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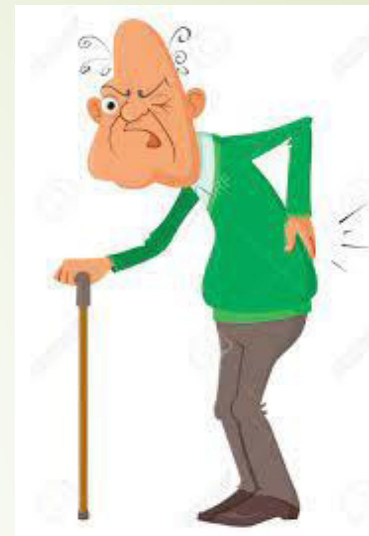
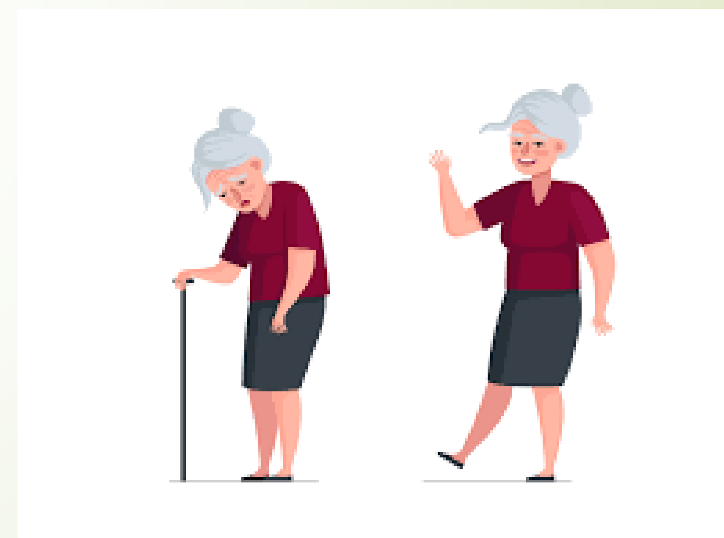
Learning Objectives

1. Distinguish addiction from tolerance
2. How to set boundaries with patients requesting pain medication
3. Determine when buprenorphine might be appropriate





Addiction vs. Tolerance

- Tolerance – requiring higher or more frequent doses for same effect
- Addiction - person continues using substance and cannot stop despite the negative impacts it causes in all aspects of their life (school/work/home)
- Substance use disorder ("SUD") is defined as recurrent use of alcohol and/or drugs that causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home.
- Not all opioid use leads to disordered use, even if there is dependence.

Case 1

- 71 y/o female DNR/DNI with goal of function
- PMH: DM2 w/ neuropathy, HFrEF, HTN, COPD, O2, chronic pancreatitis, h/o alcohol abuse, smoker, peripheral arterial disease, moderate protein calorie malnutrition, trigeminal neuralgia, seizures, migraines, depression
- Meds: gabapentin 100 3x's daily, glargine 20, metformin 1000 BID, carvedilol 6.25 BID, furosemide 20, pancrelipase 3x's daily, clopidogrel 75, atorvastatin 10, levetiracetam 500 BID, umeclidinium/vilanterol, quetiapine 12.5
- SH: sons visit regularly, bring cigarettes and food
- Trips on her walker going out to smoke and fractures Left femur, returns from hospital on hydrocodone 5/325 q4 hrs. PRN
- PT/OT report pt "refusing" to do therapy due to pain; nurses report patient is on call light every 3 hours requesting pain meds
- Concerns/Thoughts?

Evaluating patient’s request for more pain pills

- Is there a medical reason that the pain is worse now?
  - Any recent falls/injuries/hospitalizations?
  - Inadequate pain control due to worsening of vascular disease, occult fracture, etc.
  - Pain that generally doesn’t respond to opiates – neuropathic pain
- Is there a psychiatric reason to explain the request?
  - Comorbid psych conditions?
  - Any recent changes in social or medical history – death, divorce, moving into facility, stopped smoking or drinking alcohol, loneliness/isolation due to COVID

Setting Boundaries in the facility with staff

- Limit who visits the resident (if you suspect diversion or obtaining from outside source)
- Visitors limited to common areas where he/she can be directly observed
- Illegal substances vs. controlled substances
- Observe med administration

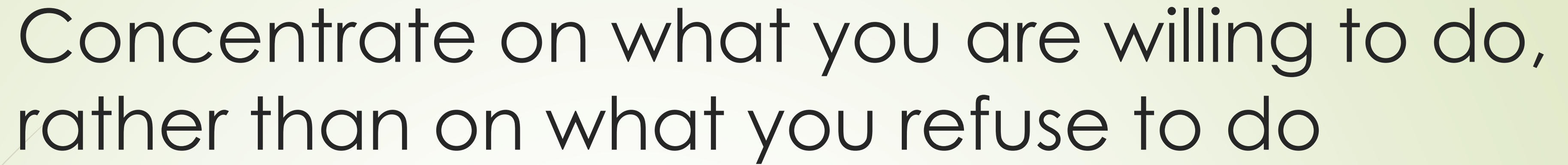
Setting Boundaries with Patient

- Pain meds may be patient's coping strategy for dealing with physical, emotional, psychological and post-traumatic pain
- Controlling pain ≠prescribing resident's preferred opiate
- Expect to be uncomfortable!
- Compassion = boundaries

