Fort Wayne-Allen County Department of Health

# Crisis Pain Management Toolkit for Allen County Healthcare Providers

A Guide for Handling Pain Clinic Patient Overflow

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# Table of Contents

Dear Colleague,

As I am sure you know by now, a local pain physician recently and abruptly closed all of his pain clinics (9 offices in the area). While a new physician is trying to absorb some of his patients, many will be left without care and have had no time to plan for alternative care for themselves. Unfortunately for everyone involved, this is a significant medical and public health issue. As you are also aware, we invited providers to meet to discuss potential options to address this issue. Below you will find our recommendations. We understand that these options are a bit painful and less than ideal, but this is an iatrogenic crisis and we need to minimize the risk that some of these people may turn to illegal drugs or illegally obtained drugs to relieve pain. Heroin, for example, is a new problem in Allen County thanks to cheap prices and the ability to just snort it versus inject it. Thanks to the large number of you who participated. Given all of the constraints of time that ***everybody has***, we propose the following solutions:

Based on the discussion at the meeting, our best guess is:

- About 5,000 to 10,000 patients will be needing care in the next months
- About 75% are Medicaid patients
- About 80% have legitimate pain issues – unfortunately a large number seem to not have been worked up appropriately and will need additional testing (e.g. MRI) by you or a pain doctor.
- About 10% to 20% may not have legitimate pain issues

1. Pain specialists are trying to work in new patients but have constraints on scheduling as well. They will see a small number of patients directly, but the majority of patients will need to be seen by their primary care doctor before they can be seen by pain specialists.
2. As a primary care doctor – especially for Medicaid patients – ***you will need to see them***. The good news is that due to the new prescribing rules, patients cannot simply expect you to fill existing prescriptions and follow treatment plans outlined by Dr.

Hedrick et al.[i] We understand that this will be time-consuming for you and so we have outlined a few options you can consider. If you have not yet reviewed the new prescribing rules, they are outlined in Appendix E. Also, there is a physician toolkit to assist with implementation of the rules (including forms, screening tools and templates, at the Bitterpill.IN.gov website you may find useful: http://www.in.gov/bitterpill/toolkit.html

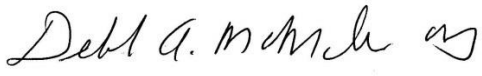
We have also attached a new toolkit to make implementing your option of choice a bit easier. We have requested that FSSA provide a list of primary care providers for Dr. Hedrick's patients such that you will have some idea of how many patients you may need to see. We have attached a list of providers for mental health and addiction for you to refer appropriate patients to as needed (Appendix B). They are all also willing to co-locate on your premises if that would make it easier for you and your patients – we do this for mental health at our facility and compliance has increased over 50 percent.

3. You may have a difficult time determining if a patient is addicted or dependent on the narcotics. If this is an issue, our pain physicians would very much appreciate it if you would refer to mental health for risk assessment ***before*** referring to them. See Appendix C for dependence and addiction definitions and Appendix D for recommendations for referral or co-location of mental health services.
4. All patients may not be able to get an appointment with primary care before their prescriptions run out. ***We need our emergency room physicians to assist us during this time.*** Again the options would include filling their current prescription for a month, tapering their opiates, or taper their opiates and provide withdrawal medications. We understand this not ideal, but this is an urgent situation.
5. We need ***our pharmacists and medical community to be on the same page during this crisis***. We need to provide a consistent message to our patients that they will need to have patience while waiting for prescriptions and they need to take their prescriptions to their usual pharmacy – do not call around to see which pharmacy has their preferred medicine. By the same token, our pharmacy colleagues might benefit from some recommendations on red flags that might need to be addressed, which can be found in Appendix F. This may limit unnecessary calls to the prescribing provider.
6. Finally, patients are not going to be happy. We are very blessed to have the Crisis Intervention Team (CIT) associated with our police force. If you have a concern about a patient's wellbeing, or if they are threatening to you and/or your staff, simply call 911 and request a CIT officer. If a patient is in crisis and makes statements that would indicate that he/she is a danger to themselves

or others, or makes any statements that indicate suicidal ideation, the clinic or pharmacy may call 911 Communications and ask for a CIT Officer to do an assessment. The CIT Officer will respond and evaluate the situation. If the CIT Officer feels in their professional opinion that the person is in need of immediate hospitalization, the CIT Officer can take that patient into custody and transport them to the nearest hospital for an Immediate Detention. Once at the hospital, a mental health professional will conduct an assessment to see if the patient is in need of further medical services, or if a 72-Hour Emergency Detention is needed. This is a wonderful resource that, unfortunately, I have had to use with patients but have found immensely helpful.

Thank you again for your assistance with this important public health issue. We understand that this will be a challenge for everyone in the next few months, but our region is known for excellence and grace under pressure. We will be communicating key issues with the media in terms of both your requirement to follow Indiana State Law and do your assessment and that everyone needs to show patience while medical practices are accommodating this surge of patients.

Sincerely,



Deborah A. McMahan, MD

Health Commissioner

## Appendix A

## Opioid Withdrawal and Treatment Options

### *Opioid Withdrawal*

Tolerance and physical and psychological dependence on opioids usually occur after three weeks of daily usage. Higher tolerance is created as the user decreases the interval and increases the dose to achieve euphoria. In general, abrupt discontinuation of opioids is not recommended because of the extreme anxiety and discomfort experienced by opioid users upon sudden drug cessation. The discontinuation of opioids leads to a constellation of withdrawal symptoms that include drug craving, anxiety, restlessness, gastrointestinal distress, diaphoresis, and tachycardia. These symptoms can be lessened with medication. Hospitalization is usually unnecessary unless the patient has concurrent medical or psychological problems.[ii]

Symptoms of Withdrawal

| Stage | Features |
|---|---|
| Stage I: Up to 8 hours | Fear of withdrawal, anxiety, drug craving |
| Stage II: 8-24 hours | Insomnia, restlessness, anxiety, yawning, stomach cramps, lacrimation, rhinorrhea, diaphoresis, mydriasis |
| Stage III: Up to 3 days | Vomiting, diarrhea, fever, chills, muscle spasms, tremor, tachycardia, piloerection, hypertension, seizures* |

Evaluate patient using Indiana Code guidelines. After your evaluation you may decide:

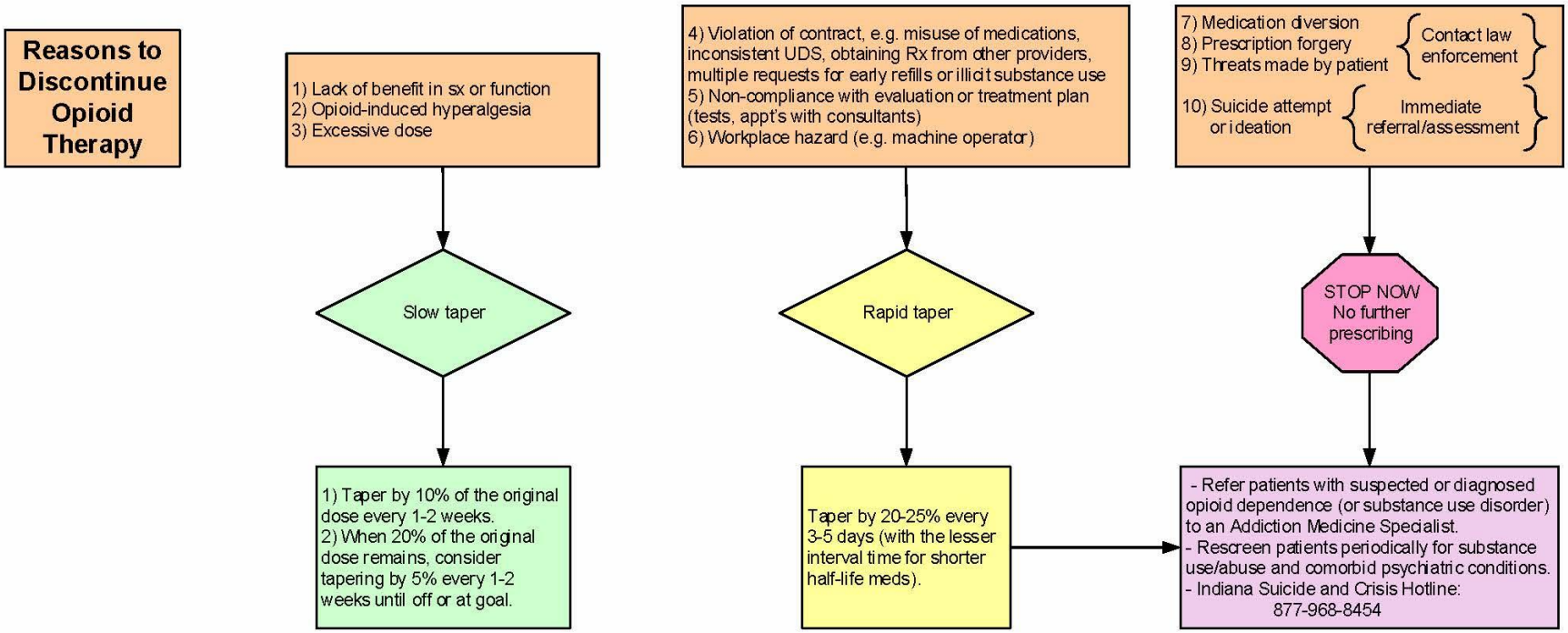
- To continue therapy at current dose or continue therapy at current and refer to pain specialist for additional evaluation and recommendation. As a medical community, I would hope that if a pain specialist evaluated patient and found that narcotics were not necessary, we in primary care would support that decision with our patients.
- To discontinue opiates and begin slow taper. The table below outlines methods that you can utilize based on your level of concern.

