substance use disorder involving prescription opioids

377 people who misused prescription opioids in the past year

2,946 people who used prescription opioids in the past year

Results from the 2015 National Survey on Drug Use and Health: Detailed Tables https://www.samhsa.gov/data/sites/default/files/NSDUH-DetTabs-2015/NSDUH-DetTabs-2015/NSDUH-DetTabs-2015.htm#tab1-23a

Rudd RA, Seth P, David F, Scholl L. *Increases in Drug and Opioid-Involved Overdose Deaths* — United States, 2010–2015. MMWR Morb Mortal Wkly Rep 2016;65:1445–1452. DOI: http://dx.doi.org/10.15585/mmwr.mm655051e1.

In 2016

An estimated **1.8M** Americans had OUD related to **prescription opioids**

626K had **heroin** related OUD

National Center for Complementary and Integrative Health

Chronic pain: a major public health problem

The Institute of Medicine says chronic pain in the U.S....[1]

Affects about 100 million adults

Costs $560-635 billion annually (health care, lost productivity)

A major cause of missed work

Chronic pain is...

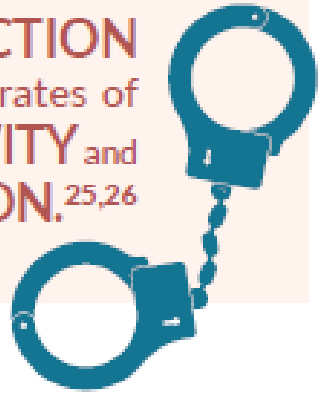
- often defined as pain >12 weeks
- complex and unique to each person

[1] Institute of Medicine. Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education, and Research. 2011

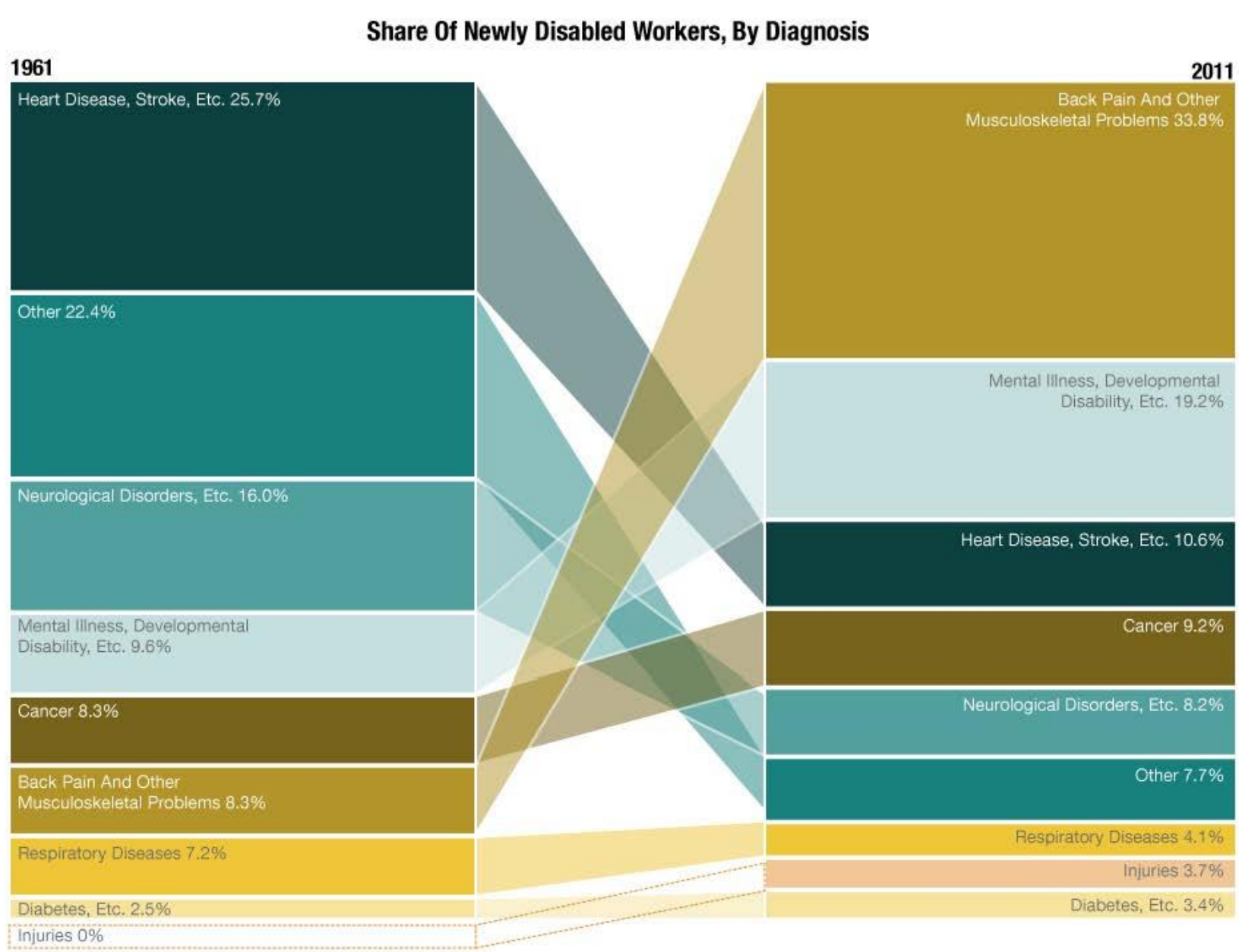
Estimated cost of the **OPIOID EPIDEMIC** was **$504 BILLION** in 2015.[2]

OPIOID-RELATED inpatient hospital stays **INCREASED 64%** nationally from 2005–2014.[24]

OPIOID ADDICTION is linked with high rates of **ILLEGAL ACTIVITY** and **INCARCERATION.**[25,26]