4 steps in setting patient boundaries

- 1. Name the behavior that is not acceptable.
  - Shouting, cursing, interrupting
- 2. Express your expectations of the patient.
  - Attend PT/OT, try non-pharm mgmt., attend counseling
- 3. Decide what will happen if the boundaries are not respected.
  - Taper off opioids
- 4. Validation.
  - Validate the pain, the emotion, the importance of boundaries

Concentrate on what you are willing to do, rather than on what you refuse to do



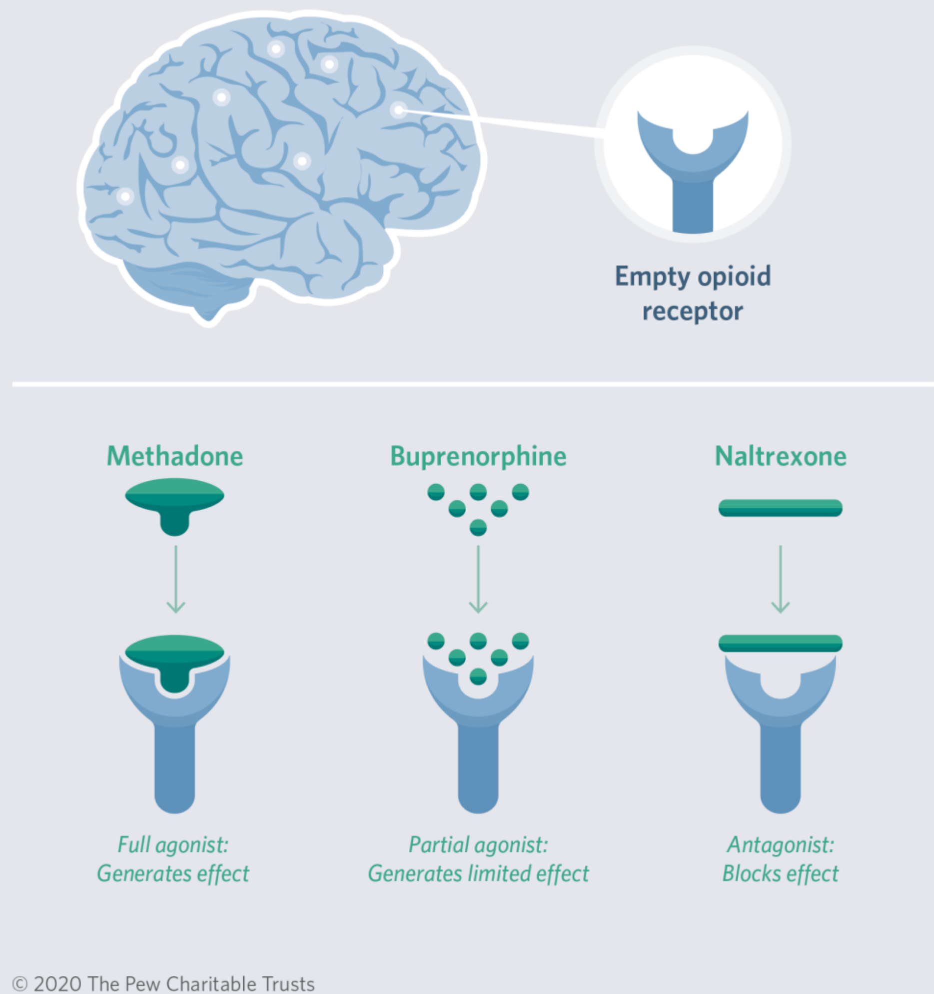
- What you will do:
  - "I'd like to be your provider and continue to help you with your pain, despite our disagreement"
- What you won't do:
  - "Prescribing more of this medicine is something that is not in your best, long term interest. It is something I feel uncomfortable with and cannot do"
  - "Unfortunately, I will not be able to X (raise the dose, give you an RX, etc.), I would like you to consider the non-narcotic treatment options we discussed, I hear you have tried them in the past with no success, I am asking you to consider trying them again.

Case 1, cont.