| CLINICAL INDICATIONS FOR TAPERING OPIOID THERAPY | TAPER METHOD |
|---|---|
| | |
| Medication adverse effects indicate risks are greater than benefit, or Comorbidities increase risk of complication Pain problem resolves | 10% every 7 days |
| | |
| Function and pain are not improved Patient expresses a desire to discontinue therapy | 10% every two weeks |
| | |
| **Rapid taper is desired (cases that involve dangerous or illegal behaviors)** | **15-33% every 3 to 7 days — While opioid withdrawal is unpleasant, it is not dangerous to the patient** |

  - Symptoms of abstinence syndrome, such as nausea, diarrhea, muscle pain and myoclonus can be managed with clonidine 0.1 – 0.2 mg orally every 6 hours or clonidine transdermal patch 0.1mg/24hrs (Catapres TTS-1™) weekly during the taper while monitoring for often significant hypotension and anticholinergic side effects. In some patients it may be necessary to slow the taper timeline to monthly, rather than weekly dosage adjustments.
  - Other medications that might be helpful are listed in Appendix B.
  - Symptoms of mild opioid withdrawal may persist for up to six months after opioids have been discontinued

        - Consider using adjuvant agents, such as antidepressants to manage irritability, sleep disturbance or antiepileptics for neuropathic pain.
        - Do not treat withdrawal symptoms with opioids or benzodiazepines after discontinuing opioids
    - **Referral for counseling or other support during this period is recommended if there are significant behavioral issues.**
    - Refer to pain specialist or chemical dependency center for complicated withdrawal symptoms

# Discontinuing Opioids

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Thank-you to the Working Group of the State of Indiana's Task Force on Prescription Drug Abuse for their valued input in the preparation of this document.

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2. Berland D, Rodgers P, Rational Use of Opioids for Management of Chronic Nonterminal Pain. *Am Fam Physician*. 2012 Aug 15;86(3):252-258.
3. Jackman RP, Purvis JM, Mallett ES, Chronic Nonmalignant Pain in Primary Care. *Am Fam Physician*. 2008 Nov 15;78(10):1155-1162.

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Medications that may be used to manage withdrawal symptoms (for patients that remain under your care):

1) Clonidine 0.1 – 0.2 mg q6h, or transdermal patch 0.1 mg/24h (monitor BP).
2) Promethazine 25 mg q6-8h, as needed for nausea.
3) Short term use of a non-BZD sleep aid for insomnia like Trazodone 50 mg qhs for 2-4 weeks, if indicated.
4) Imodium for diarrhea, if needed.

# Appendix B

## Detoxification Medications

| Medication | Initial dose (adult) | Indication |
|---|---|---|
| **Opioid** | | |
| Methadone | 10 mg intramuscularly or 20 mg orally | Naturally occurring withdrawal. |
| | | Not recommended for management of acute withdrawal triggered by an antagonist (naloxone, naltrexone). |
| **Non-opioid adjunctive medications** | | |
| Clonidine | 0.1 to 0.3 mg orally every hour with monitoring of blood pressure and heart rate | Anxiety, restlessness, dysphoria with elevated or normal blood pressure and heart rate |
| Promethazine | 25 mg PR q4h prn | Nausea, vomiting, restlessness, insomnia |
| | | |
| Diphenhydramine | 25-50 mg po q6h prn | Diarrhea, stomach cramps |

| | | |
|---|---|---|
| Hydroxyzine | 50 to 100 mg po q6h prn | Anxiety, insomnia |
| Loperamide | 4 mg orally, followed by 2 mg every loose stool | Diarrhea |
| Bismuth subsalicylate | 524 mg orally (15 ml po q30 minutes up to 8 doses/24 hours) | Antidiarrheal |
| | | |
| Acetaminophen | 500-1000 mg orally q6h prn (max 4000 mg/day) | Pain, myalgia |
| Ibuprofen | 600 mg orally q6h prn | |
| Baclofen | 5 to 10 mg orally q8h | Muscle cramping |

* If withdrawal is naturally-occurring, the physician may opt to manage the patient with either opioid or non-opioid adjunctive medication. If withdrawal is triggered by an antagonist, only non-opioid adjunctive medications should be used to manage emergent withdrawal. Refer to UpToDate topics on opioid withdrawal in adults.

http://www.uptodate.com/contents/image?imageKey=EM%2F54978&topicKey=EM%2F306&rank=3%7E150&source=see_link&search=opiate+detoxification&utdPopup=true

# Appendix C

## Physical dependence, Dependence, and Addiction

What is the difference between physical dependence, dependence, and addiction?

Physical dependence is not equivalent to dependence or addiction, and may occur with the regular (daily or almost daily) use of any substance, legal or illegal, even when taken as prescribed. It occurs because the body naturally adapts to regular exposure to a substance (e.g., caffeine or a prescription drug). A person may have a physical dependence on a substance without having an addiction. When that substance is taken away, symptoms can emerge while the body re-adjusts to the loss of the substance. Physical dependence can lead to craving the drug to relieve the withdrawal symptoms. Drug dependence and addiction refer to substance use disorders, which may include physical dependence but must also meet additional criteria. Tolerance to a drug is usually part of addiction.[iiiiv]

**Definition of Addiction**

Public Policy Statement: Definition of Addiction

Short Definition of Addiction:

Addiction is a primary, chronic disease of brain reward, motivation, memory and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors.

Addiction is characterized by inability to consistently abstain, impairment in behavioral control, and craving, diminished recognition of significant problems with one's behaviors and interpersonal relationships, and a dysfunctional emotional response. Like other chronic

diseases, addiction often involves cycles of relapse and remission. Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death.

**Long Definition of Addiction:**

Addiction is a primary, chronic disease of brain reward, motivation, memory and related circuitry. Addiction affects neurotransmission and interactions within reward structures of the brain, including the nucleus accumbens, anterior cingulate cortex, basal forebrain and amygdala, such that motivational hierarchies are altered and addictive behaviors, which may or may not include alcohol and other drug use, supplant healthy, self-care related behaviors. Addiction also affects neurotransmission and interactions between cortical and hippocampal circuits and brain reward structures, such that the memory of previous exposures to rewards (such as food, sex, alcohol and other drugs) leads to a biological and behavioral response to external cues, in turn triggering craving and/or engagement in addictive behaviors.

The neurobiology of addiction encompasses more than the neurochemistry of reward.1 The frontal cortex of the brain and underlying white matter connections between the frontal cortex and circuits of reward, motivation and memory are fundamental in the manifestations of altered impulse control, altered judgment, and the dysfunctional pursuit of rewards (which is often experienced by the affected person as a desire to “be normal”) seen in addiction--despite cumulative adverse consequences experienced from engagement in substance use and other addictive behaviors. The frontal lobes are important in inhibiting impulsivity and in assisting individuals to appropriately delay gratification. When persons with addiction manifest problems in deferring gratification, there is a neurological locus of these problems in the frontal cortex. Frontal lobe morphology, connectivity and functioning are still in the process of maturation during adolescence and young adulthood, and early exposure to substance use is another significant factor in the development of addiction. Many neuroscientists believe that developmental morphology is the basis that makes early-life exposure to substances such an important factor.

Genetic factors account for about half of the likelihood that an individual will develop addiction. Environmental factors interact with the person’s biology and affect the extent to which genetic factors exert their influence. Resiliencies the individual acquires (through

parenting or later life experiences) can affect the extent to which genetic predispositions lead to the behavioral and other manifestations of addiction. Culture also plays a role in how addiction becomes actualized in persons with biological vulnerabilities to the development of addiction.