OPIOID-RELATED EMERGENCY DEPARTMENT visits nearly doubled from 2005–2014.[22]



Source: Social Security Administration

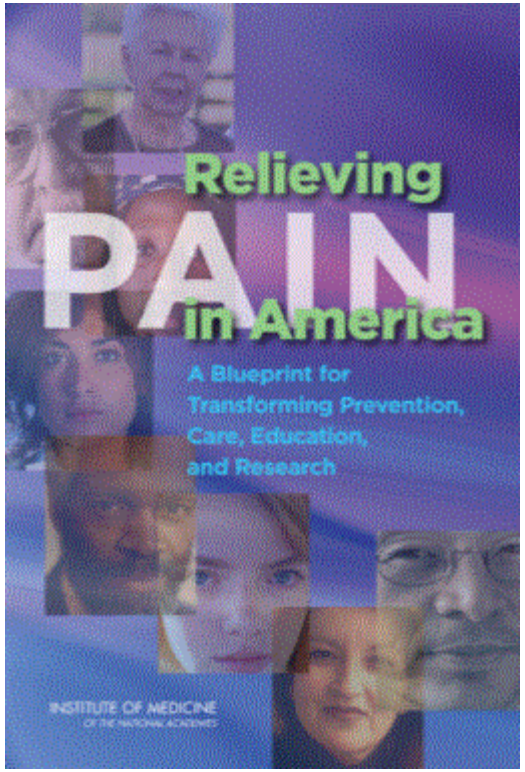
Credit: Lam Thuy Vo / NPR

Transforming Pain Care

2011

Guidance in Cultural Transformation in Pain Care and Opioid Prescribing

2018



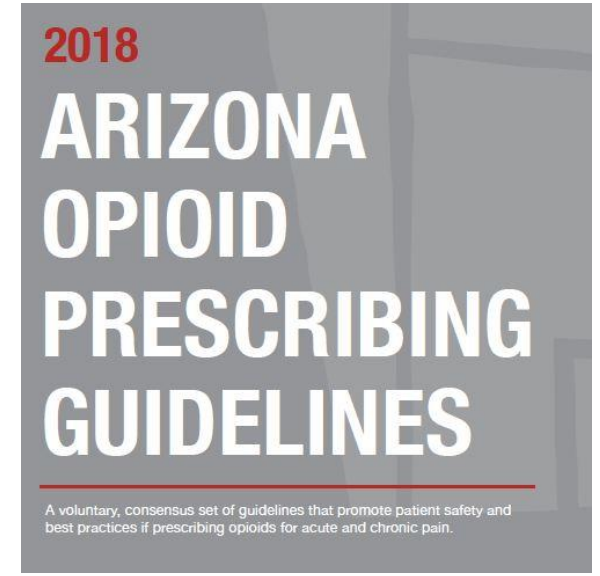
U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

VA/DoD CLINICAL PRACTICE GUIDELINE FOR OPIOID THERAPY FOR CHRONIC PAIN

February 2017

National Pain Strategy

A Comprehensive Population Health-Level Strategy for Pain



Biopsychosocial Care Model

- Focus on care of the **whole person**
  - Treat the person who has pain rather than focus on painful tissue
- Address social, psychological, and biological components of pain
- Focus on improving function
  - Create physical, mental, social, spiritual health
- Patient is activated center of care team
- Focus on **self-management** and **active treatments** that depend on active patient participation

EDITORIAL VIEWS

Anesthesiology, V 120 • No 1 January 2014

Time to Flip the Pain Curriculum?

Daniel B. Carr, M.D., Ylisabyth S. Bradshaw, D.O.

- Common way of teaching the BPS model:
  - Focus on cellular, molecular, nociceptors, and pain generators as the “real” science with vague concepts of suffering and psychosocial factors added on as mere epiphenomena or distractions.
  - “bio” > “psycho” > “social”
  - Views macro concepts (e.g. QoL, physical and social functioning) as dependend on and direct consequence of micro phenomena (subcellular physiology, nociception)
  - Resembles an approach to driver’s education in which combustion chemistry and auto mechanics are mandatory and defensive driving skills are options

Flipping the Curriculum

- Flip from “Biopsychosocial” to “Sociopsychobiological”
- Reframing pain as an interpersonal, inherently social process and recognizing recent basic science and clinical evidence that emotional, social, and cognitive aspects of pain central to chronification and associated dysfunction and disability
- Leads to early educational emphasis on:
  - Person-oriented aspects of pain
  - Factors the lead to pain related disability and SUD, incorporating behavioral medicine, and the organization of healthcare systems
- Recognizes importance of macro factors (QoL and function) in person’s life and that micro factors (ion channels, nociceptors, receptors) result from millennia of social evolution.

