“Those who cannot remember the past are condemned to repeat it.”

Though many have restated this common utterance, the original quote is attributed to Spanish philosopher George Santayana in 1905. Around this same time in the United States, heroin was being marketed by Bayer and recommended by the AMA for general medical use as a pain reliever. Needless to say, it wasn’t long before widespread addiction led to its being removed from the market. Recognizing the potential “evils” of opioids, society subsequently saw a major contraction in their use for all types of pain throughout the mid-1900s. The latter part of the century, however, saw another forceful shift in attitudes toward pain, and toward opioids. Doctors were taught that we’d been allowing patients to suffer unnecessarily for decades, that patients with “real pain” rarely become addicted, and that we had a duty to relieve suffering. Pain became the fifth vital sign, opioids returned to favor, and the rest, of course, is history... again.

How is it that we as a medical community, and a society at large, allowed this to happen? Because severe chronic pain remains an unfortunate, but all too real, part of human existence. It touches so many people that there is nobody reading this that will not have a personal friend or family member that has dealt with it. Further, it is true that a physician’s duty is to relieve suffering where able. Finally, opioids work! For severe pain that requires relief now, there remain very few medications as reliable or effective. If this were not the case, nobody would take opioids long enough to become addicted, and we would not have the problem we currently have.

So, before we return down the same path that we traveled 100 years ago, and spend the next half-century ignoring pain in the name of avoidance of “evil opioids,” let’s consider how we can slow down this swinging pendulum. Here is how I propose we do this.

First, advocate for more non-opioid options for pain. Demand that payers stop imposing coverage limits on physical therapy and certain non-opioid medications. Further, urge them to expand coverage for behavioral health and historically non-covered services like massage and acupuncture.

Second, acknowledge that there are still circumstances when opioids can play an important role in reducing pain, improving function, and providing significant benefits for overall quality of life. Despite that most of what we hear about opioids these days is negative, we do not need to abandon an entire class of medications out of fear or lack of knowledge, which is unfortunately the route some providers have already taken. Such all-or-none thinking is what has led to the swinging opioid pendulum in the first place.
Finally, providers must become comfortable with assessing the risks vs. benefits of opioids in each patient, just like for any other medical decision. Lack of knowledge, awareness, or willingness to do this is, in my opinion, the primary driving force behind much of our current opioid epidemic. It is not that opioids are inherently evil, any more than a chainsaw is inherently evil, or, for that matter, antibiotics. However, undereducated and incautious use of any of these can have dangerous consequences. Therefore, please make use of the resources that are available through this newsletter, through Ascension Wisconsin’s Opioid Guideline Toolkit and even through your own electronic health record. For example, standardized opioid risk assessment tools based on brief patient interview by provider or medical assistant are available and already embedded within the EHR for each Ascension WI legacy system. Those systems currently using EPIC will find the SOAPP-R, and all other systems have access to the ORT. These simple tools take only moments to complete, only need to be completed one time, and can provide an evidence-based estimate of your patient’s risk of developing future problematic opioid use. While these, in and of themselves, cannot tell you whether to prescribe, they can help inform this decision, as well as the extent and frequency with which the patient should be monitored.

With the current state of events and the steady stream of media about the horrors of opioids, it is understandable that some providers have decided to simply stop prescribing opioids altogether. However, throwing this baby out with the bathwater will only further perpetuate the cycle that got us here in the first place. We do not have to be carried along as passive passengers on the opioid pendulum. As healthcare providers, we are, in fact, the ones responsible for slowing its swing. With a little bit of education and effort, we can continue to fulfill our duty to provide compassionate care and relieve suffering where able, while using the appropriate tools for the appropriate circumstances. And, hopefully, we can keep history from repeating itself yet again.

AW Opioid Guideline Toolkit

Have you checked out the Opioid Guideline Toolkit lately? Highlighted this month are resources and tools related to opioid risk assessment.

