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

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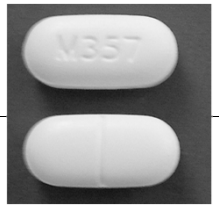
Prescription Opioids



- 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

- Maxwell JC. The prescription drug epidemic in the United States: a perfect storm. Drug Alcohol Rev. 2011;30(3):264-70.
- Vital signs: overdoses of prescription opioid pain relievers---United States, 1999--2008. MMWR Morb Mortal Wkly Rep.2011;60:1487-92.
- Hansen RN, Oster G, Edelsberg J, Woody GE, Sullivan SD. Economic costs of nonmedical use of prescription opioids. Clin J Pain. 2011;27(3):194-202.

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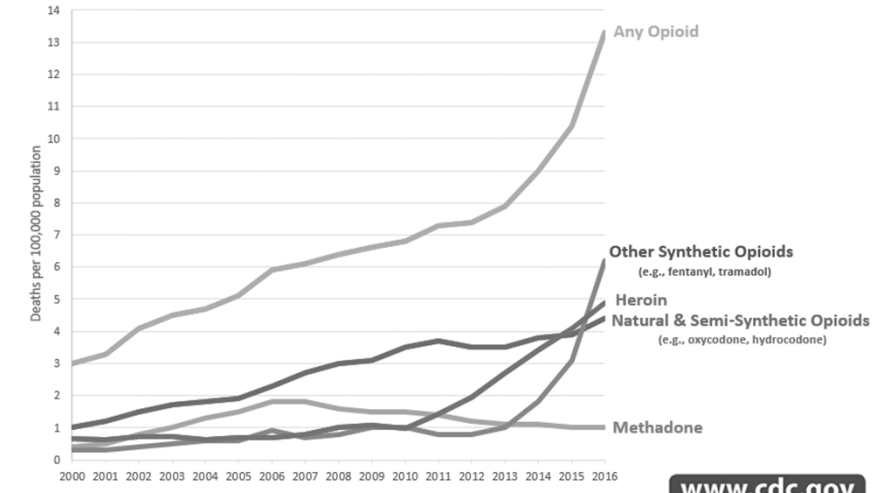
Overdose Deaths Involving Opioids, by Type of Opioid, United States, 2000-2016



SOURCE: CDC/NCHS, National Vital Statistics System, Mortality. CDC WONDER, Atlanta, GA: US Department of Health and Human Ser vices, CDC; 2017. https://wonder.cdc.gov/.

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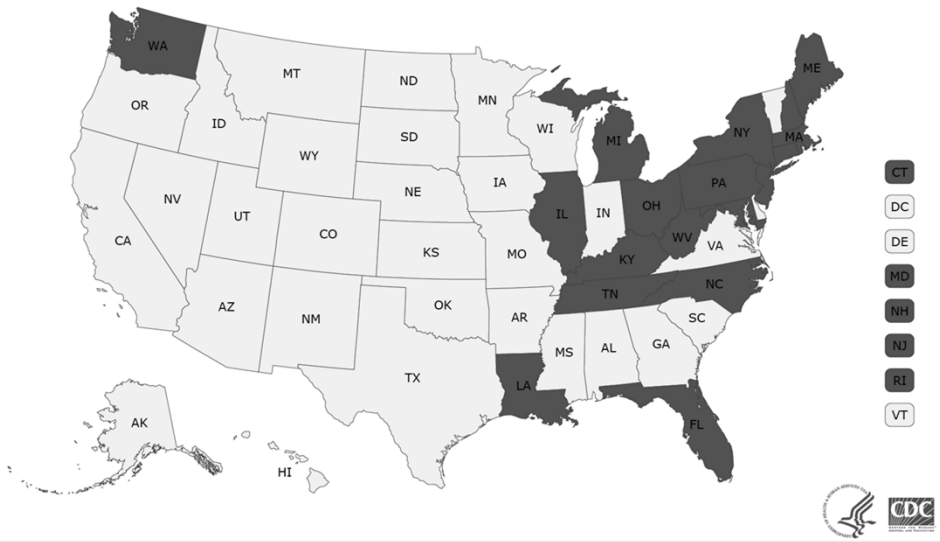
Statistically significant drug overdose death rate increase from 2014 to 2015, US states



