PAINWEEK

Policies and Practicalities:
Focusing on the Patient, Not the Opioid

Jennifer Hah, MD, MS

Disclosures

- Nothing to disclose

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Learning Objectives

- Demonstrate knowledge of current legislation and guidelines regarding opioid prescribing and opioid tapering in the context of chronic noncancer pain
- Review current evidence-based approaches to opioid tapering in chronic noncancer pain
- Explain the benefits of opioid tapering in terms of improvements in pain, function, and mood
- Identify the role of behavioral interventions in the management of pain and the data supporting their use

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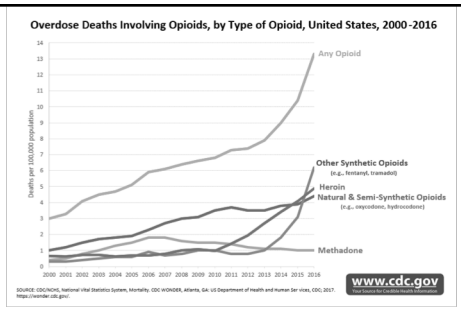

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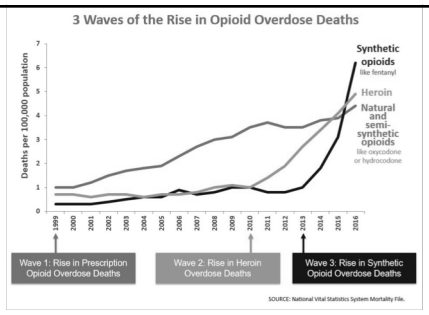

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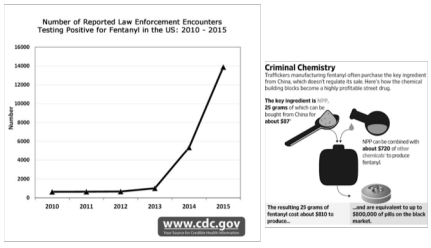

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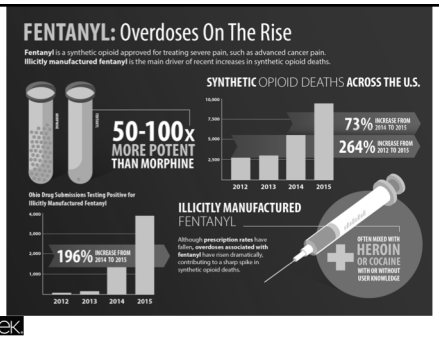

Opioid Bills in Congress

- **H.R. 6, the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act:** bipartisan bill advancing treatment and recovery initiatives, improving prevention, protecting communities, and bolstering efforts to fight deadly illicit synthetic drugs like fentanyl
- Require all state Medicaid programs to have a beneficiary assignment program that identifies Medicaid beneficiaries at-risk for substance use disorder (SUD) and assigns them to a pharmaceutical home program, which must set reasonable limits on the number of prescribers and dispensers that beneficiaries may utilize (H.R. 5808)
- Require state Medicaid programs to have safety edits in place for opioid refills, monitor concurrent prescribing of opioids and certain other drugs, and monitor antipsychotic prescribing for children (H.R. 5799)

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Opioid Bills in Congress (cont'd)

- **H.R. 6, the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act:**
- Add a review of current opioid prescriptions and, as appropriate, a screening for opioid use disorder (OUD) as part of the Welcome to Medicare initial examination (H.R. 5798)
- Incentivize post-surgical injections as a pain treatment alternative to opioids by reversing a reimbursement cut for these treatments in the Ambulatory Service Center setting, as well as collect data on a subset of codes related to these treatments (H.R. 5804)
- Require e-prescribing, with exceptions, for coverage of prescription drugs that are controlled substances under the Medicare Part D program (H.R. 3528)

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Opioid Bills in Congress (cont'd)

- H.R.4275 - Empowering Pharmacists in the Fight Against Opioid Abuse Act: This bill requires the Department HHS to develop and disseminate training programs and materials on: (1) the circumstances under which a pharmacist may refuse to fill a controlled substance prescription suspected to be fraudulent, forged, or indicative of abuse or diversion; and (2) federal requirements related to such refusal.
- H.R.5473 - Better Pain Management Through Better Data Act of 2018
- H.R.5811 - Long-Term Opioid Efficacy Act of 2018