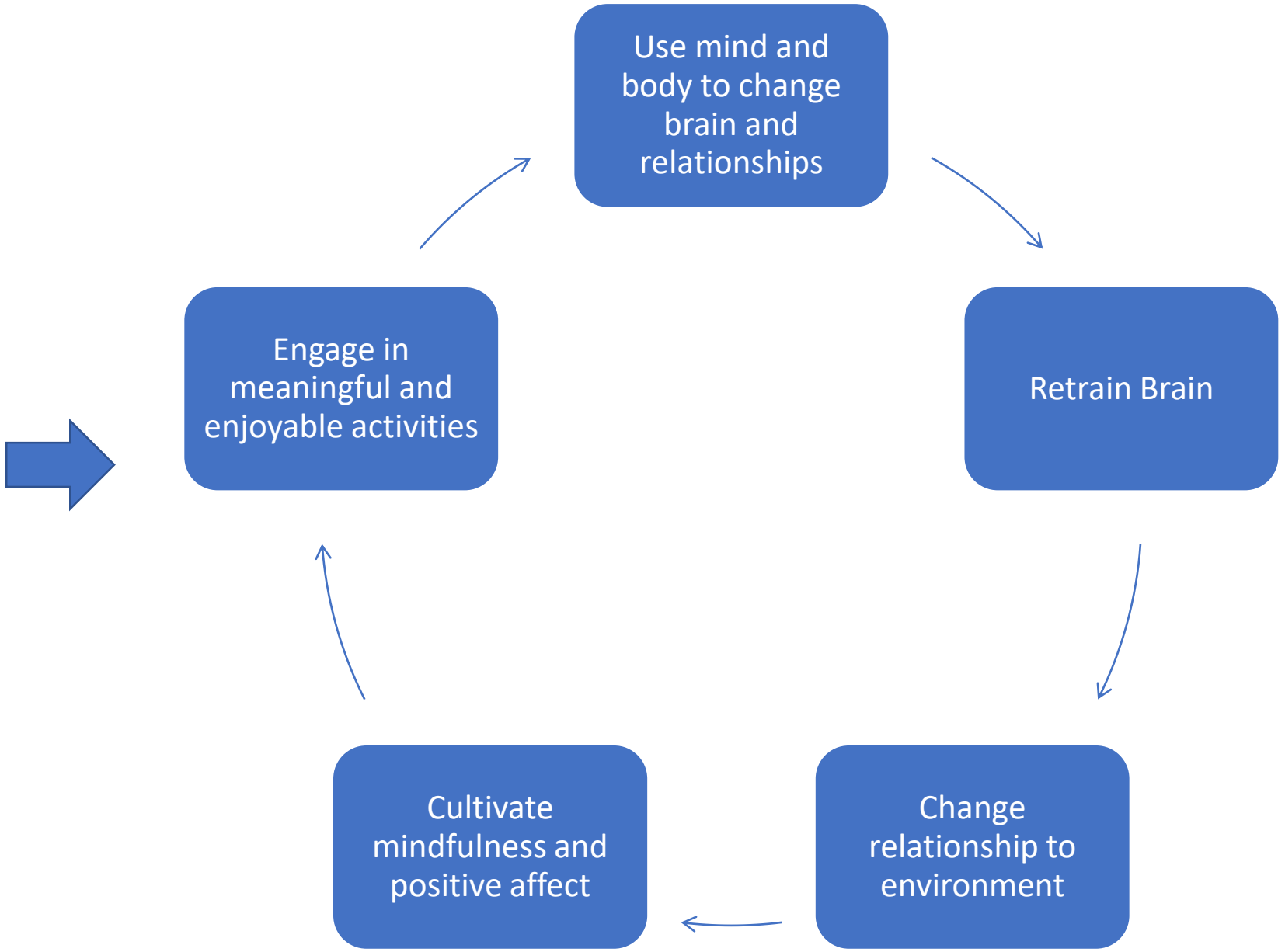
Biomedical model

Have Disease

Take Pill

Kill Something

Siddhartha Mukherjee, MD, DPhil



BPS/SPB, resilience, neuroplasticity approach

Transformation of Pain Care

- Chronic disease model
  - Shift focus from single interventions to gradual, incremental care
- Shift from focus on cure to focus on promotion of health, function, and wellness
- Integrated team approach

2018

ARIZONA OPIOID PRESCRIBING GUIDELINES

A voluntary, consensus set of guidelines that promote patient safety and best practices if prescribing opioids for acute and chronic pain.

ACUTE PAIN

1	Use non-opioid medications and therapies as first-line treatment for mild and moderate acute pain.
2	If opioids are indicated for acute pain, initiate therapy at the lowest effective dose for no longer than a 3-5 day duration; reassess if pain persists beyond the anticipated duration.
3	Do not use long-acting opioids for the treatment of acute pain.

CHRONIC PAIN

4	Prescribe self-management strategies, non-pharmacologic treatments and non-opioid medications as the preferred treatment for chronic pain.
5	Do not initiate long-term opioid therapy for most patients with chronic pain.
6	Coordinate interdisciplinary care for patients with high-impact chronic pain to address pain, substance use disorders and behavioral health conditions.

RISK MITIGATION

7	For patients on long-term opioid therapy, document informed consent which includes the risks of opioid use, options for alternative therapies and therapeutic boundaries.
8	Do not use long-term opioid therapy in patients with untreated substance use disorders.
9	Avoid concurrent use of opioids and benzodiazepines. If patients are currently prescribed both agents, evaluate tapering or an exit strategy for one or both medications.
10	Check the Arizona Controlled Substances Prescription Monitoring Program before initiating an opioid or benzodiazepine, and then at least quarterly.
11	Discuss reproductive plans and the risk of neonatal abstinence syndrome and other adverse neonatal outcomes prior to prescribing opioids to women of reproductive age.
12	If opioids are used to treat chronic pain, prescribe at the lowest possible dose and for the shortest possible time. Reassess the treatment regimen if prescribing doses ≥50 MEDs.
13	Counsel patients who are taking opioids on safety, including safe storage and disposal of medications, not driving if sedated or confused while using opioids and not sharing opioids with others.
14	Reevaluate patients on long-term opioid therapy at least every 90 days for functional improvements, substance use, high-risk behaviors and psychiatric comorbidities through face-to-face visits, PDMP checks and urine drug tests.
15	Assess patients on long-term opioid therapy on a regular basis for opioid use disorder and offer or arrange for medication-assisted therapy (e.g. methadone and buprenorphine) to those diagnosed.
16	Offer naloxone and provide overdose education for all patients at risk for opioid overdose.
17	Individualize an exit strategy from the use of long-term opioid therapy for chronic pain, while carefully monitoring for risks.