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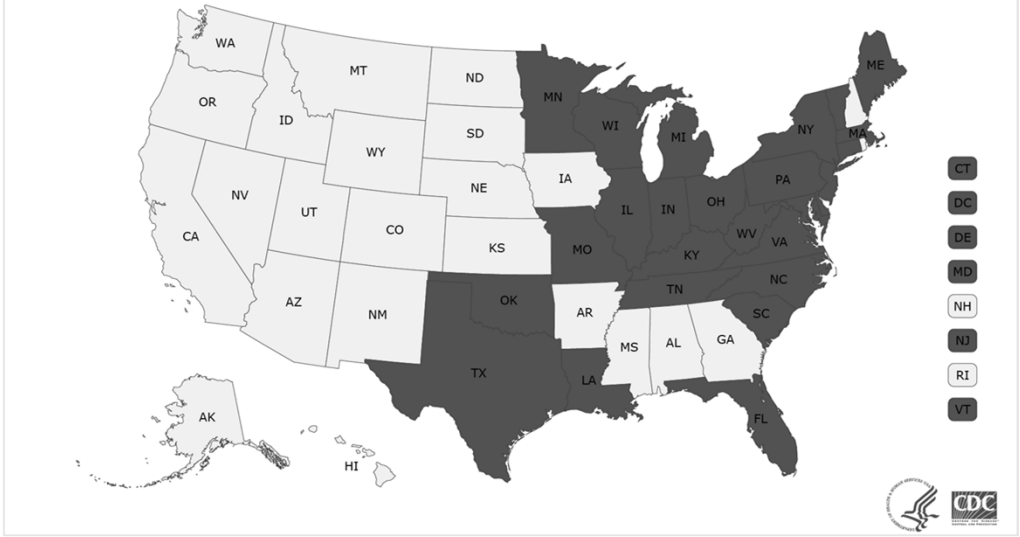
Statistically significant drug overdose death rate increase from 2015 to 2016, US states



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7

In Opioid Crisis, a New Risk for Police: Accidental Overdose

As an opioid epidemic tears across the United States, police officers tasked with reversing the effects of overdose in addicts are increasingly at risk of accidentally overdose themselves due to the potency of synthetic opioids.

https://www.usnews.com/news/best-states/maryland/articles/2017-05-27/in-opioid-crisis-a-new-risk-for-police-accidental-overdose

"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."

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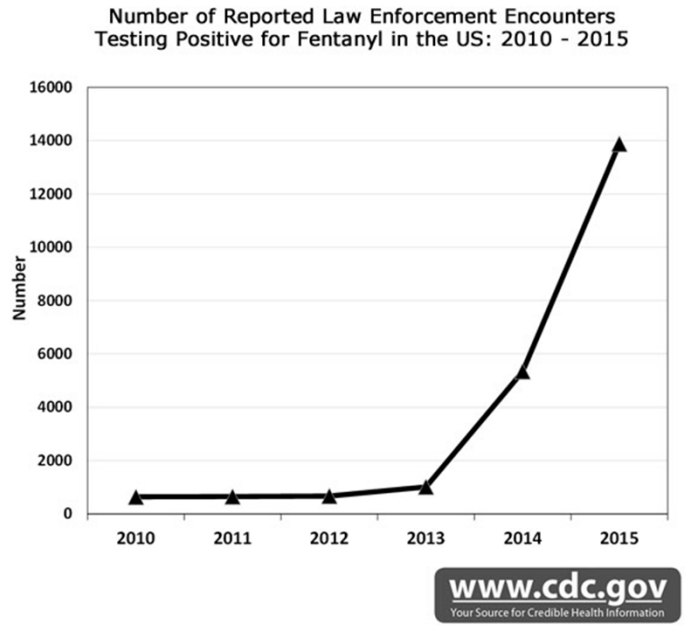

