Crisis = Opportunity: Reducing Medication Burden While Managing Chronic Pain

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Disclosure

- Nothing to disclose
Learning Objectives

- Explain the role of opioid medication in treating noncancer pain
- Identify the adverse physiologic effects of opioids and the risks of opioid misuse, abuse, and addiction in patients receiving prescription opioids for chronic noncancer pain
- List current guidelines regarding opioid tapering in the context of chronic noncancer pain
- Describe how psychological and behavioral interventions can be incorporated into treatment to help patients improve functional outcomes while concurrently minimizing reliance on opioids

Prescription Opioids

- Prescription opioid overdose death rates, sales, and substance abuse treatment admissions have climbed in parallel over the past decade
- Cost of non-medical prescription opioid use in the U.S. is over $50 billion annually

“Earlier this month, an Ohio officer overdosed in a police station after brushing off with a bare hand a trace of white powder left from a drug scene. Like Phillips, he was revived after several doses of Narcan. Last fall, 11 SWAT officers in Hartford, Connecticut, were sickened after a flash-bang grenade sent particles of heroin and fentanyl airborne.”

**Prescription Opioids**

- Tolerance/ Physical Dependence
- Immunosuppression
- Opioid-induced endocrinopathy
- Respiratory depression

Opioid-Induced Respiratory Depression

- Primary mechanism of opioid fatality
- Further potentiated by pulmonary disease, benzodiazepines

Hypoxia → Hypercapnia → Cardiorespiratory Arrest

Risk Factors for Prescription Opioid Overdose

- Mean OME >50mg/d (OR = 1.986 [95% CI, 1.509-2.614])
- Methadone Use (OR = 7.230 [95% CI, 2.346-22.286])
- Drug/Alcohol Abuse (OR = 3.104 [95% CI, 2.195-4.388])
- Other Psychiatric Illness (OR = 1.730 [95% CI, 1.307-2.291])
- Benzodiazepine Use (OR = 2.005 [95% CI, 1.516-2.652])
- Multiple Pharmacies (OR = 1.514 [95% CI, 1.003-2.286])


Overdose Deaths and Chronic Pain

- 61.5% of overdose decedents received a chronic noncancer pain diagnoses in the last year of life
- Those with chronic pain were more likely to have filled opioid and benzodiazepine prescriptions during the last 30 days of life
- Only 4% of all decedents had a diagnoses of opioid use disorder
- Higher incidence of depression and anxiety amongst those with chronic pain

Prescription Opioids

- Increased rates of substance abuse and depression exist in long-term prescription opioid users compared to non-users with chronic pain
- Pain intensity does not predict treatment with opioids vs. non-opioid analgesics
- Depression and anxiety contribute to substance use disorders amongst long-term opioid users

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Prescribing Patterns

- Statewide retrospective cohort study
- 26,785 (5.0%) of 536,767 opioid naive patients who filled an opioid prescription became long-term users
- Numbers of fills, cumulative MMEs during the initiation month were associated with long-term use
- Initiating with long-acting opioids had a higher risk of long-term use

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Take Home Points

- Limit refills
- Curb dosages
- Careful prescribing of long-acting opioids
**Non-Medical Prescription Opioid Use**

- Prospective, multi-site, observational study
- 3396 HIV-infected and uninfected patients enrolled into the Veterans Aging Cohort Study, followed from 2002-2012
- Non-medical use of prescription opioids was associated positively and independently with heroin initiation [adjusted hazard ratio (AHR) = 5.43, 95% CI = 4.01, 7.35]
  

**Are We Placing Patients At Risk?**

- Real rates of addiction following legitimate prescription opioid exposure may be as high as 10%
  

- 31-84% of prescription opioid addicts seeking inpatient treatment reported that they had legitimately been given opioids for pain by a physician that they later went on to abuse
  
Opioids for Chronic Non-Cancer Pain

- Prescribing has dramatically increased over the past decade
- Systematic reviews examining RCTs show moderately improved pain, function, and disability for opioids vs. placebo


Opioids for Chronic Non-Cancer Pain

- Prescribed for back pain, OA, neuropathic pain, myofascial pain, osteoporotic vertebral fractures, trigeminal neuralgia
- Adverse effects: GI, headache, fatigue, urinary (hesitancy, retention)
- 0.14% to 0.27% rate of addiction

Opioid Tapering

- Opioid detoxification as outpatient vs. inpatient is comparable

- Successful opioid tapering in intensive outpatient and inpatient pain rehabilitation programs (↓pain, ↑functioning, ↓depression, ↓catastrophizing)

- Patients with comorbid chronic pain and opioid misuse can undergo tapering without ↑pain or ↓QOL

Guidelines for Opioid Therapy

- Thorough patient evaluation(e.g. psychological and psychosocial factors to identify potential drug misuse and abuse)
- Adequate risks vs. benefits discussion (informed consent)
- Begin with a trial of opioid therapy
- Conservative, individualized opioid regimen
- Continued patient monitoring(loss of response, AEs, aberrant behaviors)
“6.2 Clinicians should evaluate patients engaging in aberrant drug-related behaviors for appropriateness of COT or need for restructuring of therapy, referral for assistance in management, or discontinuation of COT”

Restructuring of therapy: more frequent monitoring, temporary or permanent opioid tapering, or the addition of psychological therapies or other non-opioid treatments


“7.4 Clinicians should taper or wean patients off COT who engage in repeated aberrant drug-related behaviors or drug abuse/diversion, experience no progress toward meeting therapeutic goals, or experience intolerable adverse effects.”