Acute Pain

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Chronic Pain

Chronic Pain

4) Prescribe self-management strategies, non-pharmacologic treatments, and non-opioid medications as the preferred treatment for chronic pain
5) Do not initiate long term opioid therapy for most patients with chronic pain
6) Coordinate interdisciplinary care for patients with high-impact chronic pain to address pain, substance use disorders, and behavioral health conditions

High Value Pain Care

Low back pain 1

What low back pain is and why we need to pay attention

Jan Hartvigsen, Mark J Hancock*, Alice Kongsted, Quinette Louw, Manuela L Ferreira, Stéphane Genevay, Damian Hoy, Jaro Karppinen, Glenn Pransky, Joachim Sieper, Rob J Smeets, Martin Underwood, on behalf of the Lancet Low Back Pain Series Working Group†*

Low back pain 2

Prevention and treatment of low back pain: evidence, challenges, and promising directions

*Nadine E Foster, Johannes R Anema, Dan Cherkin, Roger Chou, Steven P Cohen, Douglas P Gross, Paulo H Ferreira, Julie M Fritz, Bart W Koes, Wilco Peul, Judith A Turner, Chris G Maher, on behalf of the Lancet Low Back Pain Series Working Group**

Low back pain: a call for action

*Rachelle Buchbinder, Maurits van Tulder, Birgitta Öberg, Lucíola Menezes Costa, Anthony Woolf, Mark Schoene, Peter Croft, on behalf of the Lancet Low Back Pain Series Working Group**

Key Messages

- Low back pain is a complex condition with **multiple contributors to both the pain and associated disability**, including psychological factors, social factors, biophysical factors, comorbidities, and pain-processing mechanisms
- For the vast majority of people with low back pain, it is **currently not possible to accurately identify the specific nociceptive source**
- Move **away from structural pathology paradigm**

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Key Messages

- Use biopsychosocial framework to guide management with initial non- pharmacological treatment, including **education** that supports self-management and **resumption of normal activities and exercise**, and **psychological programs for those with persistent symptoms**
- **Avoid harmful and useless treatments** by adopting a framework similar to that used in drug regulation—ie, only include treatments in public reimbursement packages if evidence shows that they are safe, effective, and cost-effective
- Common problems are presentations to emergency departments and **inappropriately high use of imaging, rest, opioids, spinal injections, and surgery**

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Key Messages

- **Use the notion of positive health**—the **ability to adapt and to self-manage** in the face of social, physical and emotional challenges—for the treatment of non-specific low back pain
- Address widespread misconceptions in the population and among health professionals about the causes, prognosis, and effectiveness of different treatments for low back pain, and deal fragmented and outdated models of care

Risk Mitigation

7) For patients on long-term opioid therapy, **document informed consent** which includes the risks of opioid use, options for alternative therapies, and therapeutic boundaries
8) **Do not use** LTOT in patients with **untreated substance use disorders**
9) **Avoid concurrent use of opioids and benzodiazepines**. If patients are currently prescribed both agents, evaluate tapering or an exit strategy for one or both medications.
10) **Check the AZ CSPMP** before initiating and opioid or benzodiazepine, and then at least quarterly

Risk Mitigation

11) **Discuss reproductive plans** and the **risk of neonatal abstinence syndrome** and other adverse neonatal outcomes prior to prescribing opioid to women of reproductive age.
12) If opioids are used to treat chronic pain, **prescribe the lowest possible dose and for the shortest possible time**. Reassess the treatment regimen if prescribing doses ≥ 50 mg/d MED
13) **Counsel** patients who are taking opioids **on safety**, including safe storage and disposal of medications, not driving if sedated or confused while using opioids, and not sharing opioids with others.
14) **Reevaluate** patients on LTOT **at least every 90 days** for functional improvement, substance use, high-risk behaviors, and psychiatric comorbidities through face to face visits, PDMP checks, and urine drug testing.

Risk Mitigation

15) **Assess** patients on LTOT on a regular basis **for opioid use disorder** and **offer or arrange for medication-assisted treatment** (e.g. methadone or buprenorphine) to those diagnosed.

16) **Offer naloxone** and **provide overdose education** for all patients at risk for opioid overdose.

17) **Individualize an exit strategy** from the use of LTOT for chronic pain, while carefully monitoring for risks.

Neurobehavioral Adaptations to Opioids

- Simple Opioid Dependence
  - short-lived and self-limited withdrawal symptoms after opioids are discontinued
- Complex Persistent Opioid Dependence
  - worsening pain, function, affective symptoms and sleep disturbance in response to opioid tapering or cessation
- Opioid Use Disorder
  - DSM 5 diagnostic criteria (3 C’s)

The conundrum of opioid tapering in long-term opioid therapy for chronic pain: A commentary

Ajay Manhapra, MD[a,b,c], Albert J. Arias, MD[a,c], and Jane C. Ballantyne, MD[d]

- LTOT can worsen pain and associated psychological symptoms.
  - Each dose of opioids provide lower level but **salient** pain relief
- Long standing **dependence** (not necessarily addiction), interacts **bidirectionally and dynamically** with pain, other symptoms, stress, sleep, and psychological distress, causing significant **lability** of all these, **increasing the perceived need for opioids**
- **Opioid tapering**/cessation **seems** like the **logical** solution in those with well-established opioid dependence (not necessarily addiction), **but can often result in significantly worsened pain, mood, sleep, disterss** that persist for months or weeks beyond acute withdrawals (due to persistent neuroadaptions)