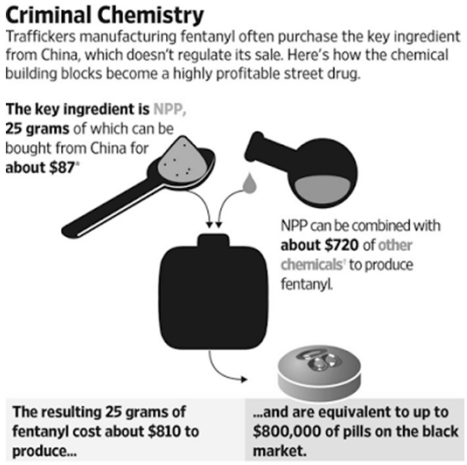

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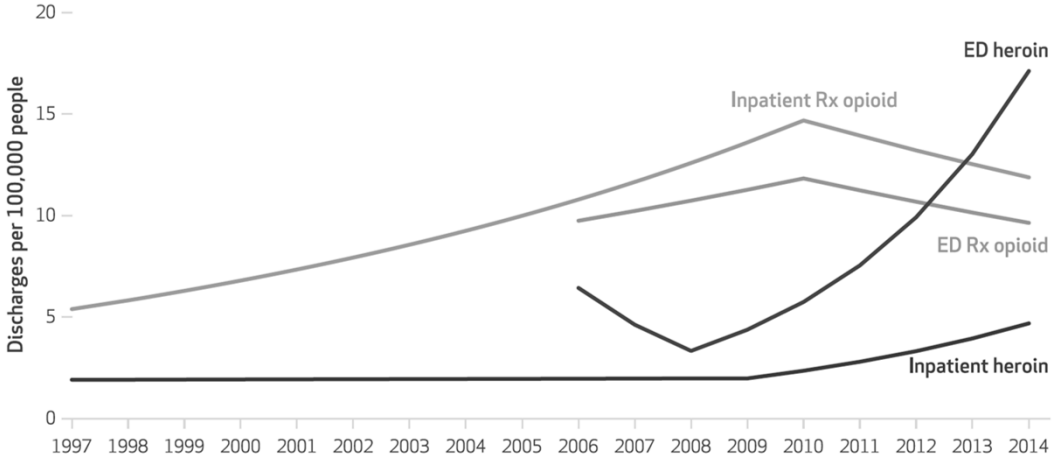
EXHIBIT 1

Population-based inpatient (1997–2014) and emergency department (ED) (2006–14) discharges for prescription opioid and heroin poisoning in the United States, by diagnostic group



Tedesco D, Asch SM, Curtin C, Hah JM, McDonald KM, Fantini MP, Hernandez-Boussard T. Opioid Abuse And Poisoning: Trends In Inpatient And Emergency Department Discharges. *Health Aff (Millwood).* 2017;36(10):1748-1753.

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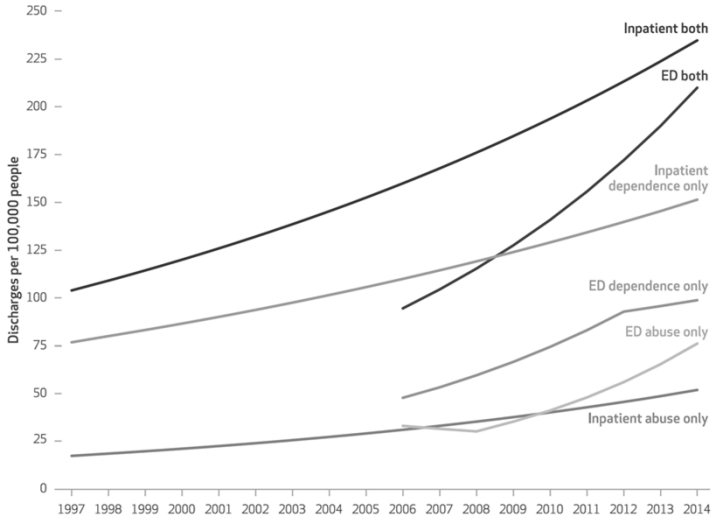
EXHIBIT 3

Population-based inpatient (1997–2014) and emergency department (ED) (2006–14) discharges for opioid dependence, abuse, and poisonings in the United States



Tedesco D, Asch SM, Curtin C, Hah JM, McDonald KM, Fantini MP, Hernandez-Boussard T. Opioid Abuse And Poisoning: Trends In Inpatient And Emergency Department Discharges. *Health Aff (Millwood).* 2017;36(10):1748-1753.

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11

Prescription Opioids

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

- Joseph EK, Reichling DB, Levine JD. Shared mechanisms for opioid tolerance and a transition to chronic pain. J Neurosci. 2010;30(13):4660-6.
- Vinik HR, Kissin I. Rapid development of tolerance to analgesia during remifentanil infusion in humans. Anesth Analg. 1998;86(6):1307-11.
- Chia YY, Liu K, Wang JJ, Kuo MC, Ho ST. Intraoperative high dose fentanyl induces postoperative fentanyl tolerance. Can J Anaesth. 1999;46(9):872-7.
- Mojadadi S, Jamali A, Khansarinejad B, Soleimanjahi H, Bamdad T. Acute morphine administration reduces cell-mediated immunity and induces reactivation of latent herpes simplex virus type 1 in BALB/c mice. Cell Mol Immunol. 2009;6(2):111-6.
- Wan Q, Wang X, Wang YJ, Song L, Wang SH, Ho WZ. Morphine suppresses intracellular interferon-alpha expression in neuronal cells. J Neuroimmunol. 2008;199(1-2):1-9.
- Daniell HW. Hypogonadism in men consuming sustained-action oral opioids. J Pain. 2002;3(5):377-84.
- Daniell HW. Opioid endocrinopathy in women consuming prescribed sustained-action opioids for control of nonmalignant pain. J Pain. 2008;9(1):28-36.