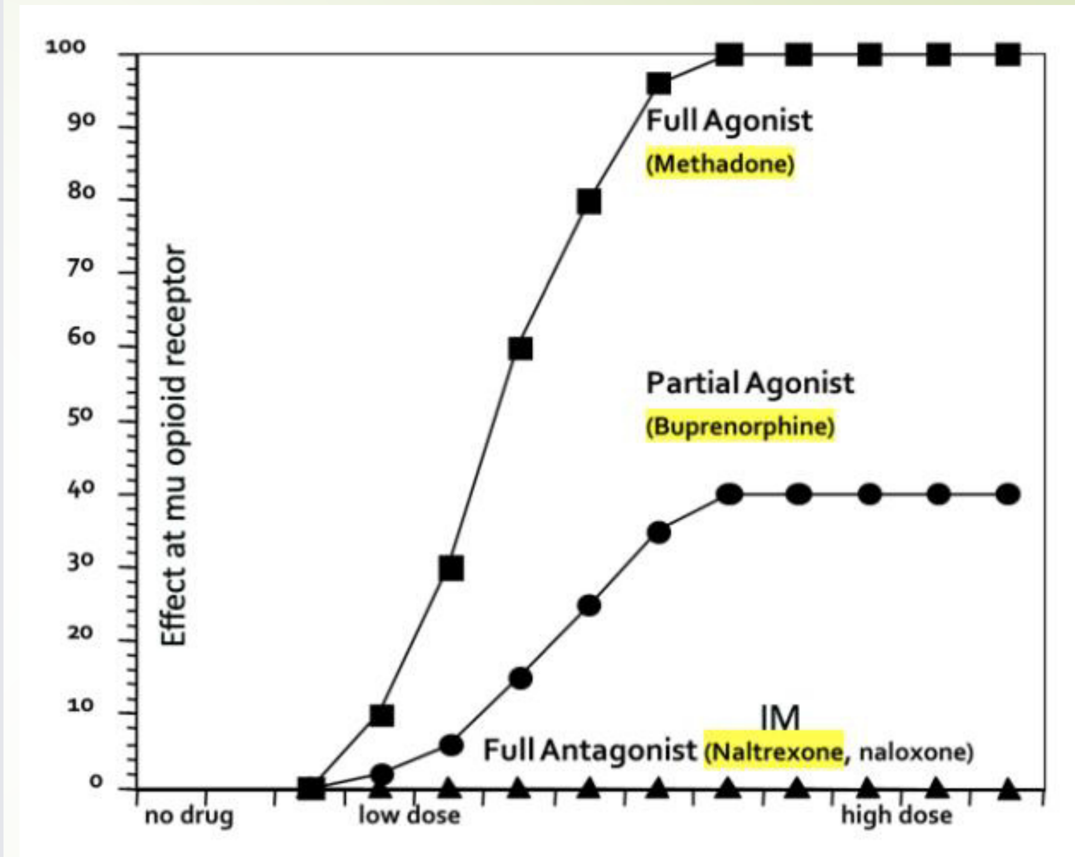
- Legitimate source of pain (femur fracture) with history of alcohol abuse
- Hydrocodone/APAP is short-acting – best to give scheduled before therapy
- Consider scheduling opioid or APAP 3x’s a day for 2 weeks
- Plan to wean off opioids at 6-8 weeks when fracture has healed
- Utilize non-pharmacologic options – lidocaine patch/cream, menthol for muscle pain after therapy, stretching/ROM every day, ice/heat
- Set expectations – will not be pain free, focus on function (not pain scores) - goal to return to ambulating with walker independently

Case 2

- 43 y/o female Full code with goal of longevity
- PMH: spina bifida with hydrocephalus, hydronephrosis, kidney stones, cystostomy, recurrent UTIs, HF, CKD3b, bipolar disorder, insomnia, GERD
- Meds: sertraline 25 mg, trazodone 50 mg, famotidine 20mg, morphine 30mg q12 hrs., hydrocodone/APAP 5/325 q6 PRN
- SH: in LTC 2 years, mother rarely visits, frequently requests hydrocodone/APAP at night or when new nursing staff present
- What is the indication for morphine and hydrocodone/APAP?
- Any concerns about opioid prescribing in this patient?
- Any other psychosocial factors to be considered?
- Would she be a good candidate for buprenorphine?



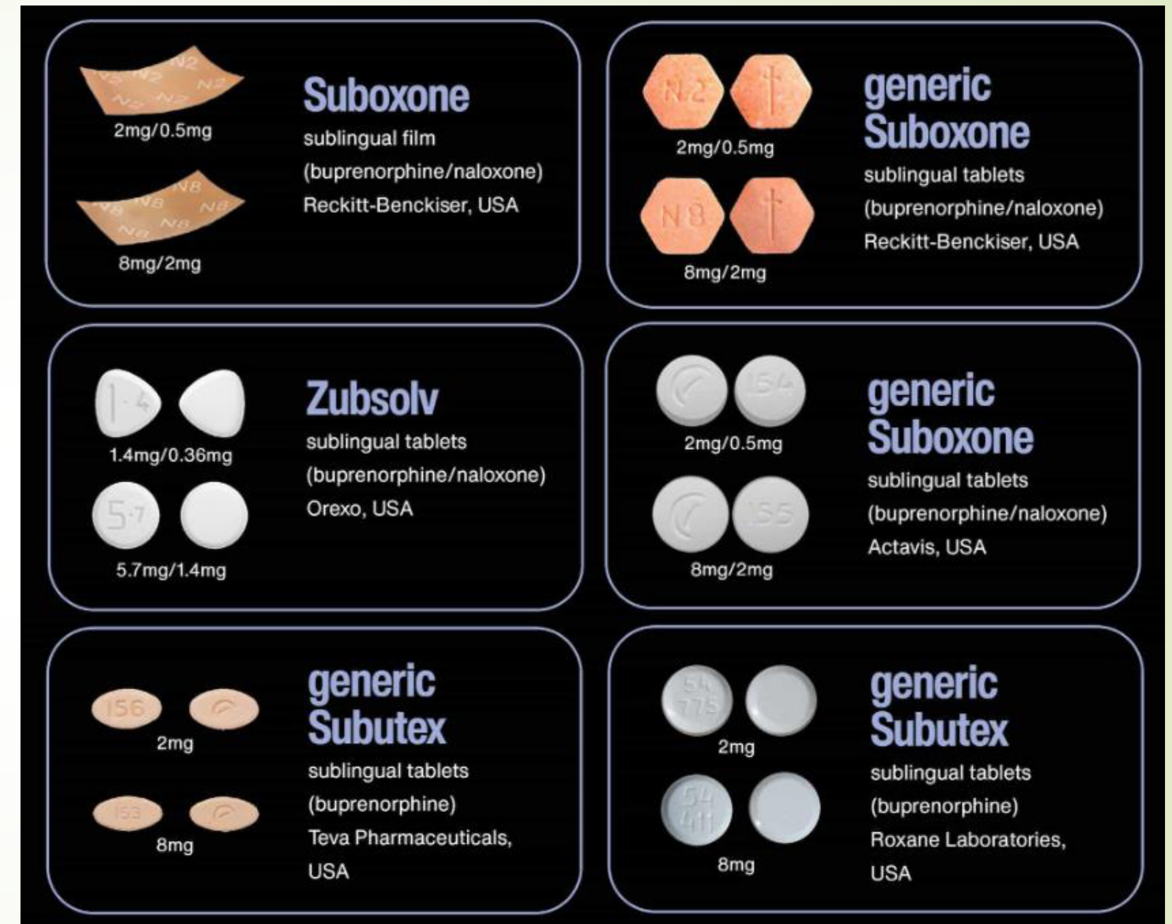
https://www.pewtrusts.org/en/research-and-analysis/fact-sheets/2020/12/medications-for-opioid-use-disorder-improve-patient-outcomes