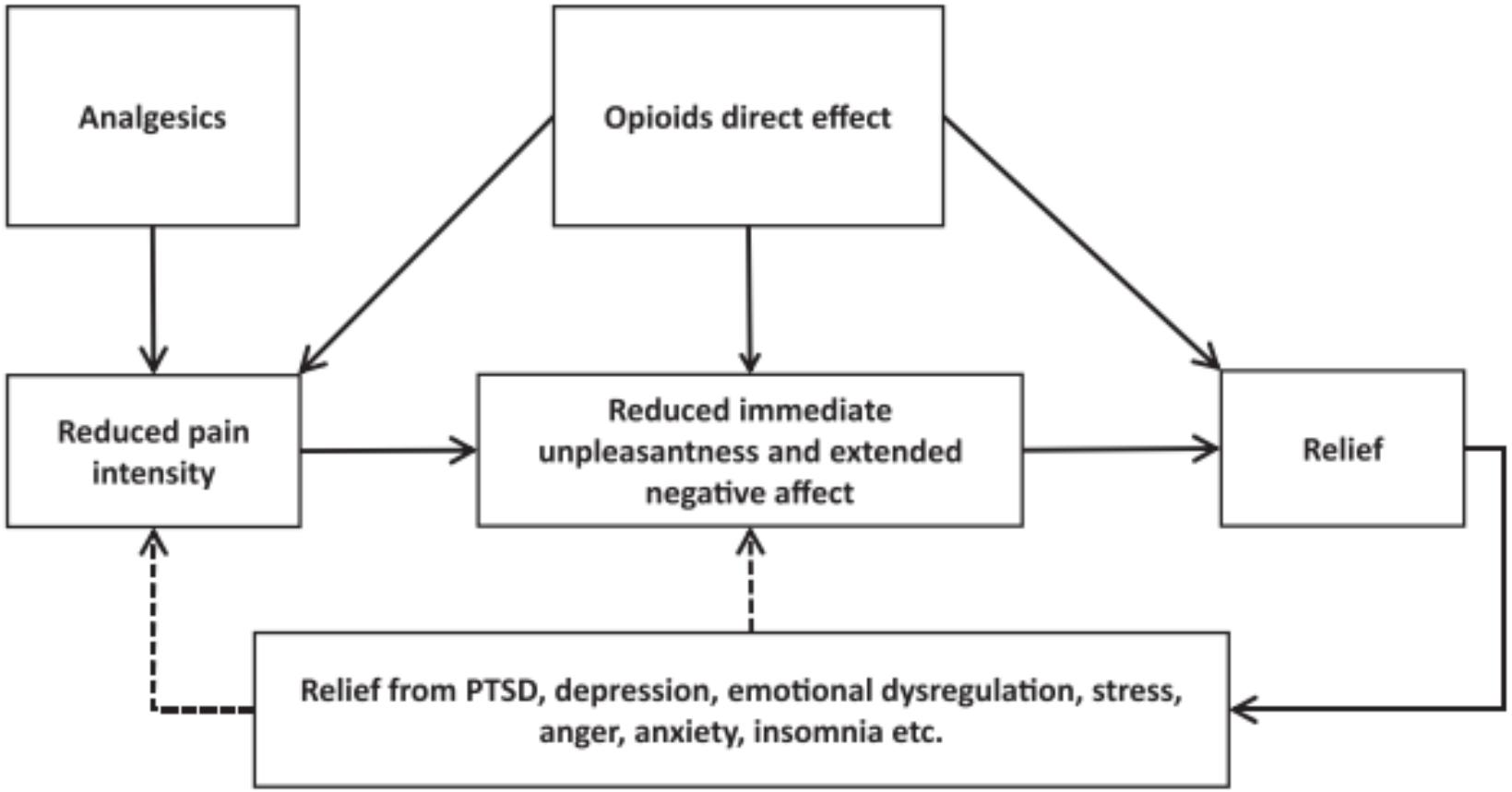
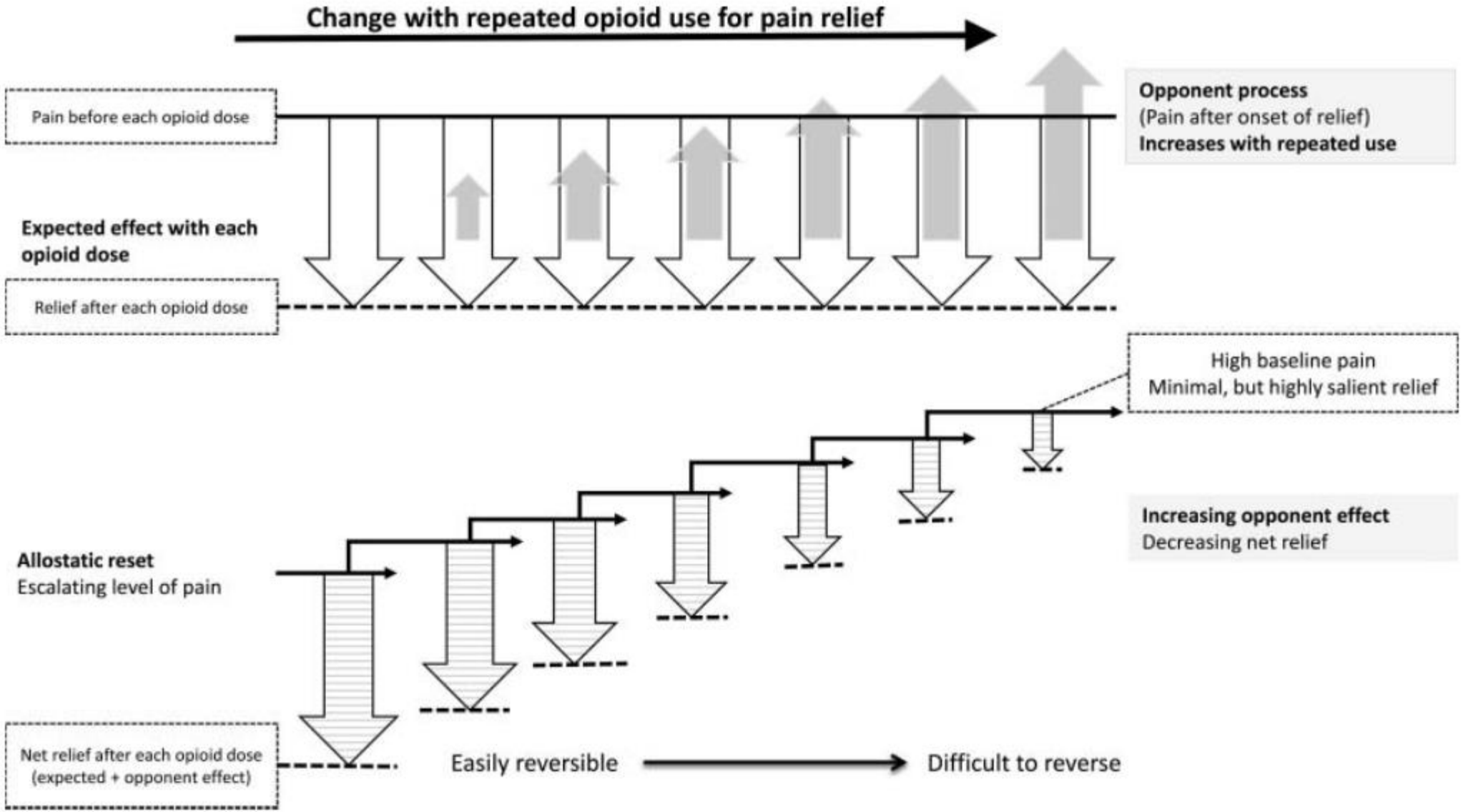