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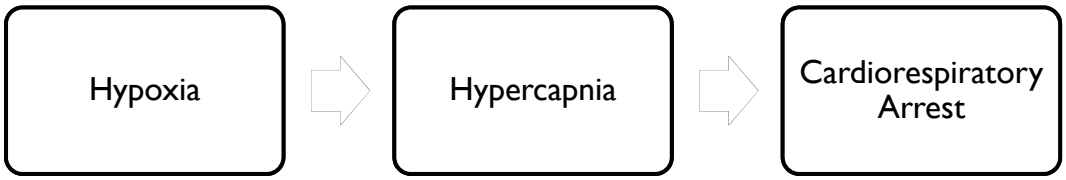
Opioid-Induced Respiratory Depression

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



- Dahan A, Aarts L, Smith TW. Incidence, Reversal, and Prevention of Opioid-induced Respiratory Depression. Anesthesiology 2010;112:226-38
- Zedler B, Xie L, Wang L, et al. Risk factors for serious prescription opioid-related toxicity or overdose among Veterans Health Administration patients. Pain medicine 2014;15:1911-29.

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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])

- Dilokthornsakul P, Moore G, Campbell JD, et al. Risk Factors of Prescription Opioid Overdose Among Colorado Medicaid Beneficiaries. *J Pain.* 2016;17(4):436-443.

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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

- Olfson M, Wall M, Wang S, Crystal S, Blanco C. Service Use Preceding Opioid-Related Fatality. *Am J Psychiatry.* 2017:appiajp201717070808.

PAINWEEK

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

- Breckenridge J, Clark JD. Patient characteristics associated with opioid versus nonsteroidal anti-inflammatory drug management of chronic low back pain. J Pain. 2003;4(6):344-50.
- Edlund MJ, Sullivan M, Steffick D, Harris KM, Wells KB. Do users of regularly prescribed opioids have higher rates of substance use problems than nonusers? Pain Med. 2007;8(8):647-56.

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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

- Deyo RA, Hallvik SE, Hildebran C, et al. Association Between Initial Opioid Prescribing Patterns and Subsequent Long-Term Use Among Opioid-Naive Patients: A Statewide Retrospective Cohort Study. *J Gen Intern Med.* Jan 2017;32(1):21-27.

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Take Home Points

- Limit refills
- Curb dosages
- Careful prescribing of long-acting opioids

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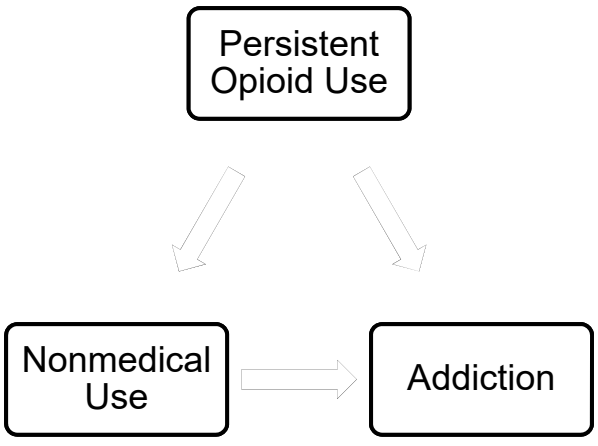

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Non-Medical Prescription Opioid Use

- 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]

- Banerjee G, Edelman EJ, Barry DT, et al. Non-medical use of prescription opioids is associated with heroin initiation among US veterans: a prospective cohort study. *Addiction.* Nov 2016;111(11):2021-2031.

PAINWEEK

Are We Placing Patients At Risk?

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

- Wasan AD, Correll DJ, Kissin I, O'Shea S, Jamison RN. Iatrogenic addiction in patients treated for acute or subacute pain: A systematic review. J Opioid Manag 2006;2:16–22.
- Ballantyne JC, LaForge KS. Opioid dependence and addiction during opioid treatment of chronic pain. Pain 2007;129:235–55

- **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**

- Passik SD, Hays L, Eisner N, Kirsh KL. Psychiatric and pain characteristics of prescription drug abusers
- entering drug rehabilitation. J Pain Palliat Care Pharmacother 2006;20:5–13.
- Potter JS, Hennessy G, Borrow JA, Greenfield SF, Weiss RD. Substance use histories in patients seeking treatment for controlled-release oxycodonedependence. Drug Alcohol Depend 2004;76:213–5.
- Hays L, Kirsh KL, Passik SD. Seeking drug treatment for OxyContin abuse: A chart review of consecutive admissions to a substance abuse treatment facility in Kentucky. J Natl Compr Canc Netw 2003;1:423–8.