Other factors that can contribute to the appearance of addiction, leading to its characteristic bio-psycho-socio-spiritual manifestations, include:

a.The presence of an underlying biological deficit in the function of reward circuits, such that drugs and behaviors which enhance reward function are preferred and sought as reinforcers;

b.The repeated engagement in drug use or other addictive behaviors, causing neuroadaptation in motivational circuitry leading to impaired control over further drug use or engagement in addictive behaviors;

c. Cognitive and affective distortions, which impair perceptions and compromise the ability to deal with feelings, resulting in significant self-deception;

d. Disruption of healthy social supports and problems in interpersonal relationships which impact the development or impact of resiliencies;

e. Exposure to trauma or stressors that overwhelm an individual's coping abilities;

f.Distortion in meaning, purpose and values that guide attitudes, thinking and behavior;

g. Distortions in a person's connection with self, with others and with the transcendent (referred to as God by many, the Higher Power by 12-steps groups, or higher consciousness by others); and

h. The presence of co-occurring psychiatric disorders in persons who engage in substance use or other addictive behaviors.

Addiction is characterized by:

a.Inability to consistently Abstain;

b. Impairment in Behavioral control;

c. Craving; or increased “hunger” for drugs or rewarding experiences;

d. Diminished recognition of significant problems with one’s behaviors and interpersonal relationships; and

e. A dysfunctional Emotional response.

The power of external cues to trigger craving and drug use, as well as to increase the frequency of engagement in other potentially addictive behaviors, is also a characteristic of addiction, with the hippocampus being important in memory of previous euphoric or dysphoric experiences, and with the amygdala being important in having motivation concentrate on selecting behaviors associated with these past experiences.

Although some believe that the difference between those who have addiction, and those who do not, is the quantity or frequency of alcohol/drug use, engagement in addictive behaviors (such as gambling or spending) 3, or exposure to other external rewards (such as food or sex), a characteristic aspect of addiction is the qualitative way in which the individual responds to such exposures, stressors and environmental cues. A particularly pathological aspect of the way that persons with addiction pursue substance use or external rewards is that preoccupation with, obsession with and/or pursuit of rewards (e.g., alcohol and other drug use) persist despite the accumulation of adverse consequences. These manifestations can occur compulsively or impulsively, as a reflection of impaired control.

Persistent risk and/or recurrence of relapse, after periods of abstinence, is another fundamental feature of addiction. This can be triggered by exposure to rewarding substances and behaviors, by exposure to environmental cues to use, and by exposure to emotional stressors that trigger heightened activity in brain stress circuits.4

In addiction there is a significant impairment in executive functioning, which manifests in problems with perception, learning, impulse control, compulsivity, and judgment. People with addiction often manifest a lower readiness to change their dysfunctional behaviors despite mounting concerns expressed by significant others in their lives; and display an apparent lack of appreciation of the magnitude of cumulative problems and complications. The still developing frontal lobes of adolescents may both compound these deficits in executive functioning and predispose youngsters to engage in “high risk” behaviors, including engaging in alcohol or other drug use. The profound drive or craving to use substances or engage in apparently rewarding behaviors, which is seen in many patients with addiction, underscores the compulsive or avolitional aspect of this disease. This is the connection with “powerlessness” over addiction and “unmanageability” of life, as is described in Step 1 of 12 Steps programs.

Addiction is more than a behavioral disorder. Features of addiction include aspects of a person’s behaviors, cognitions, emotions, and interactions with others, including a person’s ability to relate to members of their family, to members of their community, to their own psychological state, and to things that transcend their daily experience.

Behavioral manifestations and complications of addiction, primarily due to impaired control, can include:

a. Excessive use and/or engagement in addictive behaviors, at higher frequencies and/or quantities than the person intended, often associated with a persistent desire for and unsuccessful attempts at behavioral control;

b. Excessive time lost in substance use or recovering from the effects of substance use and/or engagement in addictive behaviors, with significant adverse impact on social and occupational functioning (e.g. the development of interpersonal relationship problems or the neglect of responsibilities at home, school or work);

c. Continued use and/or engagement in addictive behaviors, despite the presence of persistent or recurrent physical or psychological problems which may have been caused or exacerbated by substance use and/or related addictive behaviors;

d. A narrowing of the behavioral repertoire focusing on rewards that are part of addiction; and

e. An apparent lack of ability and/or readiness to take consistent, ameliorative action despite recognition of problems.

Cognitive changes in addiction can include:

a. Preoccupation with substance use;

b. Altered evaluations of the relative benefits and detriments associated with drugs or rewarding behaviors; and

c. The inaccurate belief that problems experienced in one's life are attributable to other causes rather than being a predictable consequence of addiction.

Emotional changes in addiction can include:

a. Increased anxiety, dysphoria and emotional pain;

b. Increased sensitivity to stressors associated with the recruitment of brain stress systems, such that "things seem more stressful" as a result; and

c. Difficulty in identifying feelings, distinguishing between feelings and the bodily sensations of emotional arousal, and describing feelings to other people (sometimes referred to as alexithymia).

The emotional aspects of addiction are quite complex. Some persons use alcohol or other drugs or pathologically pursue other rewards because they are seeking "positive reinforcement" or the creation of a positive emotional state ("euphoria"). Others pursue substance use or other rewards because they have experienced relief from negative emotional states ("dysphoria"), which constitutes "negative reinforcement. " Beyond the initial experiences of reward and relief, there is a dysfunctional emotional state present in most cases of addiction that is associated with the persistence of engagement with addictive behaviors. The state of addiction is not the same as the state of intoxication. When anyone experiences mild intoxication through the use of alcohol or other drugs, or when one engages non-pathologically in potentially addictive behaviors such as gambling or eating, one may experience a "high", felt as a "positive" emotional state associated with increased dopamine and opioid peptide activity in reward circuits. After such an experience, there is a

neurochemical rebound, in which the reward function does not simply revert to baseline, but often drops below the original levels. This is usually not consciously perceptible by the individual and is not necessarily associated with functional impairments.

Over time, repeated experiences with substance use or addictive behaviors are not associated with ever increasing reward circuit activity and are not as subjectively rewarding. Once a person experiences withdrawal from drug use or comparable behaviors, there is an anxious, agitated, dysphoric and labile emotional experience, related to suboptimal reward and the recruitment of brain and hormonal stress systems, which is associated with withdrawal from virtually all pharmacological classes of addictive drugs. While tolerance develops to the “high,” tolerance does not develop to the emotional “low” associated with the cycle of intoxication and withdrawal. Thus, in addiction, persons repeatedly attempt to create a “high”--but what they mostly experience is a deeper and deeper “low.” While anyone may “want” to get “high”, those with addiction feel a “need” to use the addictive substance or engage in the addictive behavior in order to try to resolve their dysphoric emotional state or their physiological symptoms of withdrawal. Persons with addiction compulsively use even though it may not make them feel good, in some cases long after the pursuit of “rewards” is not actually pleasurable.5 Although people from any culture may choose to “get high” from one or another activity, it is important to appreciate that addiction is not solely a function of choice. Simply put, addiction is not a desired condition.

As addiction is a chronic disease, periods of relapse, which may interrupt spans of remission, are a common feature of addiction. It is also important to recognize that return to drug use or pathological pursuit of rewards is not inevitable.

Clinical interventions can be quite effective in altering the course of addiction. Close monitoring of the behaviors of the individual and contingency management, sometimes including behavioral consequences for relapse behaviors, can contribute to positive clinical outcomes. Engagement in health promotion activities which promote personal responsibility and accountability, connection with others, and personal growth also contribute to recovery. It is important to recognize that addiction can cause disability or premature death, especially when left untreated or treated inadequately.

The qualitative ways in which the brain and behavior respond to drug exposure and engagement in addictive behaviors are different at later stages of addiction than in earlier stages, indicating progression, which may not be overtly apparent. As is the case with other chronic diseases, the condition must be monitored and managed over time to:

a. Decrease the frequency and intensity of relapses;

b. Sustain periods of remission; and

c. Optimize the person's level of functioning during periods of remission.