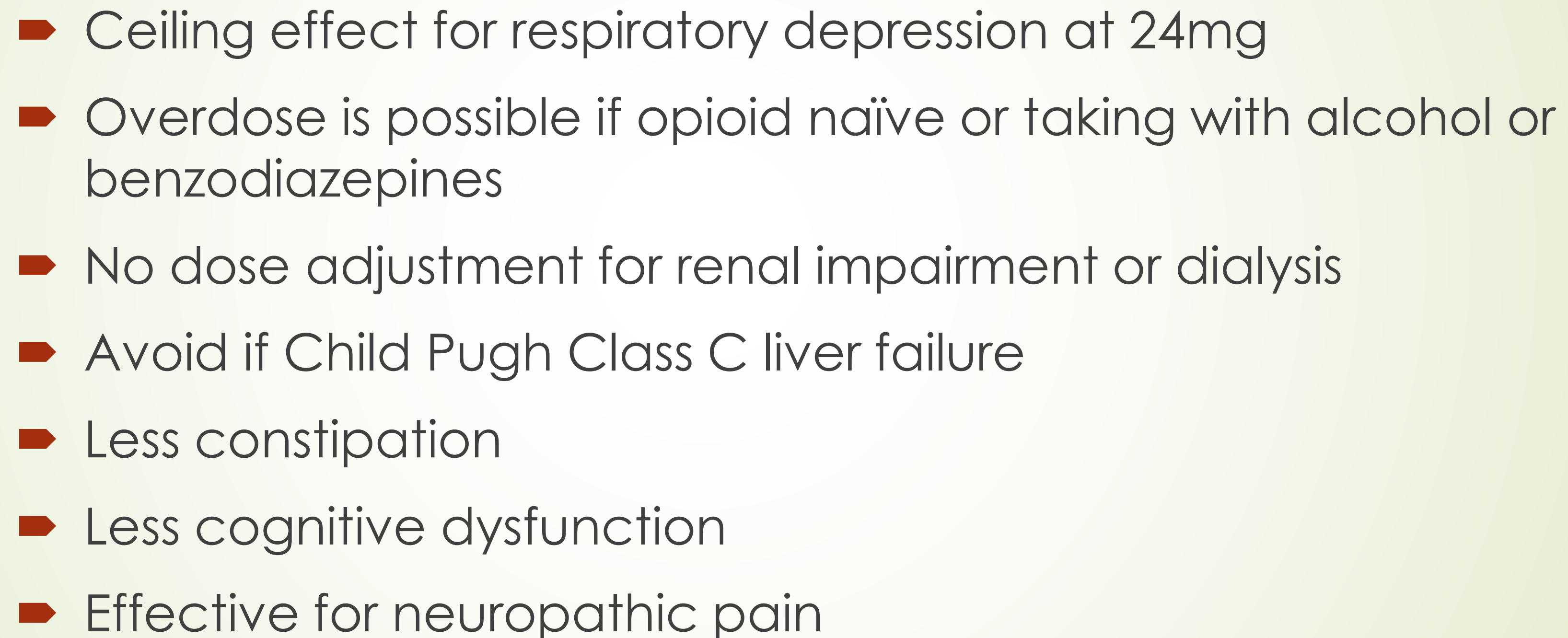
https://store.samhsa.gov/sites/default/files/pep21-02-01-002.pdf p105

Buprenorphine

- Partial mu agonist
- Suppresses and reduces cravings for opioids
- It can displace other opioids and precipitate withdrawal
- Long half-life (24-48 hrs.)
- Sublingual, buccal forms
- Schedule III, No longer need X waiver to prescribe
- FDA approved maximum dose of buprenorphine-naloxone for OUD is 24mg but can go up to 32mg.
- If cravings/use are still present at the higher doses then injectable buprenorphine could be considered (referral)



Buprenorphine, cont.



