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Identifying Patient Who Benefit from Chronic Opioid Therapy

Steven Stanos, DO
Medical Director, Swedish Health System
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Seattle, WA

Past President, American Academy of Pain Medicine
August 9, 2019

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DO ✓ Identifying Patient Who Benefit from Chronic Opioid Therapy

MAY ✓ Identifying Patient Who Benefit from Chronic Opioid Therapy

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Disclosures

- Pfizer (consulting)
- Scilex (consulting)
- Salix (consulting)

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Overview

- Considerations around decision for opioid therapy
- Extending beyond opioid “analgesia”
- Should focus and emphasis change?
- Who is not a good candidate ?
- “Patient-centered” to the test
- Can we use current “tools” more effectively?
- Two patient stories

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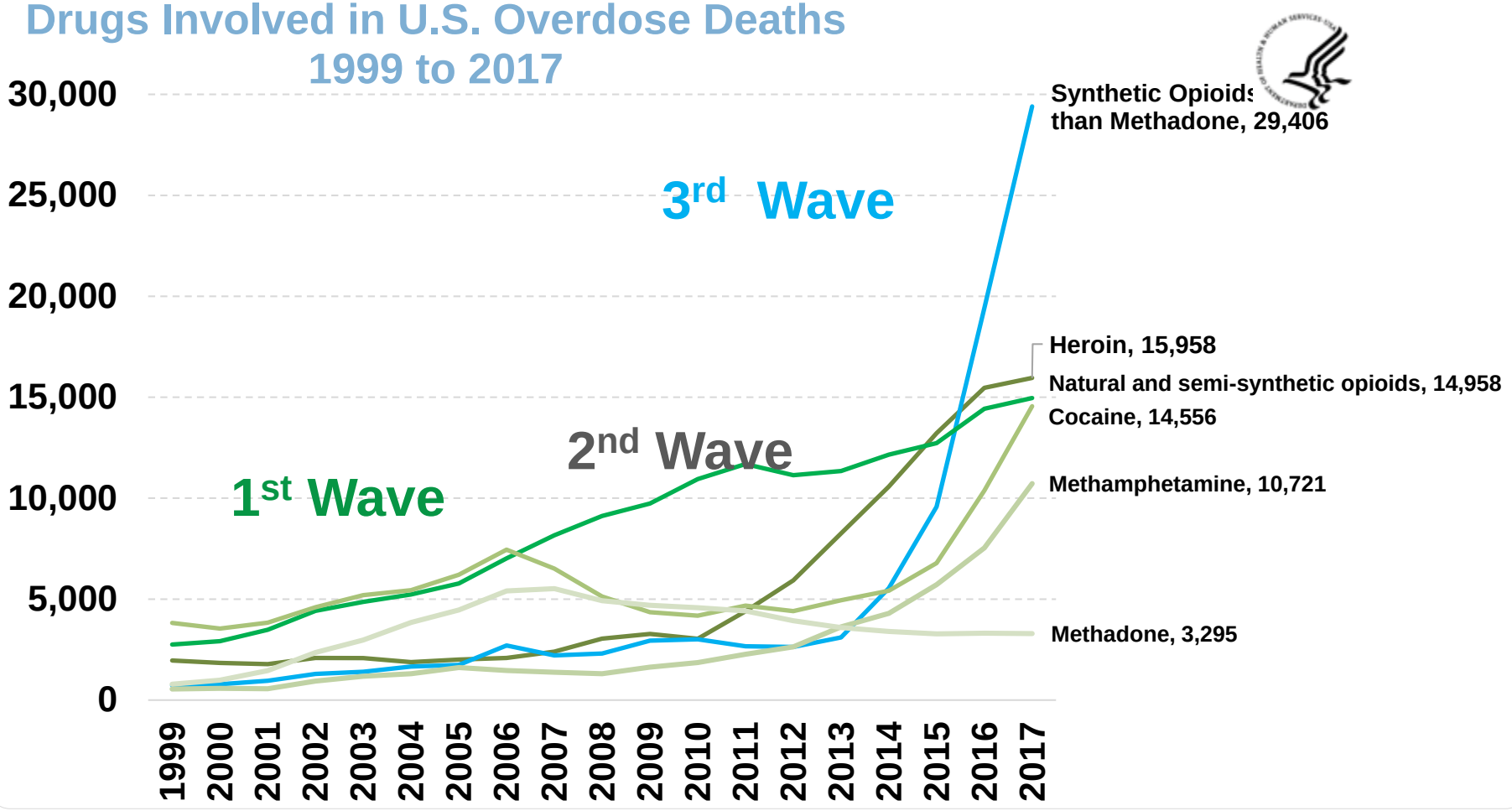
NIH National Institute on Drug Abuse