Opioid taper can occur in outpatient setting without severe medical
or psychiatric comorbidities

Opioid detoxification in a rehabilitation setting (outpatient or
inpatient)

Enforced weaning and referral to an addiction specialist may be
necessary with aberrant drug-related behaviors


10% dose reduction weekly

25-50% dose reduction every few days

At greater than 200mg/day MEQ initial wean can be more rapid

At doses of 60-80 mg/day MEQ slower tapers may be required

Improved well-being and function vs. pain hypersensitivity during
opioid withdrawal

SOAPP-R

- Cutoff score of ≥18, sensitivity was 0.80 (95% CI, 0.70 to 0.89) and specificity was 0.68 (95% CI, 0.60 to 0.75) for identification of any aberrant drug-related behavior
- Each item scored from 0 to 4, maximum score 96


ORT

- Maximum score=26
- Aberrant drug-related behaviors were identified in 6% of patients categorized as low risk, 28% of patients categorized as moderate risk, and 91% of those categorized as high risk

Aberrant drug-related behaviors were identified in 6% (1/18) of patients categorized as low risk (score, 0 to 3), compared with 28% (35/123) of patients categorized as moderate risk (score, 4 to 7) and 91% (41/44) of those categorized as high risk (score ≥8) after 12 months
COMM

- 17-items
- Self-Report
- A score of 9 or higher on the COMM has 94% sensitivity and 73% specificity to identify opioid misuse among patients prescribed opioids for pain
- Assesses behaviors within the past 30 days

National Opioid Use Guideline Group

- Tapering indications
  - Severe pain despite adequate trial of multiple opioids
  - Complications (sleep apnea, falls)
  - “Structured opioid therapy” for patients with co-morbid addiction and pain

National Opioid Use Guideline Group

- Controlled-release morphine
- Scheduled doses, consistent daily schedule
- Prescribe at frequent dispensing intervals
- 10% of total daily dose daily to 5% every 1-4 weeks
- Half the taper rate once one-third of dose is reached
- Hold or increase dose with increased pain, severe withdrawal, or worsening mood

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“It is essential to monitor for side effects and manage them appropriately including discontinuation of opioids if indicated”

- 10% of the original dose weekly
- Tapering over 6-8 weeks
- Clonidine 0.1-0.2mg PO q6hrs or Clonidine 0.1mg/24 hrs TD weekly
- Mild opioid withdrawal symptoms up to 6 months after discontinuation

American Society of Interventional Pain Physicians

“Discontinue opioid therapy for lack of response, adverse consequences, and abuse with rehabilitation.”

- Tapering or weaning is not necessary for patients who have not taken medication on a long-term basis
- Consider adjuvant treatment for continued opioid withdrawal symptoms
  - Antidepressants
  - Anti-neuropathics
  - Counseling


7. Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently. If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids (recommendation category: A, evidence type: 4).
Opioid Discontinuation/Tapering

- No improvements in pain and function
- High-risk regimens (e.g., dosages ≥50 MME/day, opioids combined with benzodiazepines) without evidence of benefit
- Patients believe benefits no longer outweigh risks or if they request dosage reduction or discontinuation
- Overdose or other serious adverse events (e.g., an event leading to hospitalization or disability) or warning signs of serious adverse events

Opioid Discontinuation/Tapering

- Reducing weekly dosage by 10%–50% of the original dosage
- Overdose: rapid taper over 2-3 weeks
- Slower tapers may be appropriate with longer durations of opioid use
- Pregnancy: risk of spontaneous abortion and premature labor
Opioid Discontinuation/Tapering

- Minimize opioid withdrawal symptoms (drug craving, anxiety, insomnia, abdominal pain, vomiting, diarrhea, diaphoresis, mydriasis, tremor, tachycardia, or piloerection)
- Discontinue when taken less than once a day
- Ultrarapid detoxification under anesthesia is associated with substantial risks, including death

Health Plan Driven Opioid Tapering

- Oregon Health Authority and the Health Evidence Review Commission implemented guidance for Oregon Medicaid members who were taking opioids for chronic pain (back and spine) in 2016.