- Ceiling effect for respiratory depression at 24mg
- Overdose is possible if opioid naïve or taking with alcohol or benzodiazepines
- No dose adjustment for renal impairment or dialysis
- Avoid if Child Pugh Class C liver failure
- Less constipation
- Less cognitive dysfunction
- Effective for neuropathic pain

Buprenorphine/Naloxone

- Addition of naloxone decreases buprenorphine's potential for misuse. In Suboxone formulation of buprenorphine/naloxone, ratio of buprenorphine to naloxone is 4:1.
- Ratio of buprenorphine to naloxone varies across products, as absorption of both active ingredients is different for buccal versus sublingual films versus tablets.
- Buprenorphine/naloxone transmucosal products are abuse-deterrent formulations, although they can still be misused. When a patient takes these formulations as prescribed, he or she absorbs buprenorphine but only a biologically negligible amount of naloxone. But if crushed or dissolved for intranasal or intravenous (IV) misuse, both medications are bioavailable.
- Naloxone then blunts immediate opioid agonist effects of buprenorphine. It also induces opioid withdrawal in people who are physically dependent on opioids.

Admitting to PAC on buprenorphine

- Continue buprenorphine at current dose
- Review administration techniques with nursing
- Review administration techniques with patient
- Document effectiveness for cravings, withdrawal symptoms
- Discuss who will prescribe at discharge
  - Recommend taper off additional opioids prior to discharge so meds can be managed.
  - Prescribe Buprenorphine at discharge (up to 30 days)
  - Prescribe Naloxone at discharge

Administration Considerations

- Buprenorphine is best absorbed under the tongue
- Films and tabs are available, but tabs most common due to cost
- If swallowed, buprenorphine absorption is reduced, and naltrexone is absorbed (withdrawal)
- Give after all other pills
- No eating, drinking, or smoking 30 minutes after
- Rinse 30 minutes after administered to reduce tooth decay

EXHIBIT 3D.1. Buprenorphine Transmucosal Products for OUD Treatment

PRODUCT NAME/ ACTIVE INGREDIENT	ROUTE OF ADMINISTRATION/ FORM	AVAILABLE STRENGTHS	RECOMMENDED ONCE-DAILY MAINTENANCE DOSE
Bunavail[235] • Buprenorphine hydrochloride • Naloxone hydrochloride	Buccal film	2.1 mg/0.3 mg 4.2 mg/0.7 mg 6.3 mg/1 mg	**Target:** 8.4 mg/1.4 mg **Range:** 2.1 mg/0.3 mg to 12.6 mg/2.1 mg
Generic combination product[236,237] • Buprenorphine hydrochloride • Naloxone hydrochloride	Sublingual tablet, film	2 mg/0.5 mg 4 mg/1 mg 8 mg/2 mg 12 mg/3 mg	**Target:** 16 mg/4 mg **Range:** 4 mg/1 mg to 24 mg/6 mg*
Generic monoproduct[238,239] • Buprenorphine hydrochloride	Sublingual tablet	2 mg 8 mg	**Target:** 16 mg **Range:** 4 mg to 24 mg*
Suboxone[240,241] • Buprenorphine hydrochloride • Naloxone hydrochloride	Sublingual film	2 mg/0.5 mg 4 mg/1 mg 8 mg/2 mg 12 mg/3 mg	**Target:** 16 mg/4 mg **Range:** 4 mg/1 mg to 24 mg/6 mg*
Zubsolv[242,243] • Buprenorphine hydrochloride • Naloxone hydrochloride	Sublingual tablet	0.7 mg/0.18 mg 1.4 mg/0.36 mg 2.9 mg/0.71 mg 5.7 mg/1.4 mg 8.6 mg/2.1 mg 11.4 mg/2.9 mg	**Target:** 11.4 mg/2.9 mg **Range:** 2.9 mg/0.71 mg to 17.2 mg/4.2 mg

*Dosages above 24 mg buprenorphine or 24 mg/6 mg buprenorphine/naloxone per day have shown no clinical advantage.[244,245]

Adapted from material in the public domain.[246]

https://store.samhsa.gov/sites/default/files/pep21-02-01-002.pdf p144

Dose adjustments

- Dose evaluation (typical doses 16-24mg)
- **Increase** dose if cravings, withdrawal, or ongoing drug use
- **Decrease** dose if sedation or side effects (nausea)
- Urine toxicology monitoring (point of care recommended)
  - Specify buprenorphine
  - **CONTINUE** buprenorphine regardless of what non-prescribed substances are in the urine

- 1. **Traditional**
  - Complete cessation of full opioid agonists before initiation
  - Mild to moderate opioid withdrawal symptoms must be experienced
  - Timing of initiation varies based on factors such as type of opioid used, frequency of use, and route of administration
- 2. **Low dose**
  - Low doses of buprenorphine given at increasing doses while continuing use of full opioid agonists during initiation.
  - Incremental doses of buprenorphine gradually displaces full opioid agonist, more tolerable
- 3. **High dose**
  - Requires opioid cessation and withdrawal onset.
  - Rapid attainment of therapeutic buprenorphine dose in 1-3 hours, practical for ER
  - Precipitated withdrawal can occur, must counsel patient before initiation

Traditional

A Guide for Patients Beginning Buprenorphine Treatment at Home

Before you begin you want to feel very sick from your withdrawal symptoms

It should be at least . . .