Drugs Involved in U.S. Overdose Deaths 1999 to 2017



4th Wave: Pharmacovigilance and Pain Management Vacuum

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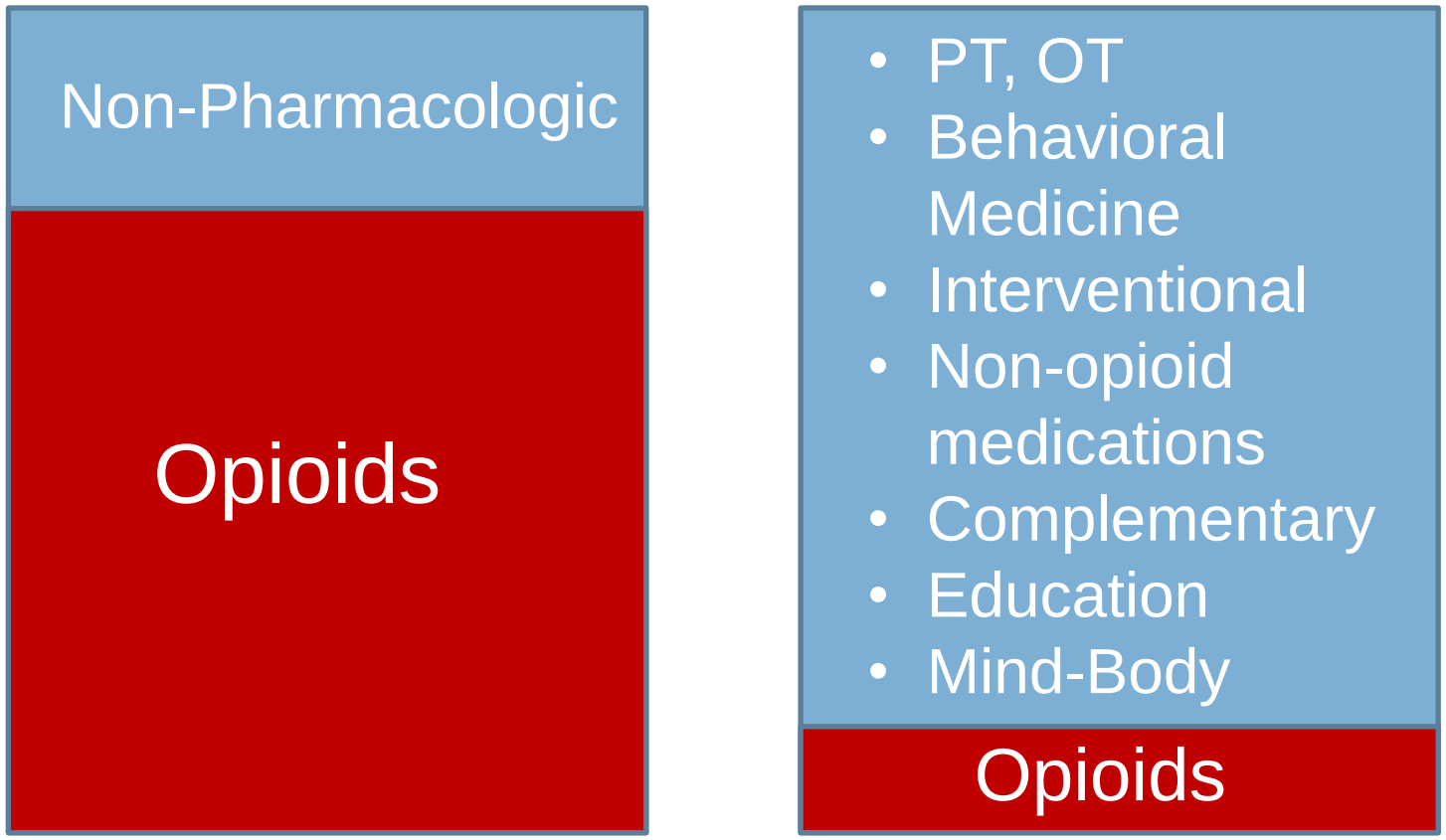
Opioid Therapy: Current & Future State

Therapeutic Options



PAST → PRESENT → FUTURE

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Why is treating pain such a challenge?

Repent !

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?

“Pain”

Most discussion of pain begin with a definition, which quickly reveals its inadequacy, followed by a quasi-philosophical discussion of the mind-body problem, with the author finally opting for dualism, psychophysical parallelism or some kind of monism in which the pain experience is epiphenomenal to the ‘real’ events taking place in the tissues and nervous system.”