In some cases of addiction, medication management can improve treatment outcomes. In most cases of addiction, the integration of psychosocial rehabilitation and ongoing care with evidence-based pharmacological therapy provides the best results. Chronic disease management is important for minimization of episodes of relapse and their impact. Treatment of addiction saves lives †

Addiction professionals and persons in recovery know the hope that is found in recovery. Recovery is available even to persons who may not at first be able to perceive this hope, especially when the focus is on linking the health consequences to the disease of addiction. As in other health conditions, self-management, with mutual support, is very important in recovery from addiction. Peer support such as that found in various "self-help" activities is beneficial in optimizing health status and functional outcomes in recovery. ‡

Recovery from addiction is best achieved through a combination of self-management, mutual support, and professional care provided by trained and certified professionals.

† See ASAM Public Policy Statement on Treatment for Alcohol and Other Drug Addiction, Adopted: May 01, 1980, Revised: January 01, 2010

‡ see ASAM Public Policy Statement on The Relationship between Treatment and Self Help: A Joint Statement of the American Society of Addiction Medicine, the American Academy of Addiction Psychiatry, and the American Psychiatric Association, Adopted: December 01, 1997

Explanatory footnotes:

1. The neurobiology of reward has been well understood for decades, whereas the neurobiology of addiction is still being explored. Most clinicians have learned of reward pathways including projections from the ventral tegmental area (VTA) of the brain, through the median forebrain bundle (MFB), and terminating in the nucleus accumbens (Nuc Acc), in which dopamine neurons are prominent. Current neuroscience recognizes that the neurocircuitry of reward also involves a rich bi-directional circuitry connecting the nucleus accumbens and the basal forebrain. It is the reward circuitry where reward is registered, and where the most fundamental rewards such as food, hydration, sex, and nurturing exert a strong and life-sustaining influence. Alcohol, nicotine, other drugs and pathological gambling behaviors exert their initial effects by acting on the same reward circuitry that appears in the brain to make food and sex, for example, profoundly reinforcing. Other effects, such as intoxication and emotional euphoria from rewards, derive from activation of the reward circuitry. While intoxication and withdrawal are well understood through the study of reward circuitry, understanding of addiction requires understanding of a broader network of neural connections involving forebrain as well as midbrain structures. Selection of certain rewards, preoccupation with certain rewards, response to triggers to pursue certain rewards, and motivational drives to use alcohol and other drugs and/or pathologically seek other rewards, involve multiple brain regions outside of reward neurocircuitry itself.

2. These five features are not intended to be used as “diagnostic criteria” for determining if addiction is present or not. Although these characteristic features are widely present in most cases of addiction, regardless of the pharmacology of the substance use seen in addiction or the reward that is pathologically pursued, each feature may not be equally prominent in every case. The diagnosis of addiction requires a comprehensive biological, psychological, social and spiritual assessment by a trained and certified professional.

3. In this document, the term "addictive behaviors" refers to behaviors that are commonly rewarding and are a feature in many cases of addiction. Exposure to these behaviors, just as occurs with exposure to rewarding drugs, is facilitative of the addiction process rather than causative of addiction. The state of brain anatomy and physiology is the underlying variable that is more directly causative of addiction. Thus, in this document, the term “addictive behaviors” does not refer to dysfunctional or socially disapproved behaviors, which can appear in many cases of addiction. Behaviors, such as dishonesty, violation of one’s values or the values of others, criminal acts etc., can be a component of addiction; these are best viewed as complications that result from rather than contribute to addiction.

4. The anatomy (the brain circuitry involved) and the physiology (the neuro-transmitters involved) in these three modes of relapse (drug- or reward-triggered relapse vs. cue-triggered relapse vs. stress-triggered relapse) have been delineated through neuroscience research.

Relapse triggered by exposure to addictive/rewarding drugs, including alcohol, involves the nucleus accumbens and the VTA-MFB-Nuc Acc neural axis (the brain's mesolimbic dopaminergic "incentive salience circuitry"--see footnote 2 above). Reward-triggered relapse also is mediated by glutamatergic circuits projecting to the nucleus accumbens from the frontal cortex.

Relapse triggered by exposure to conditioned cues from the environment involves glutamate circuits, originating in frontal cortex, insula, hippocampus and amygdala projecting to mesolimbic incentive salience circuitry.

Relapse triggered by exposure to stressful experiences involves brain stress circuits beyond the hypothalamic-pituitary-adrenal axis that is well known as the core of the endocrine stress system. There are two of these relapse-triggering brain stress circuits – one originates in noradrenergic nucleus A2 in the lateral tegmental area of the brain stem and projects to the hypothalamus, nucleus accumbens, frontal cortex, and bed nucleus of the stria terminalis, and uses norepinephrine as its neurotransmitter; the other originates in the central nucleus of the amygdala, projects to the bed nucleus of the stria terminalis and uses corticotrophin-releasing factor (CRF) as its neurotransmitter.

5. Pathologically pursuing reward (mentioned in the Short Version of this definition) thus has multiple components. It is not necessarily the amount of exposure to the reward (e.g., the dosage of a drug) or the frequency or duration of the exposure that is pathological. In

addiction pursuit of rewards persists, despite life problems that accumulate due to addictive behaviors, even when engagement in the behaviors ceases to be pleasurable. Similarly, in earlier stages of addiction, or even before the outward manifestations of addiction have become apparent, substance use or engagement in addictive behaviors can be an attempt to pursue relief from dysphoria; while in later stages of the disease, engagement in addictive behaviors can persist even though the behavior no longer provides relief.

http://www.asam.org/for-the-public/definition-of-addiction

Adopted by the ASAM Board of Directors April 19, 2011.

# Appendix D

## Local Addictions and Mental Health Providers

***Bowen Center***

**Services:**

The Bowen Center provides outpatient and community-based mental health services across 10 counties in northern Indiana, including: Allen, Lagrange, Dekalb, Noble, Steuben, Huntington, Whitley, Wabash, Kosciusko, and Marshall. Our addictions services are provided in each of our ten locations, these services include:

- Individual Counseling
- Five levels of Group Counseling
- Drug Screening
- Substance Abuse Evaluations
- Opiate Risk Evaluation*

*The Opiate Risk Evaluations will provide the referring doctor with a report to help identify the potential of abuse with a rating system of Low, Moderate, and High risk. The report will also include recommendations for further mental health treatment.

Services also include a wide range of mental health treatment that includes individual and/or family counseling, psychological testing, psychiatric medication management, and rehabilitation case management. Please call our office or review our website for more information.

**Referrals:**

Clients can call our access number directly to schedule an appointment themselves, but if the doctors are wanting feedback for risk factors and recommendations for further treatment they can fax that request themselves.

- Access #: 1-800-342-5652
- Doctor Referral Fax #: 260-471-4263

**Address:**

2100 Goshen Road

Fort Wayne, IN 46808

(260) 471-3500

**Pay-Source**: Medicaid, Medicare, most private insurance, and Self-pay with a sliding fee scale.

**Wait-time**:

For mental health appointments is 1-2 weeks. Turn-around for recommendations for continued tx and findings from assessment is 2-3 business days.

Co-locating in your office: We desire to establish more partnerships to provide direct on-site mental health treatment.

**Website:** http://www.bowencenter.org/

***Headwaters Counseling***

**Services**

We provide individual, couple, family and group therapy for individuals who are negatively impacted by mental health and/or substance abuse issues. All cases begin with a very detailed assessment

**Referrals:**

Referral need only to call 260.744.4326, ask for intake

2712 South Calhoun Street Fort Wayne, IN 46807

**Pay Source**: Headwaters Counseling has competitive fees for services. In addition to self-pay, we accept most insurance, Medicaid and Medicare. Please call 260-744-4326 to see if we are a provider for your particular insurance. In some programs, we establish co-pays based on household size and income.

**Wait times** are based on the availability of the client.

Co-locating in your office: We are more than willing to discuss co-locating

**Website:** www.headwaterscounseling.org

www.facebook.com/headwaterscounseling

***Park Center***

**Services:**

- Park Center's Addiction Services provides care to individuals who abuse or are addicted to alcohol, prescription drugs, and other drugs. Also served are those who may have coexisting psychiatric conditions.
- Addiction Services offers the following treatment programs/services for Adults:
  - Adult Structured Addiction Outpatient Program
  - Women in Recovery Services
  - Addiction Psychiatric Services
  - Opiate and Alcohol Detoxification Protocol
- Medication Assisted Opiate Detoxification: Park Center's Associate Medical Director is out of the office for an extended length of time for personal reasons. He is not expected to return till January. Those currently in the Outpatient Detoxification program will continue their detox protocol. No new admissions to the Outpatient Detoxification protocol will occur until his return.
- Addiction Services also provides a program for dually-diagnosed (Severe mental illness & substance use disorder) for men called Harmony House. Addiction Services also provides a program for youth ages 12-17 and their family/caregiver called the 'Family Empowerment Program.' If you would like more information on either of these programs I would be happy to provide it.