- **12 hours** since you used heroin/fentanyl
- **12 hours** since snorted pain pills (Oxycontin)
- **16 hours** since you swallowed pain pills
- **48-72 hours** since you used methadone

You should feel at least three of these symptoms . . .

- Restlessness
- Heavy yawning
- Enlarged pupils
- Runny nose
- Body aches
- Tremors/twitching
- Chills or sweating
- Anxious or irritable
- Goose pimples
- Stomach cramps, nausea, vomiting or diarrhea

Once you are ready, follow these instructions to start the medication

DAY 1:

8-12mg of buprenorphine

Most people feel better the first day after 8-12mg. (Dosing depends on how early on the first day you started)

Step 1.

Take the first dose — 4mg

Wait 45 minutes — 45 minutes

- Put the tablet or strip under your tongue
- Keep it there until fully dissolved (about 15 min.)
- Do NOT eat or drink at this time
- Do NOT swallow the medicine

Step 2.

Still feel sick? Take next dose — 4mg

Wait 6 hours — 6 hours

Most people feel better after two doses = 8mg

Step 3.

Still uncomfortable? Take last dose — 4mg

Stop — Stop

- Stop after this dose
- Do not exceed 12mg on Day 1

DAY 2:

16mg of buprenorphine

Take one 16mg dose

Most people feel better with a 16mg dose

16mg

Repeat this dose until your next follow-up appointment

If you develop worsening symptoms while starting buprenorphine before your scheduled outpatient appointment return to the emergency department

ASAM Advanced Buprenorphine Education: Resource Guide

Inpatient Low Dose Regimen (film or tab)*

Day	Buprenorphine Dose Sublingual Tab	Full Agonist Dose, i.e., methadone, hydromorphone, oxycodone
1	0.5 mg QD (quarter of 2 mg tab)	Same
2	0.5 mg BID (quarter of 2 mg tab)	Same
3	1 mg BID (half of 2 mg tab)	Same
4	2 mg BID (2 mg tab)**	Same
5	4 mg BID (half of 8 mg tab)	Same
6	12 mg (one and a half of 8 mg tab)***	Same
7	16 mg (two 8 mg tabs)	OFF

*Supportive Medications (ondansetron, loperamide, hydroxyzine, tizanidine, clonidine, dicyclomine)
**Option to transition to sublingual film
**Can repeat days if patient develops withdrawal, achiness

ASAM Advanced Buprenorphine Education: Resource Guide

Acute Pain

- If acute pain develops:
- Option 1: Increase buprenorphine (up to 24mg)
- Option 2: Add hydromorphone (oral)
  - Competitively binds better than oxycodone
  - Higher doses may be needed to overcome buprenorphine blockade

Case 2, cont.

- 43 y/o female with no diagnosis to support use of morphine 60mg daily
- Precipitating opioid withdrawal will be difficult on patient and staff
- Transitioning to buprenorphine tab is reasonable, will need patient buy-in
- Consider low dose initiation
- 2mg buprenorphine is equivalent to 60mg morphine
  - may not need 8mg tab BID

Appendix

Resources

- https://www.samhsa.gov/medications-substance-use-disorders/training-requirements-mate-act-resources
- SAMHSA, Buprenorphine Quick Start Guide https://www.samhsa.gov/sites/default/files/quick-start-guide.pdf
- SAMHSA, Buprenorphine Pocket Guide https://www.samhsa.gov/sites/default/files/quick-start-pocket.pdf
- SAMHSA, Advisory, Sublingual and Transmucosal Buprenorphine for Opioid Use Disorder: Review and Update https://store.samhsa.gov/sites/default/files/sma16-4938.pdf

Resources, cont.

- American Society of Addiction Medicine (ASAM) eLearning Center (https://elearning.asam.org/)
  - Advanced Buprenorphine Education: Best Practices and Emerging Evidence in Opioid Use Disorder Treatment (90 min)
- Boston Medical Center (BMC) Grayken Center for Addiction Training and Technical Assistance (TTA) (https://www.addictiontraining.org/)
  - The Nuts and Bolts of Buprenorphine Treatment (2 hrs., recorded)
- Live support from National Clinician Consultation Center (https://nccc.ucsf.edu)
- Providers Clinical Support System Mentorship Program (longitudinal mentor program and case based, not real time) (https://pcssnow.org/mentoring)
- Massachusetts Department of Public Health, The Care of Residents with Opioid & Stimulant Use Disorders in Long-Term Care Settings Toolkit (https://www.mass.gov/info-details/the-care-of-residents-with-opioid-stimulant-use-disorders-in-long-term-care-settings-toolkit)