- Clark and Hunt, 1971

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FOUR CONSIDERATIONS

1. Pain Uniformity Myth
2. Negative Affect
3. Opioid Receptor: Beyond Analgesia
4. Pitfalls of Unidimensional Tools

VAS: Visual Analogue Scale

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1. Patient “Uniformity Myth”

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Patient "Uniformity Myth"

- Chronic pain patients are heterogeneous
- Different combinations of physical, cognitive, behavioral, and affective contributions to experience of pain
- Approaches based on patient characteristics or patient preferences
- Applying principles of patient-centered approach for opioid management should be synonymous with ANY intervention

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2. Negative Affect

Negative Affect

- Correlates with increased pain intensity and poorer function with LBP patients
- Cancer postoperative pain: magnitude of negative affective symptoms correlated with higher opioid doses
- NA as a stronger predictor of opioid misuse vs pain level
- NA psychopathology predicts poor outcome in chronic LBP

1. Dworkin et al 1986
2. Gatchel and Dersh, 2002.
3. Rapp 1996
4. Morley and Williams 2002.

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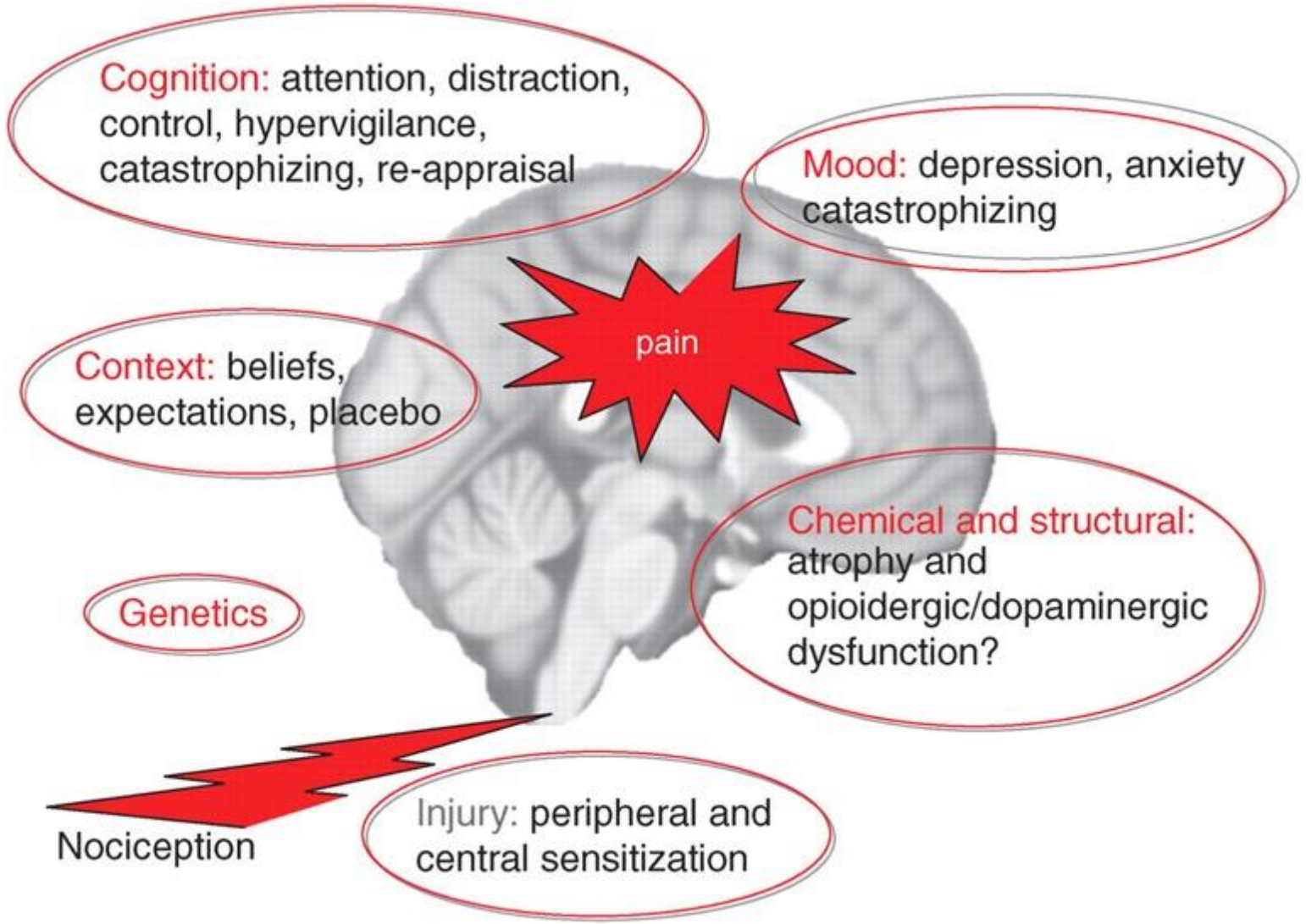
Negative Affect and Diminished Opioid Analgesia & Increased Opioid Misuse

- Negative Affect: depression, anxiety catastrophizing
- CLBP study: 6.5 month prospective study
- Treatment: opioid titration phase , 4 month continuation phase
- **Results**:
  - 25% dropout rate
  - High NA group: higher daily MED vs lower pain relief
  - High NA group: greater rate of opioid misuse (39% vs 8%), and greater opioid side effects

Wasan A, et al. *Anesthesiology* 2015;123:861-872.