**Referrals:** Phone #: 481-2800

Fax#: 969-8442

1909 Carew St.

**Pay Source:** Park Center is able to accept Medicare, Medicaid, and most private pay insurances. Park Center offers a sliding fee scale for the self-pay consumer.

**Wait times**: We are able to see individuals the same or next day for an assessment with a Master's level person. A person must physically present to 1909 Carew St. and request service. No assessment appointments are scheduled over the phone.

Co-locating in your office: We are more than willing to discuss co-locating

**Web site:** http://www.parkcenter.org/addiction_services

**Parkview Behavioral Health**

**Services:**

We treat a wide range of health issues, including:

- Depression
- Anxiety
- Post-traumatic stress
- Mood disorders
- Chemical dependency
- Severe mental illnesses

**Referrals**

Please call Access Center/Help Line 373-7602

Free confidential assessments. Monday through Friday 8:30 to 5 p.m. call for an appointment.

Walk in's accepted 1700 to 1900 Monday through Friday.

Assessments available through the ED after hours and on weekends. ED charge will apply if seen in the ED for an assessment. Assessments completed at PBH are free.

**Pay Source**: Inpatient all insurance types, outpatient discuss when referral made

**Wait times**: Scheduled appointments have little wait time, walk in's will depend on volume.

Website: http://www.parkview.com/en/health-services/behavioral-health/Pages/default.aspx

Interested in discussing co-location in your facility; open for discussion

## Appendix E

### Guidelines and Thoughts for Pharmacists on Patients with Opioid Prescriptions:

Tracy Brooks, PharmD, BCPS, BCNSP
Assistant Professor, Manchester University College of Pharmacy
Pain and Palliative Care Pharmacist, PRMC

In my class, I teach that INSPECT is only 1 piece of the puzzle. My Red Flags are as follows:

- 12 prescribers / 12 prescriptions in 12 months (especially > 6 different opioids)
- Patient alters, forges, or rewrites prescriptions (notify law enforcement)
- Patient threatens you or your staff
- Rapidly escalating doses of opioids (100% increases each time they come into the pharmacy)
- Early prescription refills multiple times

First, try not to call them drug-seekers. Sometimes it's an appropriate descriptor of what's going on with the patient, but a lot of times it's very stigmatizing and it causes a patient's actual pain or other issues to be undertreated.

Some experts recommend not fixating on whether or not you believe what a patient is telling you. There is no definitive way to parse through whom is a drug-seeker, whom is a non-drug-seeker. Trying to engage in that negative process of discovery typically leads to a more unconstructive and negative clinical interaction. They may be way off base in terms of why they think they're suffering, but nevertheless, they need a provider who is willing to help them solve a problem and not a provider who is going to stand in judgment.

What can you do as a pharmacist? Send out a POI (see below) on INSPECT to all prescribers for that patient. Give the patient information on mental health services.

## Appendix F

## New Chronic Pain Prescribing Rule

TITLE 844 MEDICAL LICENSING BOARD OF INDIANA

Final Rule

LSA Document #14-289(F)

DIGEST

Adds 844 IAC 5-6 to establish requirements for the prescribing of opioid controlled substances for pain management. Effective November 1, 2014.

844 IAC 5-6

SECTION 1. 844 IAC 5-6 IS ADDED TO READ AS FOLLOWS:

Rule 6. Opioid Prescribing Requirements

844 IAC 5-6-1 Scope

Authority: IC 25-22.5-2-7; IC 25-22.5-13-2

Affected: IC 25-1-9; IC 25-22.5

Sec. 1. This rule establishes standards and protocols for physicians in the prescribing of opioid controlled substances for pain management treatment.

(Medical Licensing Board of Indiana; 844 IAC 5-6-1)

844 IAC 5-6-2 Definitions

Authority: IC 25-22.5-2-7; IC 25-22.5-13-2

Affected: IC 25-1-9; IC 25-22.5; IC 35-48-1-9

Sec. 2. (a) The definitions in this section apply throughout this rule.

(b) "Chronic pain" means a state in which pain persists beyond the usual course of an acute disease or healing of an injury, or that may or may not be associated with an acute or chronic pathologic process that causes continuous or intermittent pain over months or years.

(c) "Controlled substances" has the meaning set forth in IC 35-48-1-9.

(d) "Morphine equivalent dose" means a conversion of various opioids to a standardized dose of morphine by the use of accepted conversion tables.

(e) "Opioid" means any of various narcotics containing opium or one (1) or more of its natural or synthetic derivatives. However, if such a narcotic is not a controlled substance, it shall not be an opioid for the purposes of this rule.

(f) "Outset of an opioid treatment plan" means that a patient has been prescribed opioids as described in section 3(c) of this rule, and, therefore, the provisions stated in section 3(a) of this rule become applicable to that patient.

(g) "Terminal" means a condition caused by injury, disease, or illness from which, to a reasonable degree of medical certainty:

(1) there can be no recovery; and

(2) progression to death can be anticipated as an eventual consequence of that condition.

(Medical Licensing Board of Indiana; 844 IAC 5-6-2)

844 IAC 5-6-3 Triggers for imposition of requirements; exemptions

Authority: IC 25-22.5-2-7; IC 25-22.5-13-2

Affected: IC 16-21; IC 16-25; IC 16-28; IC 25-1-9; IC 25-22.5

Sec. 3. (a) This section and sections 4 through 10 of this rule establish requirements concerning the use of opioids for chronic pain management for patients.

(b) Notwithstanding subsection (a), this section and sections 4 through 10 of this rule shall not apply to the use of opioids for chronic pain management for the following:

(1) Patients with a terminal condition.

(2) Residents of a health facility licensed under IC 16-28.

(3) Patients enrolled in a hospice program licensed under IC 16-25. (4) Patients enrolled in an inpatient or outpatient palliative care program of a hospital licensed under IC 16-21 or a hospice licensed under IC 16-25.

However, a period of time that a patient who was, but is no longer, a resident or patient as described in subdivisions (2) through (4) shall be included in the calculations under subsection (c).

(c) The requirements in the sections identified in subsection (a) only apply if a patient has been prescribed:

(1) more than sixty (60) opioid-containing pills a month for more than three (3) consecutive months;

(2) a morphine equivalent dose of more than fifteen (15) milligrams per day; for more than three (3) consecutive months;

(3) a transdermal opioid patch for more than three (3) consecutive months;

(4) at any time it is classified as a controlled substance under Indiana law, tramadol, but only if the patient's tramadol dose reaches a morphine equivalent dose of more than sixty (60) milligrams per day for more than three (3) consecutive months; or

(5) a hydrocodone-only extended release medication that is not in an abuse deterrent form.

Subsections (c) (1) and (c)(2) do not apply to the controlled substances addressed by subsections (c)(3) through (c)(5)

(d) Because the requirements in the sections identified in subsection (a) do not apply until the time stated in subsection (c), the initial evaluation of the patient for the purposes of sections 4, 7(a), and 8(a) of this rule shall not be required to take place until that time.

(e) Notwithstanding subsection (d), the physician may undertake those actions earlier than required if the physician deems it medically appropriate and, if those actions meet the requirements, a further initial evaluation is not required. If the physician conducts actions earlier than required under this subsection, any subsequent requirements are determined by when the initial evaluation would have been required and not at the earlier date it actually was conducted.

(Medical Licensing Board of Indiana; 844 IAC 5-6-3)

844 IAC 5-6-4 Evaluation and risk stratification by physician

Authority: IC 25-22.5-2-7; IC 25-22.5-13-2

Affected: IC 25-1-9; IC 25-22.5

Sec. 4. (a) The physician shall do the physician's own evaluation and risk stratification of the patient by doing the following in the initial evaluation of the patient:

(1) Performing an appropriately focused history and physical exam and obtain or order appropriate tests, as indicated.

(2) Making a diligent effort to obtain and review records from previous health care providers to supplement the physician's understanding of the patient's chronic pain problem, including past treatments, and documenting this effort.

(3) Asking the patient to complete an objective pain assessment tool to document and better understand the patient's specific pain concerns.

(4) Assessing both the patient's mental health status and risk for substance abuse using available validated screening tools.

(5) After completing the initial evaluation, establishing a working diagnosis and tailoring a treatment plan to meaningful and functional goals with the patient reviewing them from time to time.

(b) Where medically appropriate, the physician shall utilize nonopioid options instead of or in addition to prescribing opioids.