References

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- https://store.samhsa.gov/sites/default/files/pep21-02-01-002.pdf
- Pain Management Clinical Practice Guideline – AMDA
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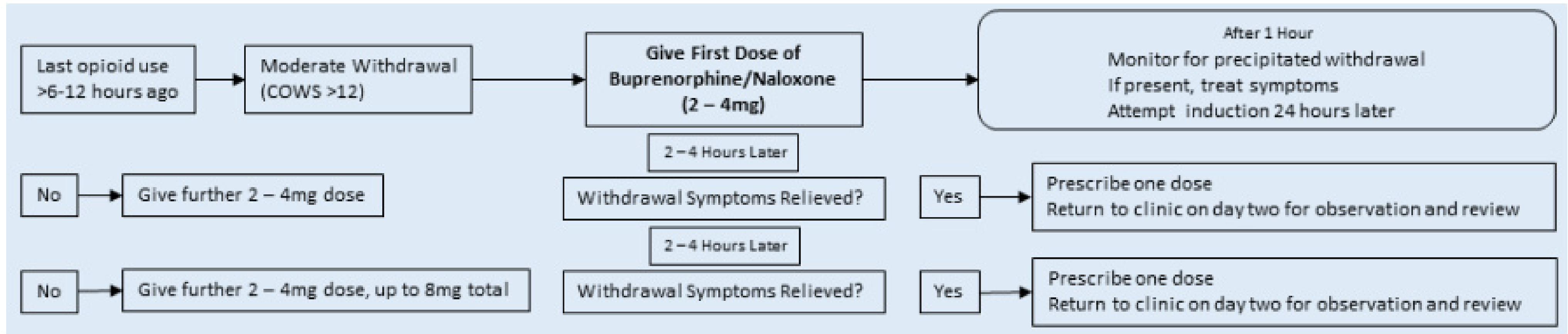
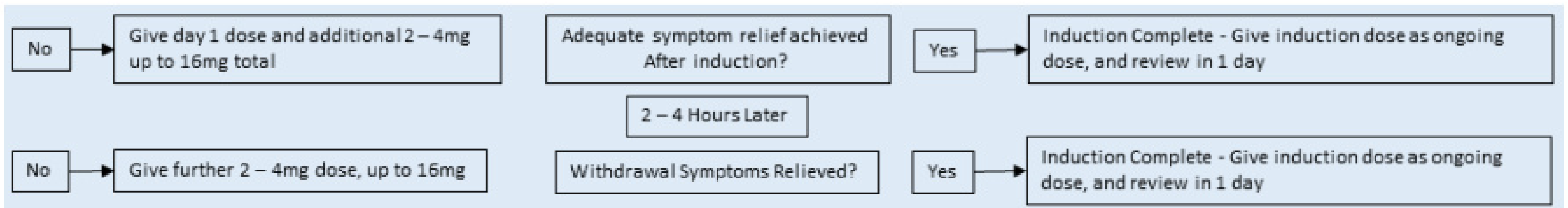
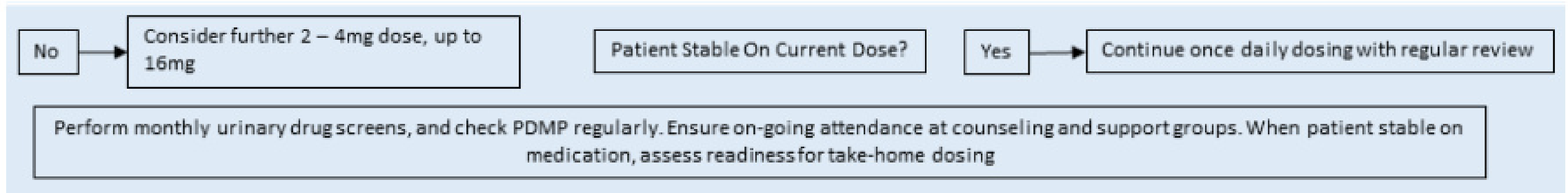
SAMHSA Quick Start







https://www.samhsa.gov/sites/default/files/quick-start-guide.pdf

Table III: Approximate Absorption Rates and Dose Equivalency of Buprenorphine.

Preparation	Absorption rate / Bioavailability*	Amount taken	Amount absorbed
Suboxone	25%	4 mg	1mg
Zubsolv	35%	2.9 mg	1 mg
Bunavail	50%	2.1 mg	1 mg
Belbuca	55%	1.8 mg	1 mg
Butrans patch	15%	20 mg is contained in a patch	20 mcg/h (0.48mg/d)
Buprenex	100%	1 mg	1 mg

*Information based on corresponding package inserts.

https://www.medcentral.com/addiction-med/oud/buprenorphine-promising-yet-overlooked-tool

Opioid Equivalent Doses

Roughly equivalent daily doses of various opioids

Buprenorphine Doses	Oxycodone	Morphine	Heroin	Methadone
2 mg	30 mg	60 mg	1-2 bags	10 mg
4 mg	60 mg	120 mg	3 bags	20 mg
6 mg	90 mg	180 mg	4 bags	30 mg
8 mg	120 mg	240 mg	6 bags	40 mg
12 mg	180 mg	360 mg	8 bags	60 mg
16 mg	240 mg	480 mg	10 bags	80 mg

From: Vermont Buprenorphine Practice Guidelines
http://contentmanager.med.uvm.edu/docs/default-source/vchip-documents/vchip_2buprenorphine_guidelines.pdf?sfvrsn=2

https://emcrit.org/ibcc/buprenorphine/

Equianalgesic Doses of Opiates

- Hydromorphone>oxycodone>morphine>hydrocodone>tramadol>codeine

Morphine	**15mg**	**30mg**
Oxycodone	10	20
Hydromorphone	3	7.5
Hydrocodone	10-15	30
Codeine	100	120
Tramadol	60	120

Fentanyl Patch	**Oral morphine equivalent per 24 hrs.**
12	30
25	60
50	120
75	180
100	240