- Opioid Risk Assessment
- Risk Stratification
- Aberrant Behaviors / Red Flags

The AMG and WI Medical Examining Board opioid prescribing guidelines represent best practices for the treatment of acute and chronic pain and are not intended for patients receiving comfort care or hospice care. They may not be appropriate for patients with certain conditions such as pain related to advanced cancer.
Medication Highlight – Opioid and Benzodiazepine Co-prescribing

- There is no clear evidence for long-term use of opioids or benzodiazepines.
- In 2017, 18% of patients prescribed an opioid by an Ascension Wisconsin primary care prescriber had at least one benzodiazepine prescription.
- The risk of opioid-related overdose increases five-fold in the first 90 days of concurrent opioid and benzodiazepine use.
- More than 30 percent of overdoses involving opioids also involve benzodiazepines.

Identify Patients at Risk

- Review the ePDMP to identify patients prescribed opioids and benzodiazepines.

- Obtain a urine drug test (UDT) prior to start of opioid therapy and at minimum once per year. Up to 1 in 5 patients testing positive for prescribed opioids also tested positive for non-prescribed benzodiazepines (McClure, 2017).

Minimize the Risk

- Co-prescribing of opioids and benzodiazepines should be avoided when possible.
- Have a conversation with the patient to help them understand the risk.
  - “Like opioids for acute pain, benzodiazepines can be helpful for acute anxiety, but the long-term use of each of them is likely to pose more risks than benefits for many patients, and each are highly addictive.”
  - “Taking an opioid with a sedative such as a benzodiazepine can be dangerous; it may cause you to stop breathing and cause you to overdose”
  - “We will work together to find other ways to manage your pain and anxiety, to minimize the use of both opioids and benzos.”
- In cases where, despite other treatments, pain is so severe to require opioids, AND anxiety is so severe to require benzodiazepines, the risks STILL probably outweigh the benefits of using BOTH. Patient should select which one is contributing more to quality of life, and work to taper off the other one.
- Close patient monitoring can help reduce the potential for withdrawal symptoms and the fear patients will likely experience with tapering a long-term medication.
- Refer to specialty care, Pain Management and/or Behavioral Health, if the patient is unable to successfully taper off controlled substances.
- Clearly DOCUMENT in the medical record the discussion, including weighing of risks/benefits/alternatives, patient understanding/agreeing to these risks, and rationale behind medical decisions.
- Prescribe naloxone for patients receiving concurrent opioid and benzodiazepine prescriptions. Instruct patient and family on signs of overdose and how to use their naloxone device.

NALOXONE SAVES LIVES.
CME Requirements for License Renewal

- MD and DO physicians are required to take two CME hours on responsible opioid prescribing via a MEB-approved course. Physicians who do not hold a U.S. DEA number to prescribe controlled substances are exempted under the rules.
- The alignment of MD/DO renewal dates means the opioid CME requirement needs to be completed in this biennium, 1/1/2018 to 12/31/2019, for renewals due 10/31/2019 for both MDs and DOs.
- Specific questions regarding CME and license renewal should be directed to the Medical Examining Board / DSPS dps@wi.gov
- APNPs must include at least 2 contact hours in responsible prescribing of controlled substances as part of the 16 contact hours in clinical pharmacology per biennium.
- Courses may be combined to meet the two-hour requirement.

Education and CME Opportunities

- **Acute Care Treatment in an Opioid Epidemic** is the November topic in the AMG opioid webinar series, scheduled for Tuesday, Nov. 13th 0700. CME is available.
- In case you missed it, the webinar recording for Safe and Compassionate Opioid Wean and presentation slides are now available.
- NOTE: The AMG opioid webinar series is currently not MEB approved CME; this is being explored for future webinars.
- COMING SOON to InReach: MEB approved, on-demand course on interpretation and use of drug testing.
- **Identifying Opioid Abuse Risk in the Chronic Pain Patient: Techniques for Mastering Accuracy** (MEB approved; course fee applies), Click [here](#) to learn more.

For questions, contact a member of the Pain Advisory Council leadership team.

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