(Medical Licensing Board of Indiana; 844 IAC 5-6-4)

844 IAC 5-6-5 Physician discussion with patient; treatment agreement

Authority: IC 25-22.5-2-7; IC 25-22.5-13-2

Affected: IC 25-1-9; IC 25-22.5

Sec. 5. The physician shall discuss with the patient the potential risks and benefits of opioid treatment for chronic pain, as well as expectations related to prescription requests and proper medication use. In doing so, the physician shall:

(1) Where alternative modalities to opioids for managing pain exist for a patient, discuss them with the patient.

(2) Provide a simple and clear explanation to help patients understand the key elements of their treatment plan.

(3) Counsel women between fourteen (14) and fifty-five (55) years of age with child bearing potential about the risks to the fetus when the mother has been taking opioids while pregnant. Such described risks shall include fetal opioid dependency and neonatal abstinence syndrome (NAS).

(4) Discuss with the patient risks of dependency and addiction.

(5) Discuss with the patient safe storage practices for prescribed opioids.

(6) Provide a written warning to the patient disclosing the risks associated with taking extended release medications that are not in an abuse deterrent form, if the physician prescribes for the patient a hydrocodone-only extended release medication that is not in an abuse deterrent form.

(7) Together with the patient, review and sign a "Treatment Agreement", which shall include at least the following:

(A) The goals of the treatment.

(B) The patient's consent to drug monitoring testing in circumstances where the physician determines that drug monitoring testing is medically necessary.

(C) The physician's prescribing policies, which must include at least a:

(i) requirement that the patient take the medication as prescribed; and

(ii) prohibition of sharing medication with other individuals.

(D) A requirement that the patient inform the physician:

(i) about any other controlled substances prescribed or taken by the patient; and

(2) if the patient drinks alcohol while taking opioids.

(E) The granting of permission to the physician to conduct random pill counts.

(F) Reasons the opioid therapy may be changed or discontinued by the physician.

A copy of the treatment agreement shall be retained in the patient's chart.

(Medical Licensing Board of Indiana; 844 IAC 5-6-5)

844 IAC 5-6-6 Patient visits to physician

Authority: IC 25-22.5-2-7; IC 25-22.5-13-2

Affected: IC 25-1-9; IC 25-22.5

Sec. 6. (a) Physicians shall not prescribe opioids for patients without periodic scheduled visits. Visits for patients with a stable medication regimen and treatment plan shall occur face to face at least once every four (4) months. More frequent visits may be appropriate for patients working with the physician to achieve optimal management. For patients requiring changes to the medication and treatment plan, if changes are prescribed by the physician, the visits required by this subsection shall be scheduled at least once every two (2) months until the medication and treatment has been stabilized.

(b) During the visits required by subsection (a), the physician shall evaluate patient progress and compliance with the patient's treatment plan regularly and set clear expectations along the way, such as attending physical therapy, counseling, or other treatment options.

(Medical Licensing Board of Indiana; 844 IAC 5-6-6)

844 IAC 5-6-7 INSPECT report

Authority: IC 25-22.5-2-7; IC 25-22.5-13-2

Affected: IC 25-1-9; IC 25-22.5; IC 35-48-7-11.1

Sec. 7. At the outset of an opioid treatment plan, and at least annually thereafter, a physician prescribing opioids for a patient shall run an INSPECT report on that patient under IC 35-48-7-11.1(d)(4) and document in the patient's chart whether the INSPECT report is consistent with the physician's knowledge of the patient's controlled substance use history.

(Medical Licensing Board of Indiana; 844 IAC 5-6-7)

844 IAC 5-6-8 Drug monitoring testing

Authority: IC 25-22.5-2-7; IC 25-22.5-13-2

Affected: IC 25-1-9; IC 25-22.5

Sec.8. (a) After December 31, 2014, at any time the physician determines that it is medically necessary, whether at the outset of an opioid treatment plan, or any time thereafter, a physician prescribing opioids for a patient shall perform or order a drug monitoring test, which must include a confirmatory test using a method selective enough to differentiate individual drugs within a drug class, on the patient.

(b) In determining whether a drug monitoring test under subsection (a) is medically necessary, the physician shall consider, subject to the provisions of subsection (c), each of the following factors where applicable and reasonably feasible:

(1) Whether there is reason to believe a patient is not taking the prescribed opioids or is diverting the opioids.

(2) Whether there has been no appreciable impact on the patient's chronic pain despite being prescribed opioids for a period of time that would generally have an impact.

(3) Whether there is reason to believe the patient is taking or using controlled substances other than opioids or other drugs or medications including illicit street drugs that might produce significant polypharmacological effects or have other detrimental interaction effects.

(4) Whether there is reason to believe the patient is taking or using opioids in addition to the opioids being prescribed by the physician and any other treating physicians.

(5) Attempts by the patient to obtain early refills of opioid containing prescriptions.

(6) The number of instances in which the patient alleges that their opioid containing prescription has been lost or stolen.

(7) When the patient's INSPECT report provides irregular or inconsistent information.

(8) When a previous drug monitoring test conducted on the patient raised concerns about the patient's usage of opioids.

(9) Necessity of verifying that the patient no longer has substances in the patient's system that are not appropriate under the patient's treatment plan.

(10) When the patient engages in apparent aberrant behaviors or shows apparent intoxication.

(11) When the patient's opioid usage shows an unauthorized dose escalation.

(12) When the patient is reluctant to change medications or is demanding certain medications.

(13) When the patient refuses to participate in or cooperate with a full diagnostic workup or examination.

(14) Whether a patient has a history of substance abuse.

(15) When the patient has a health status change (for example, pregnancy).

(16) Co-morbid psychiatric diagnoses.

(17) Other evidence of chronic opioid use, controlled substance abuse or misuse, illegal drug use or addiction, or medication noncompliance.

(18) Any other factor the physician believes is relevant to making an informed professional judgment about the medical necessity of a prescription.

(c) It shall not be considered a violation of this section for a physician to fail to conduct a review of all eighteen (18) factors listed in subsection (b) if the physician reasonably determines following a review of less than all of the factors listed in subsection (b) that a drug monitoring test is medically necessary.

(d) Nothing about subsection (b) shall be construed to prohibit the physician from performing or ordering a drug monitoring test at any other time the physician considers appropriate.

(e) If a test performed under subsection (a), or conducted under subsection (d), reveals inconsistent medication use patterns or the presence of illicit substances, a review of the current treatment plan shall be required. Documentation of the revised treatment plan and discussion with the patient must be recorded in the patient's chart.

(Medical Licensing Board of Indiana; 844 IAC 5-6-8)

844 IAC 5-6-9 Morphine equivalent doses above 60; revising of assessments and treatment plans

Authority: IC 25-22.5-2-7; IC 25-22.5-13-2

Affected: IC 25-1-9; IC 25-22.5

Sec. 9. When a patient's opioid dose reaches a morphine equivalent dose of more than sixty (60) milligrams per day, a face-to-face review of the treatment plan and patient evaluation must be scheduled, including consideration of referral to a specialist. If the physician elects to continue providing opioid therapy at a morphine equivalent dose of more than sixty (60) milligrams per day, the physician must develop a revised assessment and treatment plan for ongoing treatment. The revised assessment and treatment plan must be documented in the patient's chart, including an assessment of increased risk for adverse outcomes, including death, if the physician elects to provide ongoing opioid treatment.

(Medical Licensing Board of Indiana; 844 IAC 5-6-9)

844 IAC 5-6-10 Physicians assistants and advanced practice nurses

Authority: IC 25-22.5-2-7; IC 25-22.5-13-2

Affected: IC 25-1-9; IC 25-22.5; IC 25-23-1; IC 25-27.5-5; IC 25-27.5-6

Sec. 10. (a) IC 25-27.5-5 addresses the scope of practice of physician assistants in their dependent practice under supervising physicians including limiting the duties and responsibilities of physician assistants to those that are delegated by the supervising physician and that are within the supervising physician's scope of practice. IC 25-27.5-6 addresses supervisory responsibilities of the supervising physician, or when applicable, a physician designee. The prescribing of opioids for chronic pain management as regulated by this rule falls within the requirements on supervising physicians, or when applicable, on physician designees, under IC 25-27.5-5 and IC 25-27.5-6 including appropriate delegating of duties and responsibilities to physician assistants and appropriate supervision of physician assistants.

(b) IC 25-23-1-19.4 through IC 25-23-1-19.8 and 848 IAC 5 address the practice of advanced practice nurses with prescriptive authority in collaboration with a physician. The prescribing of opioids for chronic pain management as regulated by this rule falls within the requirements on collaborating physicians regarding the prescriptive authority for advanced practice nurses under IC 25-23-1-19.4 though IC 25-23-1-19.8 and 848 IAC 5.