Figure 1. Multimodal action of opioids in pain relief.


Change with repeated opioid use for pain relief
Pain before each opioid dose
Opponent process
(Pain after onset of relief)
Increases with repeated use
Expected effect with each opioid dose
Relief after each opioid dose
High baseline pain
Minimal, but highly salient relief
Increasing opponent effect
Decreasing net relief
Allostatic reset
Escalating level of pain
Net relief after each opioid dose (expected + opponent effect)
Easily reversible
Difficult to reverse

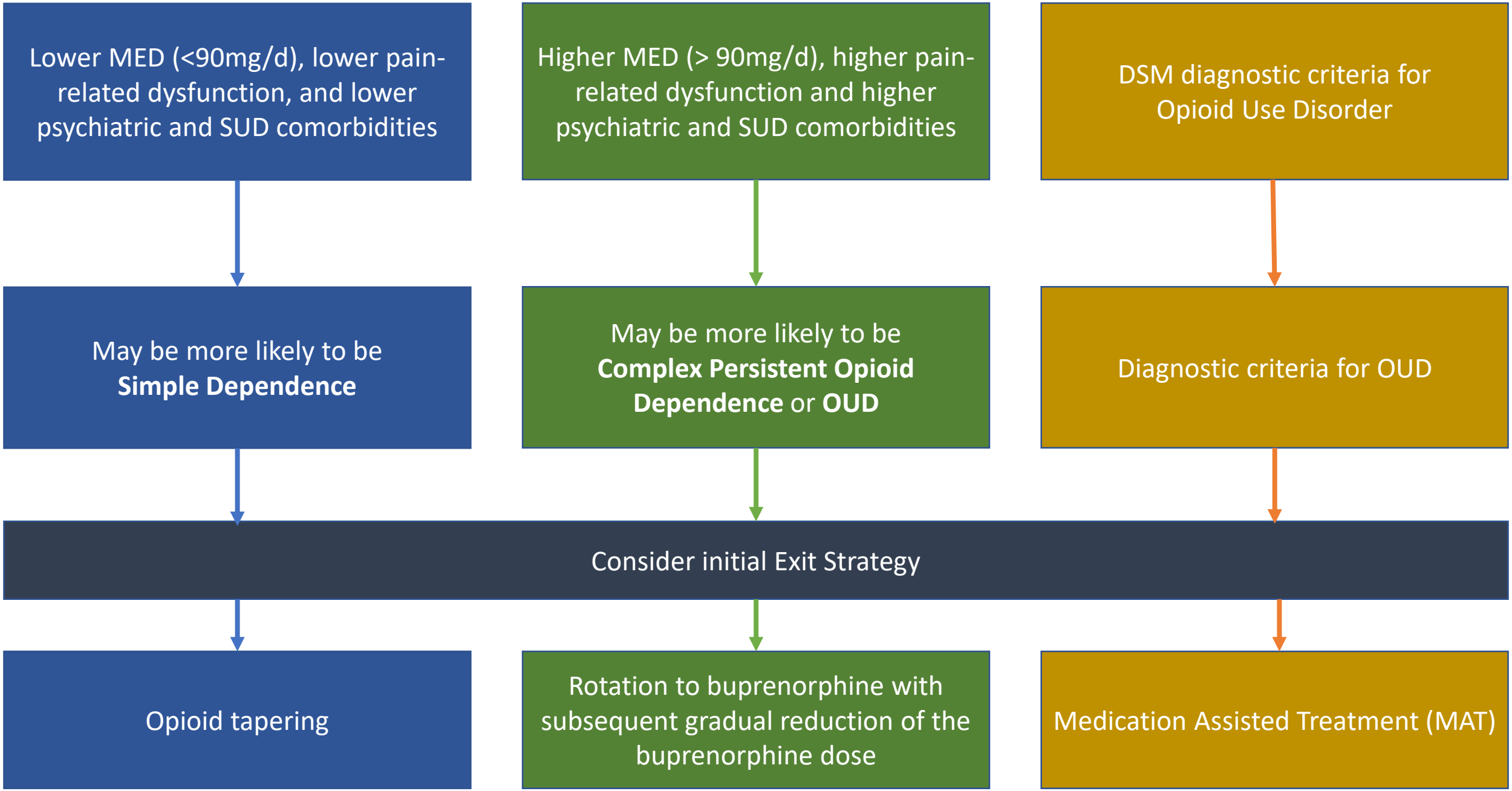
DSM 5 Criteria for OUD

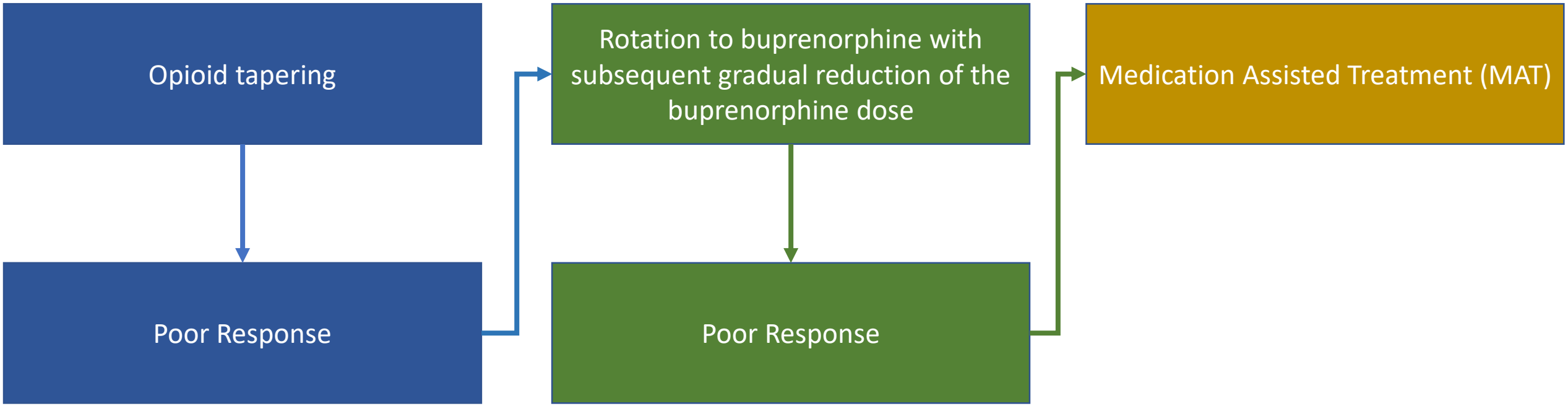
LOSS OF CONTROL	Using larger amounts of opioids or over a longer period than initially intended	EXAMPLE: taking more than prescribed (e.g. repeated requests for early refills)
	Persistent desire or inability to cut down on or control opioid use	EXAMPLE: has tried to reduce dose or quit opioid because of family's concerns about use but has been unable to
	Spending a lot of time to obtain, use or recover from opioids	EXAMPLE: driving to different doctors' offices to get renewals for various opioid prescriptions
CRAVING	Craving or strong desire or urge to use opioids	EXAMPLE: describing constantly thinking about/needing opioid
USE DESPITE NEGATIVE CONSEQUENCES	Failure to fulfill obligations at work, school or home due to use	EXAMPLE: not finishing tasks due to effect of taking opioids; getting fired from jobs
	Continued opioid use despite persistent or recurrent social or interpersonal problems related to opioids	EXAMPLE: spouse of family member worried or critical about patient's opioid use
	Activities are given up or reduced because of use	EXAMPLE: no longer participating in weekly softball league despite no additional injury or reason for additional pain
	Recurrent use in situations that are physically hazardous	EXAMPLE: repeatedly driving under the influence
	Continued use despite physical or psychological problems related to opioids	EXAMPLE: unwilling to discontinue or reduce opioid use despite non-fatal accidental overdose