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2019 Medicare Advantage and Part D Rate Announcement and Call Letter 4.2.18

- Opioid naïve patients: To reduce the potential for chronic opioid use or misuse, we expect all Part D sponsors to implement a hard safety edit to limit initial opioid prescription fills for the treatment of acute pain to no more than a 7 days' supply.
- High risk opioid users: We are building upon and expanding the Overutilization Monitoring System (OMS), which has already significantly reduced the number of high risk beneficiaries. The OMS retrospectively identifies those beneficiaries we consider at significant risk (using high levels of opioids from multiple prescribers and pharmacies). Sponsors review these cases and perform case management with the beneficiaries' prescribers.

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2019 Medicare Advantage and Part D Rate Announcement and Call Letter 4.2.18 (cont'd)

- Chronic opioid users: We expect all sponsors to implement real-time safety alerts at the time of dispensing as a proactive step to engage both patients and prescribers about overdose risk and prevention.
- We expect all sponsors to implement an opioid care coordination edit at 90 morphine milligram equivalent (MME) per day. This formulary-level safety edit should trigger when a beneficiary's cumulative MME per day across their opioid prescriptions reaches or exceeds 90 MME. In implementing this edit, sponsors should instruct the pharmacist to consult with the prescriber, document the discussion, and if the prescriber confirms intent, use an override code that specifically states that the prescriber has been consulted. Sponsors will have the flexibility to include a prescriber and/or pharmacy count in the opioid care coordination edit. Sponsors will also have the flexibility to implement hard safety edits (which can only be overridden by the sponsor) and set the threshold at 200 MME or more and may include prescriber/pharmacy counts.

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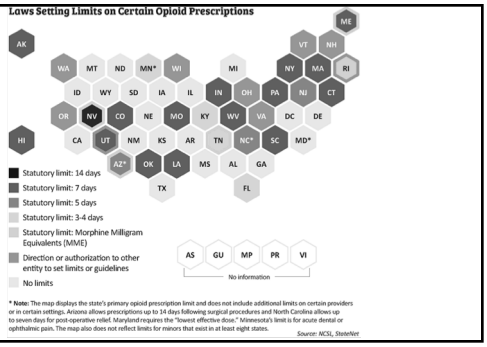

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State Legislation

- Most legislation limits initial opioid prescribing to a certain number of days, 7 days is most commons (or 3, 5, or 14 days)
- In a few cases, states also set dosage limits (morphine milligram equivalents, or MMEs)
- Nearly half the states with limits specify that they apply to treating acute pain, and most states set exceptions for chronic pain treatment, palliative care, cancer pain treatment, MAT, or provider judgement
- Many laws stipulate that any exceptions must be documented in the patient's medical record
- Certain states authorize other entities (eg, provider regulatory boards, commercial insurers, state Medicaid programs) to implement policies for prescribing certain controlled substances

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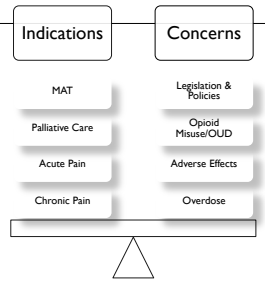
Balancing Opioid Prescribing



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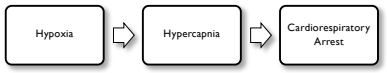
Opioid-Induced Respiratory Depression

- 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.

PAINWEEK

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Risk Factors for Prescription Opioid Overdose

- Mean OME >50 mg/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])

Dunn KM, Saunders KW, Rutter CM, et al. Opioid prescriptions for chronic pain and overdose: a cohort study. *Ann Intern Med*. 2010;152(2):85-92.

PAINWEEK

Overdose Deaths and Chronic Pain

- 61.5% of overdose decedents received a chronic noncancer pain diagnosis 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 nonusers with chronic pain
- Pain intensity does not predict treatment with opioids vs nonopioid 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.