(Medical Licensing Board of Indiana; 844 IAC 5-6-10)

SECTION 2. SECTION 1 of this document takes effect November 1, 2014.

[ii] 844 IAC 5-6-4 Evaluation and risk stratification by physician
Authority: IC 25-22.5-2-7; IC 25-22.5-13-2
Affected: IC 25-1-9; IC 25-22.5

Sec. 4. (a) The physician shall do the physician's own evaluation and risk stratification of the patient by doing the following in the initial evaluation of the patient:
(1) Performing an appropriately focused history and physical exam and obtain or order appropriate tests, as indicated.
(2) Making a diligent effort to obtain and review records from previous health care providers to supplement the physician's understanding of the patient's chronic pain problem, including past treatments, and documenting this effort.
(3) Asking the patient to complete an objective pain assessment tool to document and better understand the patient's specific pain concerns.
(4) Assessing both the patient's mental health status and risk for substance abuse using available validated screening tools.
(5) After completing the initial evaluation, establishing a working diagnosis and tailoring a treatment plan to meaningful and functional goals with the patient reviewing them from time to time.
(b) Where medically appropriate, the physician shall utilize nonopioid options instead of or in addition to prescribing opioids.
(Medical Licensing Board of Indiana; 844 IAC 5-6-4)
[ii] http://www.uptodate.com/contents/medically-supervised-opioid-withdrawal-during-treatment-for-addiction?source=machineLearning&search=opiate+detoxification&selectedTitle=1%7E150&sectionRank=1&anchor=H2#H2

[iii] http://www.drugabuse.gov/publications/media-guide/science-drug-abuse-addiction-basics
[iv] http://umm.edu/health/medical/ency/articles/drug-dependence

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# OPIOID TAPERING

## Safely Discontinuing Opioid Analgesics

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Release Date: March 2006

### Introduction

Severe hurricanes in the Gulf Coast during 2005 caused many hardships for patients and healthcare providers alike. An important concern coming to light during this time of crisis was the inability to obtain prescription medications, including opioid analgesics. Patients with chronic pain and their healthcare providers faced the daunting task of either somehow procuring the opioids or, if this was not possible, tapering the medications to prevent onset of opioid withdrawal.

***Safely discontinuing, or tapering, opioid analgesics is an ongoing concern, both in times of crisis and on a daily basis.***

In response to the crisis in the Gulf Coast, a multi-organization Working Group published "Recommendations to Physicians Caring for Katrina Disaster Victims on Chronic Opioids" (AAPM et al. 2005). The National Pain Foundation also published information for patients regarding withdrawing from medications (NPF 2005). Safely discontinuing, or tapering opioid analgesics is not only a concern in times of natural disaster, but an issue that pain services and primary care providers confront daily as they try to balance the benefits and adverse effects of analgesics.

### Reasons for Tapering

There are many reasons for considering opioid tapering, both from healthcare provider and patient perspectives. Patients may decide that they wish to stop their opioid therapy if they experience adverse effects. Opioid rotation is an option; however, patients may be wary to try another agent or may experience intolerable adverse effects with certain chemical classes of opioids. Their pain may not be opioid-responsive, their underlying disease process may have improved as a result of surgery or other interventions, or despite increasing their dose at regular intervals an adequate pain response was not realized. Patients may be reluctant to continue opioids because of a negative social stigma attached to this therapy. In some cases the opioid may be discontinued due to the cost associated with obtaining the prescription or because a newly assigned medical clinician refuses to provide such therapy chronically.

***There are many reasons for considering opioid tapering, such as adverse effects, inadequate pain relief, and medication costs.***

Providers may engage in tapering an opioid due to safety concerns. One of the controversies in chronic opioid management is the phenomenon of opioid-induced hyperalgesia (Chu et al. 2006; Doverty et al. 2001; White 2004), which suggests that in certain patients chronic exposure to opioids results in an increased sensitivity to pain. This may occur as early as one month after initiating opioid therapy.

Other potential consequences of long-term opioid use include hypogonadism and resultant osteoporosis (Daniell 2002; Abs et al. 2000). Serum testosterone levels have been shown to fall within hours after ingestion of a single dose, and low serum levels of testosterone and estradiol are associated with an increased risk of osteoporosis (Daniell 2002; Moyad 2003).

Providers also may have concerns about efficacy. If they do not see an improvement in patient function and quality of life, they may feel that the risks of the therapy (as mentioned above) outweigh a questionable benefit. Finally, providers may consider tapering opioids due to patient non-compliance with the medication regimen or violation of the patient's opioid agreement with the pain management team.

Guidance for starting medications is fairly easily obtained from product package inserts and reference books; however, it is more difficult to find information about switching or stopping opioid medications. Many practitioners, particularly specialists, tend to have their own formulas for managing conversions and tapers; although, there is no single strategy that can be applied to all patients, and each situation must be handled on an individual basis. The most important factor to consider is how acutely the taper or conversion is needed.

***There is no single strategy that can be applied to all patients. Each situation must be handled on an individual basis.***

## Detoxification Settings

Tapering off opioids (often called detoxification or "detox") may be done within a chemical-dependency treatment setting, specialty clinic, or primary care practice. Protocols vary between institutions and outpatient centers and, depending on how acutely the taper is needed, several options are available:

***Several options are available, depending on how acutely the taper is needed.***

***Ultra-rapid detoxification*** is performed in the inpatient setting under general anesthesia. The usefulness of this method is controversial and is inappropriate for agents that have a long biological half-life (e.g., methadone).

***Inpatient detoxification*** usually employs a fairly rapid tapering protocol in conjunction with behavioral therapy. This setting is considered for those patients who: a) are medically unstable, b) fail outpatient programs, c) are non-compliant, d) have comorbid psychiatric illness, or e) require polysubstance detoxification. Due to the financial burden of inpatient programs, many facilities have shifted to partial hospitalizations or intensive outpatient programs.

***Outpatient detoxification*** commonly employs a slower tapering protocol. While it is common practice to replace short-acting opioids with extended release products (e.g., MS Contin® or Oxycontin®) or one with a long half-life, such as methadone, a taper using the prescribed short-acting opioid is frequently employed. There is no single protocol that has been proven more efficacious than another and, regardless of the strategy used, the provider needs to be involved in the process and remain supportive of the patient and his/her family.

## Duration of Taper

The duration of the taper depends on its complexity and the patient's needs. The universal goal is to taper as quickly as the patient's physiologic and psychological status allows. The presence of multiple comorbidities, polysubstance abuse, female gender, and older age are among factors increasing the difficulty of tapering and tend to lengthen its duration. Patients with a long history of taking chronic opioids, or any centrally acting medication involving receptor pharmacology (e.g., dopamine agonists, SSRIs) are more likely to experience withdrawal from a taper that is too rapid, and therefore may require a longer taper period to avoid such symptoms. Some patients may have a great deal of anxiety about the potential for increased pain or experiencing withdrawal symptoms. In all cases, it is important to make decisions about tapering therapy on an individual basis.

***The universal goal is to taper as quickly as the patient's physiologic and psychological status allows.***

The Katrina Disaster Working Group's recommended tapering schedules are found in ***Table 1*** (AAPM 2005). The VA Clinical Practice Guideline on chronic opioid therapy also contains suggested tapering regimens for several different opioids, as presented in ***Tables 2 and 3*** (USVA 2003). The VA regimens are quite rapid and are not tolerated by many patients. Unless there is a pressing need for a rapid taper, a slower taper is tolerated much better.

**Table 1. Katrina Disaster Working Group Suggested Tapering Regimens** [AAPM 2005]

- Reduction of daily dose by 10% each day, or…
- Reduction of daily dose by 20% every 3-5 days, or…
- Reduction of daily dose by 25% each week.

**Table 2. VA Suggested Tapering Regimens for *Short-Acting* Opioids** [USVA 2003]

- Decrease dose by 10% every 3-7 days, or…
- Decrease dose by 20%-50% per day until lowest available dosage form is reached (e.g., 5 mg of oxycodone)
- Then increase the dosing interval, eliminating one dose every 2-5 days.

**Table 3. VA Suggested Tapering Regimens for *Long-Acting* Agents** [USVA 2003]

***Methadone***

- Decrease dose by 20%-50% per day to 30 mg/day, then…
- Decrease by 5 mg/day every 3-5 days to 10 mg/day, then...
- Decrease by 2.5 mg/day every 3-5 days.

***Morphine CR*** (controlled-release)

- Decrease dose by 20%-50% per day to 45 mg/day, then…
- Decrease by 15 mg/day every 2-5 days.