Opioid Risk Tool

Mark each box that applies	Female	Male
Family history of substance abuse		
Alcohol	1	3
Illegal drugs	2	3
Rx drugs	4	4
Personal history of substance abuse		
Alcohol	3	3
Illegal drugs	4	4
Rx drugs	5	5
Age between 16—45 years	1	1
History of preadolescent sexual abuse	3	0
Psychological disease		
ADD, OCD, bipolar, schizophrenia	2	2
Depression	1	1
Scoring totals		

Opioid Risk Tool

- Should be administered to patients upon an initial visit prior to beginning opioid therapy for pain management
- Score of 3 or lower indicates **low** risk for future opioid abuse
- Score of 4 to 7 indicates **moderate** risk for opioid abuse
- Score of 8 or higher indicates a **high** risk for opioid abuse

https://nida.nih.gov/sites/default/files/opioidrisktool.pdf

Compassion Traps

- PATIENT - Do you want me to be in pain, unable to walk?
- PROVIDER - I want you to have safe and effective pain control and it is my medical opinion that your current medicine won't give you that.
- PATIENT - Do you have pain?
- PROVIDER - I want to use every minute of our time today to talk about *your* pain management plan.
- PATIENT - I wish you could feel my pain.
- PROVIDER - I know you're suffering and I'm sure that we can work together to reduce pain, so you don't have to suffer.

https://www.oregonpainguidance.org/wp-content/uploads/2017/11/common-traps-and-negotiation-strategies.pdf?x89172

All-or-Nothing Traps

- PATIENT - So you're going to do nothing for me then?
- PROVIDER - I am confident that together we will find safe and effective options.
- PATIENT - You're cutting me off and I have to live with my pain?
- PROVIDER - There are many, many things that people with chronic pain can do other than opiates to manage their pain. Would you like to hear about them?
- PATIENT - I've tried all of that stuff, none of it works.
- PROVIDER - I want to hear what you've tried so we can find a way for it to be more helpful this time.

https://www.oregonpainguidance.org/wp-content/uploads/2017/11/common-traps-and-negotiation-strategies.pdf?x89172

Addiction Labeling Traps

- PATIENT - Are you accusing me of being an addict?
- PROVIDER - I have never accused anyone of diabetes but I've diagnosed him or her with it and that is what I am trying to now, diagnose.
- PATIENT - Don't label me as a druggie.
- PROVIDER - I have no interest in labels at all; I am interested in helping people who are struggling with medical problems.
- PATIENT - So you're basically saying that I'm a junkie.
- PROVIDER - I'm saying that addiction is a medical problem that responds to treatment, not a problem of bad morals or behavior

https://www.oregonpainguidance.org/wp-content/uploads/2017/11/common-traps-and-negotiation-strategies.pdf?x89172

Desperate and Threatening Traps

- PATIENT - I heard it's illegal for you to let me go into withdrawal.
- PROVIDER - Withdrawal is uncomfortable but not life threatening. I can prescribe you medicines to help with the withdrawal symptoms.
- PATIENT - Don't bother with any other meds, I'll just kill myself.
- PROVIDER - I need to ask you some more questions about your thoughts about suicide.
- PATIENT - I'm getting a lawyer (the medical board, your boss, etc....).
- PROVIDER - You do what you feel is right, of course. That's what I'm doing for you, too.

https://www.oregonpainguidance.org/wp-content/uploads/2017/11/common-traps-and-negotiation-strategies.pdf?x89172

Endgame

- PATIENT - Behavior is angry, despondent, avoidant, etc.…
- PROVIDER - At this point, I suggest we agree to disagree, what I have laid out is what I believe to be the safest and most effective course of action right now. Now, how do you want to spend the rest of our time?
- PATIENT - I hate you, I am leaving, you suck, etc.…
- PROVIDER - It is understandable that you are upset. It is my job to keep you safe and I care about you. I will be back in the next few days/weeks to talk to about next steps.

https://www.oregonpainguidance.org/wp-content/uploads/2017/11/common-traps-and-negotiation-strategies.pdf?x89172

Buprenorphine Preparations

Table II: Brand Preparations of Buprenorphine Currently Approved in the US.

Type	Buprenorphine	Buprenorphine/Naloxone	Buprenorphine long-acting
Indication	pain	opioid dependence substitution indication	opioid dependence substitution indication
Brands (available doses)	Belbuca (75, 150, 300, 450, 600, 750, or 900 mcg)	Suboxone (2/0.5, 4/1, 8/2, or 12/3 mg)	Sublocade injection (100, 300 mg monthly)
	Butrans (5, 7.5, 10, 15, or 20 mcg/h or a 7-day patch)	Zubsolv (0.7/0.18, 1.4/036, 2.9/071, 5.7/1.4, 8.6/2.1, 11.4/2.9 mg)	Probuphine implant (74.2 mg every six months)
	Buprenex (300 mcg/ml via intramuscular or intravenous administration)	Bunavail (2.1/0.3, 4.2/0.7, 6.3/1 mg)	Brixadi injection (8, 16, 24 or 32 mg weekly; 64, 96, or 128 mg monthly)

***Information based on corresponding package inserts.**

https://www.medcentral.com/addiction-med/oud/buprenorphine-promising-yet-overlooked-tool