PAINWEEK

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

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

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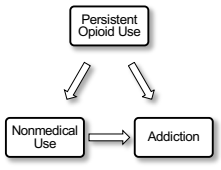

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Nonmedical Prescription Opioid Use

- Prospective, multisite, observational study
- 3396 HIV-infected and uninfected patients enrolled into the Veterans Aging Cohort Study, followed from 2002-2012
- Nonmedical 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

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)
  - Criscotomo 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 (eg, 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.

PAINWEEK

American Pain Society—
American Academy of Pain Medicine (cont'd)

"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.

PAINWEEK

American Pain Society—
American Academy of Pain Medicine (cont'd)

- 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.

PAINWEEK

American Pain Society— American Academy of Pain Medicine (cont'd)

- 10% dose reduction weekly
- 25% to 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.

PAINWEEK

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

Figure 1. List of SOAPP-R questions

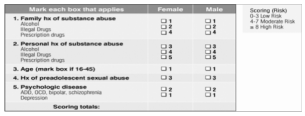
1. How often do you have mood swings?
2. How often have you felt a need for higher doses of medication to treat your pain?
3. How often have you felt impatient with your doctors?
4. How often have you felt that things are just too overwhelming that you can't handle them?
5. How often is there tension 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?

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.

PAINWEEK

ORT

- Maximum score=26
- 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 Illegal Drugs Prescription drugs	☐ 1 ☐ 2 ☐ 4	☐ 1 ☐ 2 ☐ 4
2. Personal hx of substance abuse Alcohol Illegal Drugs Prescription drugs	☐ 3 ☐ 4 ☐ 5	☐ 3 ☐ 4 ☐ 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 Depression	☐ 2 ☐ 1	☐ 2 ☐ 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.

PAINWEEK

American Society of Interventional Pain Physicians

"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 (cont'd)

"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
  - –Antineuropathics
  - –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.

PAINWEEK

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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GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN

Opioid Discontinuation/Tapering

- No improvements in pain and function
- High-risk regimens (eg, 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 (eg, an event leading to hospitalization or disability) or warning signs of serious adverse events

PAINWEEK

GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN

Opioid Discontinuation/Tapering (cont'd)

- 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

PAINWEEK

GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN

Opioid Discontinuation/Tapering (cont'd)

- 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.

> 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.

http://www.oregon.gov/oha/HPA/CSI-HERC/PrioritizedList/0116%20Prioritized%20List%20of%20Health%20Services.pdf

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Health Plan Driven Opioid Tapering (cont'd)

- Provider Outreach (Introductory Letter, Summary Letter—an example 10% taper plan, a nonopioid analgesic therapy resource, a noninterventional 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.

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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

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.

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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 (cont'd)

- 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 (cont'd)

- 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 (cont'd)

- 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

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.

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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

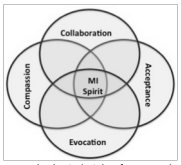
MI-Based Interventions (cont'd)

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



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

Pain Types

Acute Pain	Chronic Pain
▪ Hurt = Harm – Avoidance decreases damage	▪ Hurt ≠ Harm – Fear-avoidance cycle
▪ Etiology: – Clear pathway – Often single cause	▪ Etiology: – Many unknowns – Multifactorial
▪ Treatment Course – Fixed end point – Immobilization often essential for recovery – Medications	▪ Treatment Course – No fixed end point – Immobilization can worsen condition – Medications: Caution

PAINWEEK

Chronic Pain Management

- Development of active self-management tools
- Goals focus on functional improvement and increasing self-efficacy rather than pain reduction

PAINWEEK

Chronic Pain Management (cont'd)

- Medical optimization
  - Physician, NP, PA
- Physical reconditioning
  - Rehabilitation provider (PT, OT)
- Behavioral/lifestyle modification
  - Pain psychologist

PAINWEEK

Chronic Pain Management Dilemma

- Medical optimization
  - Physician, NP, PA
- ~~Physical reconditioning~~
  - ~~Rehabilitation provider (PT, OT)~~
- ~~Behavioral/lifestyle modification~~
  - ~~Pain psychologist~~