For patients with chronic pain from diagnoses on these lines currently treated with long term opioid therapy, opioids must be tapered off using an individual treatment plan developed by January 1, 2017 with a quit date no later than January 1, 2018. Taper plans must include nonpharmacological treatment strategies for managing the patient’s pain based on Guideline Note 56 NON-INTERVENTIONAL TREATMENTS FOR CONDITIONS OF THE BACK AND SPINE. If a patient has developed dependence and/or addiction related to their opioids, treatment is available on Line 4 SUBSTANCE USE DISORDER.
**Health Plan Driven Opioid Tapering**

- Provider Outreach (Introductory Letter, Summary Letter—an example 10% taper plan, a nonopioid analgesic therapy resource, a non-interventional therapy resource, and an “Opioid Tapering FAQ” patient handout.)
- 16 members (14.2%) had a decrease in MEDD
- 23 members (20.4%) had no change in MEDD
- 72 members (63.7%) had an increase in MEDD
- 2 members (1.8%) were unable to be analyzed because of lapsed CCO coverage


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**Voluntary Patient-Centered Opioid Tapering**

- Patients with CNCP prescribed long-term opioids at a community pain clinic
- Provided education about the benefits of opioid reduction
- Physicians offered to partner with patients to slowly reduce their opioid dosages over 4 months
- 51 of 83 patient completed the 4-month follow-up
- Baseline median MEDD 288 (153-587)
- Follow-up median MEDD 150 (IQR, 54-248) mg ($P = .002$)
- No increase in pain intensity or interference

Facilitators of Opioid Tapering

- Empathizing with the patient's experience
- Preparing patients for opioid tapering
- Individualizing implementation of opioid tapering
- Supportive guidelines and policies


Outcomes in Dose Reduction or Discontinuation of Long-Term Opioid Therapy

- 67 studies (11 randomized trials and 56 observational studies)
- Interdisciplinary pain programs, behavioral interventions
- Most studies report dose reduction but discontinuation rates were highly variable
- Improvements in pain severity, function, and quality of life

Outcomes in Dose Reduction or Discontinuation of Long-Term Opioid Therapy

- 4-month interactive voice response intervention vs. usual care among patients with chronic pain ($n = 51$)
- Optional opioid dose reduction
- Reduced mean opioid dose significantly at 4-months ($P = 0.04$) and 8-months ($P = 0.004$) follow-up
  

Outcomes in Dose Reduction or Discontinuation of Long-Term Opioid Therapy

- 8-week group intervention based on mindfulness meditation and cognitive behavioral therapy with usual care among patients receiving LTOT ($n = 35$)
- Did not explicitly encourage dose reduction
- The mean change in the daily opioid dose from baseline to 26 weeks was $-10.1$ mg MED in the intervention group compared with $-0.2$ mg MED in the control group ($P = 0.8$)

Outcomes in Dose Reduction or Discontinuation of Long-Term Opioid Therapy

- Patient barriers to opioid tapering
- Strategies to enhance patients engagement
- Less resource intensive models of opioid tapering
- No studies address mandatory opioid tapering
- Need for long-term surveillance regarding adverse events (overdose, suicide)


Patient-Provider Communication

Explaining

Negotiating

Difficult Conversations

Non-abandonment

People are generally better persuaded by the reasons which they have themselves discovered than by those which have come into the mind of others.

-Blaise Pascal

MI is a collaborative, goal-oriented style of communication with particular attention to the language of change. It is designed to strengthen personal motivation for and commitment to a specific goal by eliciting and exploring the person’s own reasons for change within an atmosphere of acceptance and compassion.

Processes of MI

Engaging
- Establishing a connection and a working relationship

Focusing
- Deciding on a particular agenda

Evoking
- Eliciting client’s own motivation for change

Planning
- Formulating a specific plan of action

Motivational Interviewing

Tools
- Open questions
- Affirmations
- Reflections
- Summary

Change Talk
- Desire- “I want to…”
- Ability- “I can…”
- Reasons- “I would probably feel better if…”
- Need- “I have to…”
- Commitment- “I will…”
- Activation- “I’m ready to…”
- Taking steps- “This week I started…”
Motivational Interviewing

- Substance Abuse
- Peer Violence and Alcohol Use in Teens
- Cannabis Use
- Crack cocaine Use
- Adolescent Substance Use
- Drug Use in the setting of Methadone Maintenance
- Opioid Detoxification

MI

- Improved Treatment Engagement
- Improved Treatment Outcomes
- Increased Medication Adherence
- Decreased Illicit Drug Use
MI-Based Interventions

- Pilot RCT of taper support intervention (psychiatric consultation, opioid dose tapering, and 18 weekly meetings with a physician assistant to explore motivation for tapering and learn pain self-management skills) vs. usual care
- Lower opioid doses and pain severity ratings in both groups

MI-Based Interventions

- MI-based session concerning opioid tapering that included:
  - Eliciting the patient’s history related to pain, opioid therapy, and related difficulties
  - Eliciting change talk related to tapering
  - Education about dose-related health risks
  - Identifying practical and psychological barriers to tapering opioid dose and problem-solving ways to overcome these; and developing a commitment to change with respect to opioid therapy.
- Significant improvements in pain interference, pain self-efficacy, and perceived opioid problems
Conclusions

- Patients with CNCP at-risk for PO overdose or those demonstrating a lack of improvement in pain and function while receiving long-term opioid therapy should be considered for opioid tapering
- Emphasis should be placed on optimizing treatment of CNCP with an interdisciplinary strategy
- Opioid tapering can occur with improvements in pain, function, and quality of life
- Opioid tapering should occur in a voluntary and collaborative approach to maximize patient engagement and outcomes