***Oxycodone CR*** (controlled-release)

- Decrease by 20%-50% per day to 30 mg/day, then…
- Decrease by 10 mg/day every 2-5 days.

***Fentanyl*** – first rotate to another opioid, such as morphine CR or methadone.

## Agents Used to Taper

Depending on the situation, several options for tapering agents are available. The same opioid medication the patient has been taking may be used. This can be accomplished even with short-acting agents, as mentioned previously. The average daily dose should be spaced evenly throughout the day (and "prn" doses eliminated), usually with a frequency of every 4 or 6 hours. Once the patient has been stabilized on a scheduled dosing frequency, the tapering regimen may be implemented (***Table 2***).

Short-acting agents may be replaced with another medication with a long half-life, such as methadone, or an extended release product such as MS Contin® or OxyContin® [already mentioned above]. Many programs use methadone, as it is less likely to produce euphoria and is inexpensive compared with the other long-acting agents. It must be made clear however that the methadone is being used to treat pain, and that the taper is being done for medical reasons, not for substance abuse rehabilitation.

Usually after a dosing conversion has been completed, a "test dose" or "test regimen" will be given with close monitoring. If the dose of the long-acting agent is too low, the patient may develop withdrawal symptoms; however, if the dose is too high, the patient may develop sedation. During the first week, the dose of the long-acting agent should be adjusted to control

any withdrawal symptoms. After the patient has been stabilized, the tapering regimen may be implemented (***Table 3***).

**Author's Comment:**

When rotating opioids in a patient with cancer or with escalating pain needs, I suggest a more *aggressive* conversion, using a short-acting agent for breakthrough pain. For chronic nonmalignant pain, I recommend a more *conservative* conversion and allow patients a small supply of short-acting opioid for breakthrough pain during the time of dosing adjustment. This is particularly helpful when switching from a short-acting agent to a long-acting agent, or when switching to methadone, as it takes several days to reach steady state blood levels. The ability to use a short-acting agent for a week or two allows flexibility and gives the patient some sense of control. It also prevents the risk of overdosing, particularly with methadone.

## Adjusting Tapering Regimens

Individual patients may have differing responses to the tapering regimen chosen. For those who have been on long-term opioid therapy, there may be fear and anxiety about reducing and/or eliminating their opioid(s). Patients may be concerned about the recurrence or worsening of pain. They also may be concerned about developing withdrawal symptoms. Typically, the last stage of tapering is the most difficult. The body adapts fairly well to the proportional dosage reduction to a point and then (less than 30-45 mg of opioid/day) the body cannot adapt as well to the changes in concentration and receptor activity, which precipitates withdrawal if the tapering regimen is not slowed.

Adjustments in tapering schedules are shown above in ***Tables 2 and 3***. Patients may also not be emotionally ready for the next stage of dose reduction. If the patient has been making a reasonable effort and has followed through with the tapering plan, slowing the taper may be the most reasonable adjustment.

**Author's Example 1:**

A patient who has been taking methadone for back pain has required escalating doses during the last 3 months without any noted pain relief. Since her pain is not opioid-responsive, you would like to taper her off methadone and try another approach. She is currently taking methadone 40 mg TID and there is no acute need to taper her rapidly, so a slow taper as follows is reasonable.

**Proposed regimen starting with 10 mg methadone tablets:**

Week 1: 30 mg TID
Week 2: 20 mg TID
Week 3: 15 mg TID
Week 4: 10 mg TID
Week 5: 10 mg qam, 5 mg qnoon, 10 mg qpm
Week 6: 5 mg qam, 5 mg qnoon, 5 mg qpm
Week 7: 5 mg qam, 5 mg qnoon, 5 mg qpm

***Switch to 5mg methadone tablets…***

Week 8: 5 mg qam, 2.5 mg qnoon, 5 mg qpm
Week 9: 2.5 mg qpm, 2.5 mg qnoon, 5 mg qpm
Week 10: 2.5 mg TID
Week 11: 2.5 mg BID
Week 12: 2.5 mg Daily
Then discontinue

**Author's Example 2:**

A patient is having intolerable constipation with controlled release morphine, and you have tried every option for a bowel regimen without success. The patient has had to go to the ER for bowel impaction twice. You feel that an opioid rotation and/or taper off of the morphine is the most reasonable option. The patient is currently taking 120 mg morphine BID (total 240 mg daily).

**Option A:** Convert to methadone, approx. 20 mg daily (split 10 mg BID)
Begin a taper off of this (see above), as the patient tolerates

**Option B:** Taper starting with 30 mg morphine tablets
Week 1: 90 mg BID
Week 2: 60 mg BID
Week 3: 30 mg BID
*Switch to 15 mg tabs*
Week 4: 15 mg qam, 30 mg qpm
Week 5: 15 mg BID
Week 6: 15 mg Daily
Then discontinue

**Author's Example 3:**

A patient is about 8 weeks out from orthopedic surgery and is ready to taper off her regular schedule of hydrocodone/acetaminophen. She is currently taking 2 tabs every 6 hours (8 tablets per day).

**Option A:** Rapid taper (duration 10 days)
1 tab every 6 hrs x 1 day (4/day), then…
1 tab every 8 hrs x 3 days (3/day), then…
1 tab every 12 hrs x 3 days (2/day), then…
1 tab every daily x 3 days (1/day), then…
Discontinue

**Option B:** Slow taper (duration 3 weeks)
Reduce by 1 tablet/day every 3 days until off

## Adjunctive Therapy

Patients should always be made aware of the signs and symptoms of opioid withdrawal – see ***Table 4*** – so that they may contact the provider to adjust the taper. Opioid withdrawal is typically not dangerous, but it may cause considerable discomfort. Some providers will add clonidine to attenuate the autonomic symptoms such as hypertension, nausea, cramps, diaphoresis (perspiring), and/or tachycardia. Antihistamines or trazodone may be used to help with insomnia and restlessness. Nonsteroidal anti-inflammatory agents may be used for muscle aches, dicyclomine for abdominal cramps, and Pepto-Bismol® for diarrhea.

**Table 4. Opioid Withdrawal Signs/Symptoms**

- Abdominal cramps
- Anxiety
- Diaphoresis
- Diarrhea
- Dilated pupils
- Goose bumps
- Hypertension
- Insomnia
- Lacrimation
- Muscle twitching
- Rhinorrhea
- Tachycardia
- Tachypnea

## Advising Patients on Emergency Tapering

Following the Katrina Hurricane, the National Pain Foundation (NPF 2005) offered some recommendations for what patients can do when all access to continuing pain medications is cut off, as during an emergency or other crisis. These are adapted here and a version of this might be provided to patients whenever chronic opioid analgesics are prescribed.

**Stopping Opioid Painkillers in an Emergency**

If you are unable to refill or get your opioid medications, symptoms of withdrawal will vary depending on how long you were on the opioid medication and what type you were taking. People taking morphine, hydromorphone, or oxycodone may experience withdrawal symptoms within 6 to 12 hours of the last dose while those taking methadone or controlled-release opioids will experience symptoms 1 to 4 days after the last dose. Typically, withdrawal from morphine takes 5 to 10 days while withdrawal from methadone or other long-acting opioids takes longer.

Ideally, discontinuing the medication would be a slow tapering process under the care of a physician or other appropriate medical provider. If this cannot be accomplished, it is important to make an effort to taper the dose on your own as slowly as possible.

The best way to avoid serious withdrawal symptoms is to reduce the amount of medication you are taking or how often you are taking it before you run out. Reducing the amount by 25% per day, or by 25% every other day, may result in some withdrawal symptoms, but it is better than having to suddenly stop the medication when you run out.

If you are taking any of the extended release versions of opioids, such as OxyContin® or Kadian®, or fentanyl patches, do not tamper with them in any way. Breaking or opening these capsules, or cutting patches, can release the entire dose at once, causing overdose and possible death. Instead, take the whole tablet or capsule or use the whole patch, but take or use the medication less often to reduce the dosage.

Drink a lot of fluid, try to stay calm, and keep reassuring yourself that the withdrawal reaction will pass and you will eventually feel better. One of the symptoms during opioid withdrawal is a state of sensitized pain, meaning your pain may feel more intense or severe. This also will pass with time.

***Remember:*** Always seek professional healthcare assistance as soon as you can — if possible, before running out of medication.

## Summary

Currently there is no standard protocol for tapering opioids; however, there are now some suggested guidelines. Regardless of the reason for tapering opioids, the plan must be individualized to each patient's needs. Close follow-up and psychosocial support are essential.

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## References

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