PAINWEEK

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

- Steinman MA, Komaiko KD, Fung KZ, Ritchie CS. Use of Opioids and Other Analgesics by Older Adults in the United States, 1999-2010. Pain medicine 2014.
- Furlan A, Chaparro LE, Irvin E, Mailis-Gagnon A. A comparison between enriched and nonenriched enrollment randomized withdrawal trials of opioids for chronic noncancer pain. Pain research & management : the journal of the Canadian Pain Society = journal de la societe canadienne pour le traitement de la douleur 2011;16:337-51.
- Papaleontiou M, Henderson CR, Jr., Turner BJ, Moore AA, Olkhovskaya Y, Amanfo L, Reid MC. Outcomes associated with opioid use in the treatment of chronic noncancer pain in older adults: a systematic review and meta-analysis. Journal of the American Geriatrics Society 2010;58:1353-69.

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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

- Noble M, Treadwell JR, Tregear SJ, Coates VH, Wiffen PJ, Akafomo C, Schoelles KM. Long-term opioid management for chronic noncancer pain. The Cochrane database of systematic reviews 2010:CD006605.

PAINWEEK

Opioid Tapering

- Opioid detoxification as outpatient vs. inpatient is comparable
  - Day E, Strang J. Outpatient versus inpatient opioid detoxification: a randomized controlled trial. J Subst Abuse Treat. 2011;40(1):56-66.
- Successful opioid tapering in intensive outpatient and inpatient pain rehabilitation programs (↓pain, ↑functioning, ↓depression, ↓catastrophizing)
  - Crisostomo RA, Schmidt JE, Hooten WM, Kerkvliet JL, Townsend CO, Bruce BK. Withdrawal of analgesic medication for chronic low-back pain patients: improvement in outcomes of multidisciplinary rehabilitation regardless of surgical history. American journal of physical medicine & rehabilitation / Association of Academic Physiatrists. 2008;87(7):527-36.
  - Hooten WM, Townsend CO, Sletten CD, Bruce BK, Rome JD. Treatment outcomes after multidisciplinary pain rehabilitation with analgesic medication withdrawal for patients with fibromyalgia. Pain Med. 2007;8(1):8-16.
  - Baron MJ, McDonald PW. Significant pain reduction in chronic pain patients after detoxification from high-dose opioids. J Opioid Manag. 2006;2(5):277-82. Epub 2007/02/27. PubMed PMID: 17319259.
- Patients with comorbid chronic pain and opioid misuse can undergo tapering without ↑pain or ↓QOL
  - Nilsen HK, Stiles TC, Landro NI, Fors EA, Kaasa S, Borchgrevink PC. Patients with problematic opioid use can be weaned from codeine without pain escalation. Acta Anaesthesiol Scand. 2010;54(5):571-9.

PAINWEEK

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)
  - Cheung CW, Qiu Q, Choi SW, Moore B, Goucke R ,Irwin M .Chronic opioid therapy for chronic non-cancer pain: a review and comparison of treatment guidelines. Pain Physician. 2014;17: 401-14.

PAINWEEK

American Pain Society- American Academy of Pain Medicine

- "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

- Chou R, Fanciullo GJ, Fine PG, et al. Clinical guidelines for the use of chronic opioid therapy in chronic noncancer pain. J Pain. 2009;10: 113-30.

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American Pain Society- American Academy of Pain Medicine

"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."

- Chou R, Fanciullo GJ, Fine PG, et al.Clinical guidelines for the use of chronic opioid therapy in chronic noncancer pain. J Pain. 2009;10: 113-30.

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American Pain Society- American Academy of Pain Medicine

- 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

- Chou R, Fanciullo GJ, Fine PG, et al.Clinical guidelines for the use of chronic opioid therapy in chronic noncancer pain. J Pain. 2009;10: 113-30.

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American Pain Society- American Academy of Pain Medicine

- 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

- Chou R, Fanciullo GJ, Fine PG, et al.Clinical guidelines for the use of chronic opioid therapy in chronic noncancer pain. J Pain. 2009;10: 113-30.

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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

- Chou R, Fanciullo GJ, Fine PG, et al. Opioids for chronic noncancer pain: prediction and identification of aberrant drug-related behaviors: a review of the evidence for an American Pain Society and American Academy of Pain Medicine clinical practice guideline. *J Pain.* Feb 2009;10(2):131-146.