PAINWEEK

Stanford Comprehensive Interdisciplinary Pain Program (SCIPP)

- Typical patient
- Pain conditions accepted
- Admission criteria

PAINWEEK

Interdisciplinary Treatment

- Physical therapy
- Occupational therapy
- Medication optimization (cocktail)
- Lifestyle/behavioral modification

PAINweek

Scheduled Activities

- AM rounds
- Physical therapy
- Occupational therapy
- Pain coping skills class
- Individual provider visits

PAINweek

Unscheduled Activities

- Independent practice
- Walking
- Activity tracking log

PAINweek

Behaviors Reinforced

- Consistent across all team members, including nursing
- Application of self-management skills
- Increased activity levels
- Focus on functioning

PAINWEEK

Behaviors Not Reinforced

- Pain behavior
- Medication focus
- Somatic complaints
- Inactivity

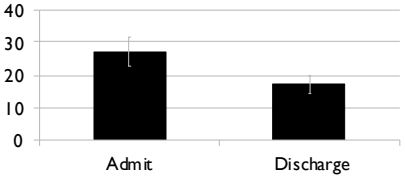
PAINWEEK

SCIPP Outcomes

- n = 44 (19 male, 25 female)
- Minimum of 1 pain diagnosis
- Assessments:
  - Center for Epidemiologic Study of Diseases—Depression Scale (CESD)
  - McGill Pain Questionnaire (MPQ)
  - McGill Pain Questionnaire-Visual-Analog Scale (MPQ-VAS)
  - Profile of Mood States (POMS)
- Administered within 24 hours of admission and discharge

PAINWEEK

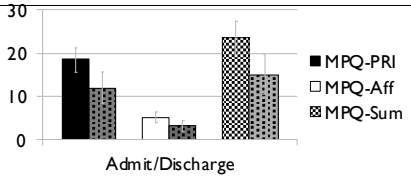
CESD



Total CESD score was significantly lower at discharge than at admission (p<.001).

PAINWEEK

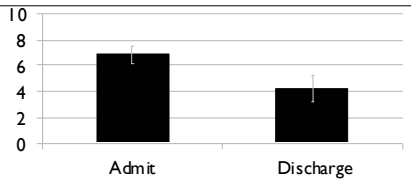
MPQ



Significant reductions were detected on the MPQ sum score (p=.005) and each of the MPQ subscales – PRI (single item pain rating index; p=.007) and Affective (p=.01).

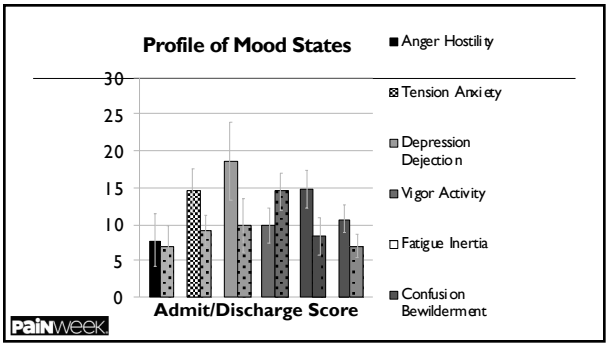
PAINWEEK

MPQ-VAS



Average pain as assessed by the MPQ-VAS was also significantly lower upon discharge than at admission (p<.001).

PAINWEEK



SCIPP Outcomes

- Significant changes on
  - CESD (p<.001)
  - MPQ-VAS average pain (p<.001)
  - MPQ summary score (p=.005)
  - MPQ pain rating index (p=.007)
  - MPQ affective score (p=.01)
  - POMS Tension-Anxiety (p=.005)
  - POMS Depression-Dejection (p=.001)
  - POMS Vigor-Activity (p=.005)
  - POMS Fatigue-Inertia (p=.002)
  - POMS Confusion-Bewilderment (p=.003)
  - POMS Total Mood Disturbance (p=.01)
- No significant difference on
  - POMS Anger-Hostility

PAINWEEK

Outpatient Application

- Participation in CBT-based coping skills class
- Concurrent medication reduction
- Consider joint psych-MD appointments

PAINWEEK