	Tolerance*	EXAMPLE: needing to take more to achieve the same effect
	Withdrawal*	EXAMPLE: feeling sick if opioid not taken on time or exhibiting withdrawal effects

*Tolerance and Withdrawal are not counted as DSM 5 criteria for OUD when the patient is taking opioid medications as prescribed

Opioid Use Disorder (OUD)

- **OUD** may co-exist with chronic pain and may occur in **up to 26-41%** of patients with chronic pain who use long term opioid therapy (Boscarino 2010 and 2015)
- **OUD** is associated with **mortality rate of 6-20x higher** than the general population (Hser 2015)
- **Medication assisted treatment** (with buprenorphine and methadone) **lowers mortality rates** when used to treat OUD (Sordo 2017)
- **Most** patients with **OUD who are tapered off opioids will restart opioids** and not engage in recommended therapies (SAMHSA TIP 63)


Lower MED (<90mg/d), lower pain-related dysfunction, and lower psychiatric and SUD comorbidities
Higher MED (> 90mg/d), higher pain-related dysfunction and higher psychiatric and SUD comorbidities
DSM diagnostic criteria for Opioid Use Disorder
May be more likely to be **Simple Dependence**
May be more likely to be **Complex Persistent Opioid Dependence** or **OUD**
Diagnostic criteria for OUD
Consider initial Exit Strategy
Opioid tapering
Rotation to buprenorphine with subsequent gradual reduction of the buprenorphine dose
Medication Assisted Treatment (MAT)



Adapted from Manhapra, Arias, Ballantyne 2017

Practice Implications

- Work to **build rapport** and therapeutic alliance with patients
  - Motivational interviewing, validation of patient's suffering does not necessitate starting or increasing opioids
  - Clear therapeutic boundaries
- Optimize **whole person care plan**
- Pursue **incremental changes**
- **Assess all patients on LTOT for opioid tapering** and consider a gradual opioid taper with risks of continued opioid therapy outweigh risks of tapering
- **Consider use of buprenorphine**/naloxone for patients who have difficulty with opioid taper as treatment for complex persistent opioid dependence