Figure 1. List of SOAPP-R questions

1. How often do you have mood swings?
2. How often have you felt a need for higher doses of medication to treat your pain?
3. How often have you felt impatient with your doctors?
4. How often have you felt that things are just too overwhelming that you can't handle them?
5. How often is there tension in the home?
6. How often have you counted pain pills to see how many are remaining?
7. How often have you been concerned that people will judge you for taking pain medication?
8. How often do you feel bored?
9. How often have you taken more pain medication than you were supposed to?
10. How often have you worried about being left alone?
11. How often have you felt a craving for medication?
12. How often have others expressed concern over your use of medication?
13. How often have any of your close friends had a problem with alcohol or drugs?
14. How often have others told you that you have a bad temper?
15. How often have you felt consumed by the need to get pain medication?
16. How often have you run out of pain medication early?
17. How often have others kept you from getting what you deserve?
18. How often, in your lifetime, have you had legal problems or been arrested?
19. How often have you attended an AA or NA meeting?
20. How often have you been in an argument that was so out of control that someone got hurt?
21. How often have you been sexually abused?
22. How often have others suggested that you have a drug or alcohol problem?
23. How often have you had to borrow pain medications from your family or friends?
24. How often have you been treated for an alcohol or drug problem?

PAINWEEK

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

Mark each box that applies	Female	Male
1. Family hx of substance abuse		
Alcohol	☐ 1	☐ 1
Illegal Drugs	☐ 2	☐ 2
Prescription drugs	☐ 4	☐ 4
2. Personal hx of substance abuse		
Alcohol	☐ 3	☐ 3
Illegal Drugs	☐ 4	☐ 4
Prescription drugs	☐ 5	☐ 5
3. Age (mark box if 16-45)	☐ 1	☐ 1
4. Hx of preadolescent sexual abuse	☐ 3	☐ 3
5. Psychologic disease		
ADD, OCD, bipolar, schizophrenia	☐ 2	☐ 2
Depression	☐ 1	☐ 1
Scoring totals:		

Scoring (Risk)
0-3 Low Risk
4-7 Moderate Risk
≥ 8 High Risk

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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

- Butler SF, Budman SH, Fernandez KC, et al. Development and validation of the Current Opioid Misuse Measure. Pain 2007;130:144-56.1950245.

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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

- Kahan M, Mailis-Gagnon A, Wilson L, Srivastava A ,National Opioid Use Guideline G.Canadian guideline for safe and effective use of opioids for chronic noncancer pain: clinical summary for family physicians. Part 1: general population. Can Fam Physician. 2011;57: 1257-66, e407-18.

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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

- Manchikanti L, Abdi S, Atluri S, et al.American Society of Interventional Pain Physicians (ASIPP) guidelines for responsible opioid prescribing in chronic non-cancer pain: Part 2--guidance. Pain Physician. 2012;15: S67-116.

PainWeek

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

- Manchikanti L, Kaye AM, Knezevic NN, et al. Responsible, Safe, and Effective Prescription of Opioids for Chronic Non-Cancer Pain: American Society of Interventional Pain Physicians (ASIPP) Guidelines. *Pain Physician.* Feb 2017;20(2S):S3-S92.

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CDC

GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN

- 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).

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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

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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

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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

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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.
  - http://www.oregon.gov/oha/HPA/CSI-HERC/PrioritizedList/7-1-2016%20Prioritized%20List%20of%20Health%20Services.pdf

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.

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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

- Page J, Traver R, Patel S, Saliba C. Implementation of a Proactive Pilot Health Plan-Driven Opioid Tapering Program to Decrease Chronic Opioid Use for Conditions of the Back and Spine in a Medicaid Population. *J Manag Care Spec Pharm.* 2018;24(3):191-196.

PAINWEEK

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

- Darnall BD, Ziadni MS, Stieg RL, Mackey IG, Kao MC, Flood P. Patient-Centered Prescription Opioid Tapering in Community Outpatients With Chronic Pain. *JAMA Intern Med.* 2018.

PAINWEEK

Facilitators of Opioid Tapering

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

- Kennedy LC, Binswanger IA, Mueller SR, et al. "Those Conversations in My Experience Don't Go Well": A Qualitative Study of Primary Care Provider Experiences Tapering Long-term Opioid Medications. *Pain Med.* 2017.

PAINWEEK

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

- Frank JW, Lovejoy TI, Becker WC, et al. Patient Outcomes in Dose Reduction or Discontinuation of Long-Term Opioid Therapy: A Systematic Review. *Ann Intern Med.* 2017;167(3):181-191.

PAINWEEK

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

- Frank JW, Lovejoy TI, Becker WC, et al. Patient Outcomes in Dose Reduction or Discontinuation of Long-Term Opioid Therapy: A Systematic Review. *Ann Intern Med.* 2017;167(3):181-191.

PAINWEEK

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)

- Frank JW, Lovejoy TI, Becker WC, et al. Patient Outcomes in Dose Reduction or Discontinuation of Long-Term Opioid Therapy: A Systematic Review. *Ann Intern Med.* 2017;167(3):181-191.

PAINWEEK

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)

- Frank JW, Lovejoy TI, Becker WC, et al. Patient Outcomes in Dose Reduction or Discontinuation of Long-Term Opioid Therapy: A Systematic Review. *Ann Intern Med.* 2017;167(3):181-191.

PAINWEEK

Patient-Provider Communication

Explaining

Negotiating

Difficult Conversations

Non-abandonment

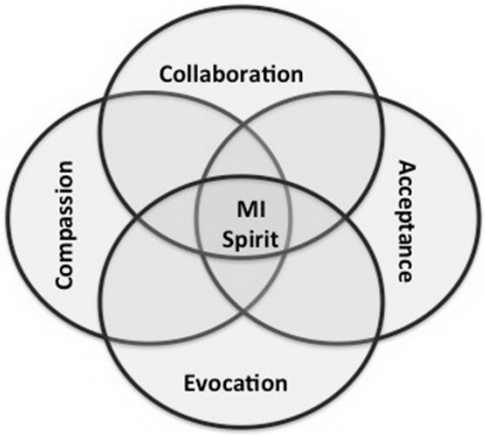
Matthias MS, Johnson NL, Shields CG, et al. "I'm Not Gonna Pull the Rug out From Under You": Patient-Provider Communication About Opioid Tapering. *J Pain.* 2017;18(11):1365-1373.

PAINWEEK

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

PAINWEEK



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.

Miller WR, Rollnick S. Motivational interviewing : helping people change. 3rd ed. New York, NY: Guilford Press, 2013.

PAINWEEK

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

PaiNweek

Motivational Interviewing

Tools

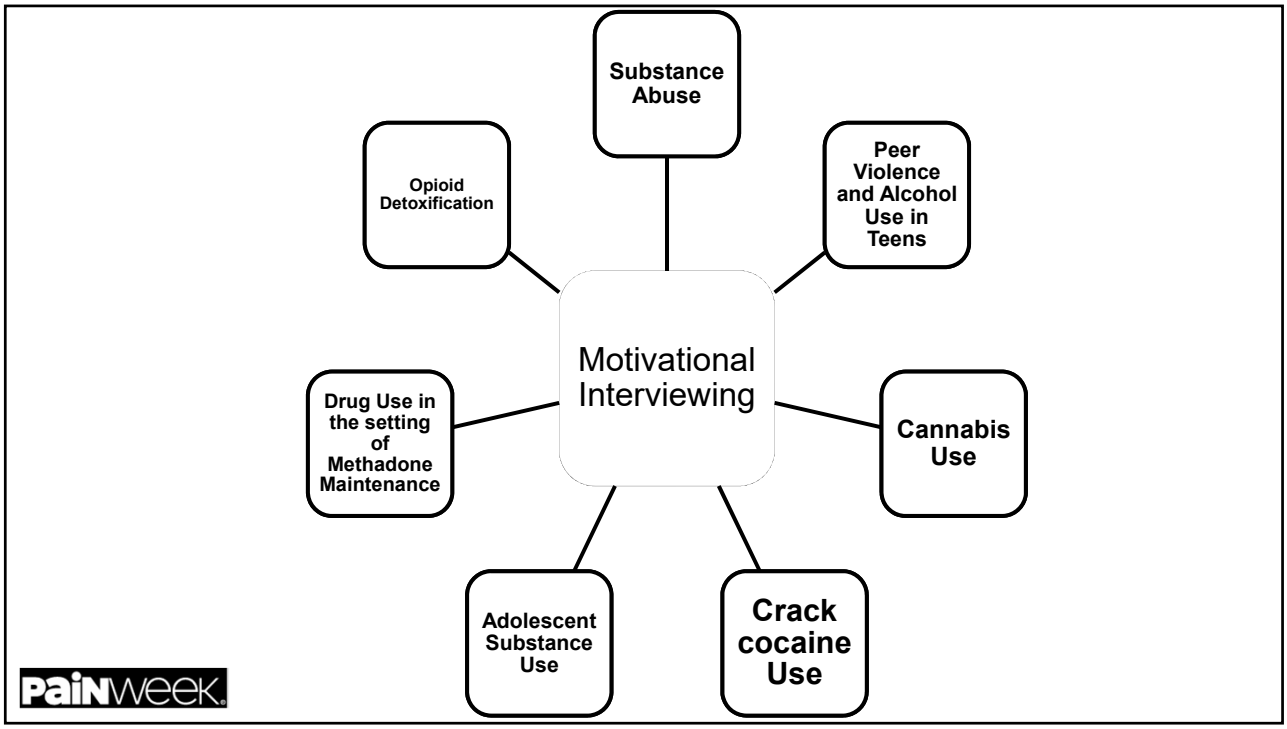
- Open questions
- Affirmations
- Reflections
- Summary