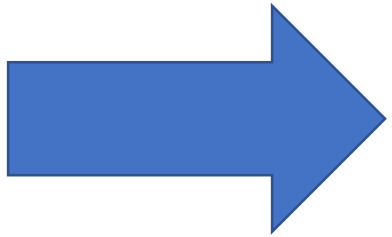
Opioid Tapering

- Not One-Size-Fits-All
- **Regular re-evaluation and modification** of plan according to individual situation of the patient is essential
- **Invest in relationship** and developing therapeutic alliance
- Develop "**care plan for the person with pain**" rather than a "pain plan"
- Identify and develop care plan for **common comorbidities** (depression, anxiety, PTSD, sleep, obesity, OSA, diabetes, etc) and dysfunctional coping strategies (catastrophizing, kinesiophobia, social isolation, deconditioning)
- Focuses on **improving health and wellbeing**

Transforming the Care System

Addressing Systems of Care

- Our system is designed to provide **biomedical** pain care
  - Episodic
  - Single discipline
  - Short term focus
  - Disease focus
  - Reductionism
  - Single treatment focus:
    - procedures and opioids



- We need a system to provide **biopsychosocial** pain care
  - Longitudinal
  - Team based
  - Long term focus
  - Wellness and Prevention
  - Whole Person + environment
  - Multimodal focus:
    - Self-management + biopsychosocial treatment plan

Reimbursement

- Value **cognitive work** (time spent with patients) equally to procedural work
- Provide reimbursement for **pain psychological services**
- Provide economic **incentives to provide integrated interdisciplinary care**
- NPS: Tailor payment to promote and incentivize high-quality, coordinated pain care through an integrated biopsychosocial approach that is cost-effective, value-based, patient-centered, comprehensive, and improves outcomes for people with pain.

Focus on Treatment Teams

- Focus on functions rather than disciplines
  - Case Manager (RN, SW)
  - Movement therapy (PT, RT, KT, yoga therapist, etc)
  - Behavioral therapy (psychologist, counselor)
  - Health Coach (LPN, RN, RD, non-licensed)
  - Addiction provider with ability to prescribe Medication Assisted Treatment
  - PCP – medical provider (MD/DO, NP, PA)
- May require virtual teams (ideally linked by care manager)
- Shared Medical Appointments
- Treatment and Education Groups
- Integrated Interprofessional Pain Rehabilitation

BioPsychoSocial Approaches

I understand that you are frustrated that the back injections and back surgery did not help your pain. Unfortunately, there are no simple medical solutions for this complex problem of chronic pain. The good news is we can work together to help you feel better and begin doing more of what you would like to be doing despite having some pain.

I realize there are no simple solutions and I am willing to work at improving my ability to cope with my pain

I wish there was a cure for my pain, but I will work on my PTSD since it is related to my pain

Pain is complex. PTSD and pain affect each other. The good news is that by working on your PTSD symptoms, your pain will be less overwhelming over time

We work together as a team, with you at the center, to help you find ways to build greater mental and physical health. Over time, if you become an active participant at the center of the team, and as you learn skills and build health, you can return to the driver's seat of your life.

Questions?

Extras

Arizona Law SB 1001

Arizona Opioid Epidemic Act

- Signed into law 1/26/18
- 71 page wide ranging bill

- Provisions include:
  - Access to treatment
  - Access to Naloxone
  - Preventing Addiction for AZ Youth
  - Targeting “Bad Actors”
  - Good Samaritan Law
  - Angel Initiative
  - Prescriber Education
  - E-Prescribing
  - Dose Limits (with exceptions)
  - 5-Day Limits on First Fills
  - Expediting Prior Authorization
  - Opioid Packaging
  - Doctor Shopping
  - Preventing Illegal Use

Arizona State Board of Pharmacy
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Frequently Asked Questions:

2018 Arizona Opioid Epidemic Act

What are the new limits regarding the length of time opioids may be prescribed?

Beginning April 26, 2018, a health professional shall limit the initial prescription for a schedule II opioid to not more than a five-day supply, except an initial opioid prescription following a surgical procedure is limited to a 14-day supply. (A.R.S. 32-3248)

The initial prescription 5-day supply limitation does not apply if:

a) The prescription is following a surgical procedure. Surgical procedure prescriptions are limited to a 14-day supply
b) The patient has an active oncology diagnosis;
c) The patient has a traumatic injury, excluding a surgical procedure;
d) The patient is receiving hospice care, end-of-life care, palliative care, treatment for burns or skilled nursing care;
e) The patient is receiving MAT for a substance use disorder; or
f) The patient is an infant being weaned off opioids at the time of hospital discharge.

What is the maximum morphine milligram equivalents (MME) a prescription may be written for?
The Act prohibits a health professional who is authorized to prescribe controlled substances from issuing a new prescription for a schedule II opioid that exceeds 90 morphine milligram equivalents (MMEs).

A health professional who believes a patient requires more than 90 MMEs per prescription must consult with a licensed physician who is a board-certified pain specialist. A health professional is permitted to prescribe in excess of the 90 MME limitation if the consulting physician is not available for consult within 48 hours, and provides that the consultation may occur subsequent to the prescription being issued.

A health professional may write for a prescription that is more than 90 MME per day if it is:

a) A continuation of a prior prescription order issued within the previous 60 days;
b) An opioid with a maximum approved total daily dose in the labeling as approved by the U.S. Food and Drug Administration (FDA);
c) For a patient who has an active oncology diagnosis or a traumatic injury, not including a surgical procedure;
d) For a patient who is hospitalized;
e) For a patient who is receiving hospice care, end-of-life care, palliative care, skilled nursing facility care or treatment for burns; or
f) For a patient who is receiving MAT for a substance use disorder.

Prescriber education

- Requires all health professionals who are able to prescribe Schedule II controlled substances to complete 3 hours of opioid related CME each license renewal cycle
- Requires all medical students (possibly all with DEA license) to complete 3 hours of opioid related clinical education