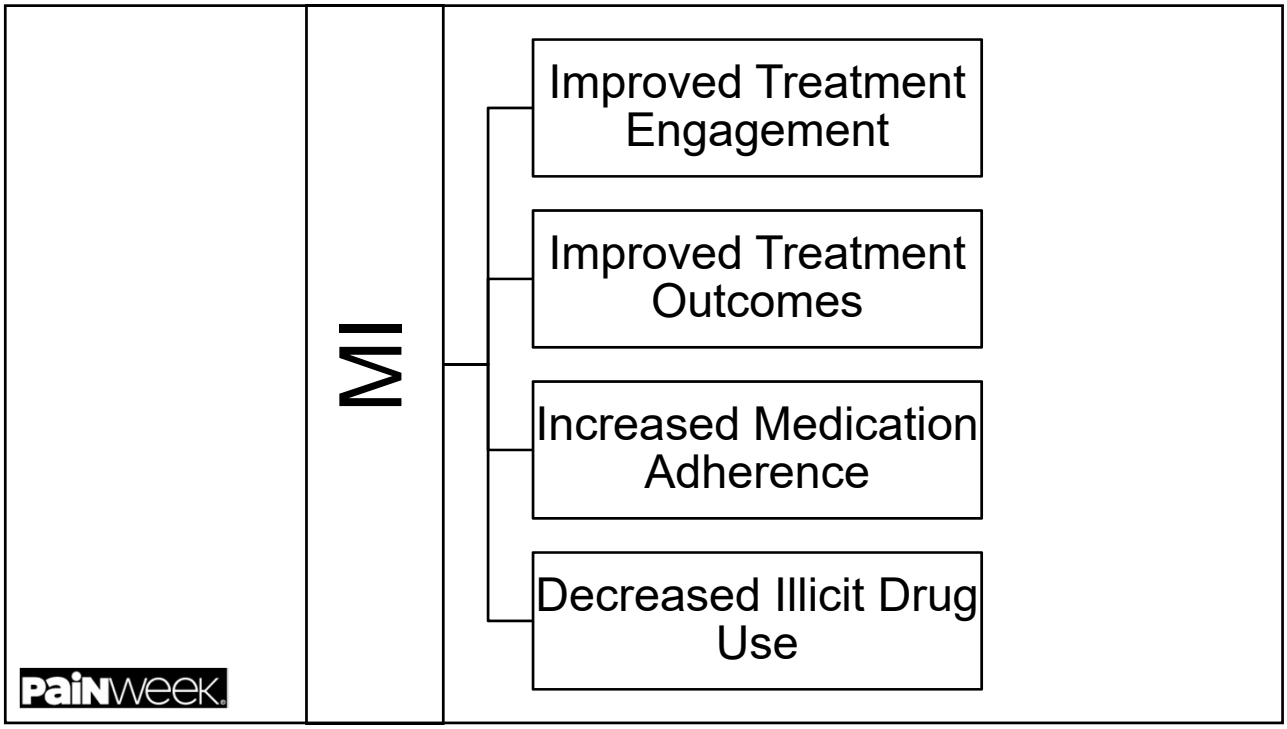
Change Talk

- 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…"

PaiNweek


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


MI
Improved Treatment Engagement
Improved Treatment Outcomes
Increased Medication Adherence
Decreased Illicit Drug Use
PaiNweek

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

- Sullivan MD, Turner JA, DiLodovico C, et al. Prescription Opioid Taper Support for Outpatients With Chronic Pain: A Randomized Controlled Trial. *J Pain.* Mar 2017;18(3):308-318.

PAINWEEK

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

- Sullivan MD, Turner JA, DiLodovico C, et al. Prescription Opioid Taper Support for Outpatients With Chronic Pain: A Randomized Controlled Trial. *J Pain.* Mar 2017;18(3):308-318.

PAINWEEK

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

PAINWEEK