Factors That influence Nociceptive Inputs Affecting pain perception



Tracey I. *Br J Anaesth.* 2008;101(1):32-39.

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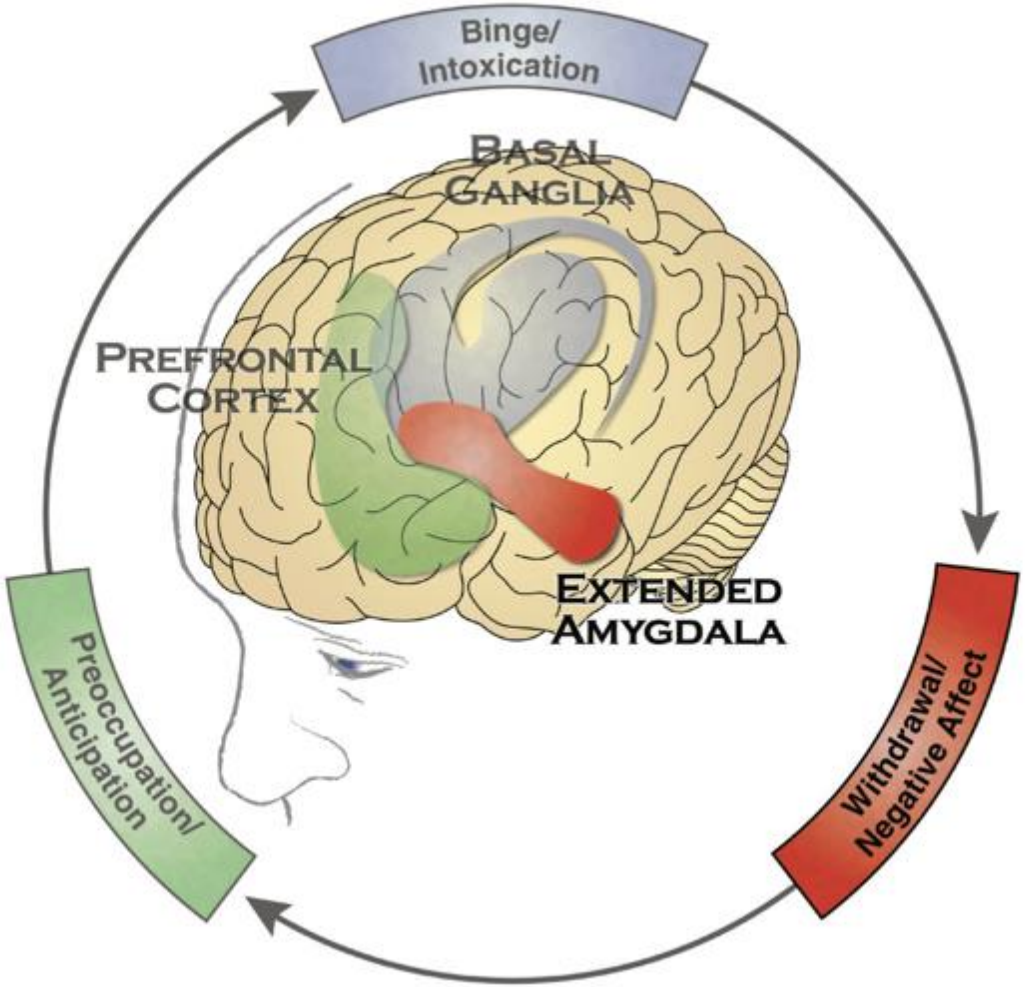
General

Analgesia
Altered mood
Decreased anxiety
Respiratory depression
Inhibition central reflexes
(-) GI motility
Cough suppression
(-) CRF, ACH
Miosis
Pruritus, nausea, vomiting



Reinforcing Effects

Reduce anxiety
Decrease boredom
Decrease aggression
Increase self-esteem

1. Epstein S. In: *Clinical Manual Addiction Psychopharmacology*, 2005.
2. *Facing Addiction In America. Surgeon General's Report*. US Dept. HHS, 2016.

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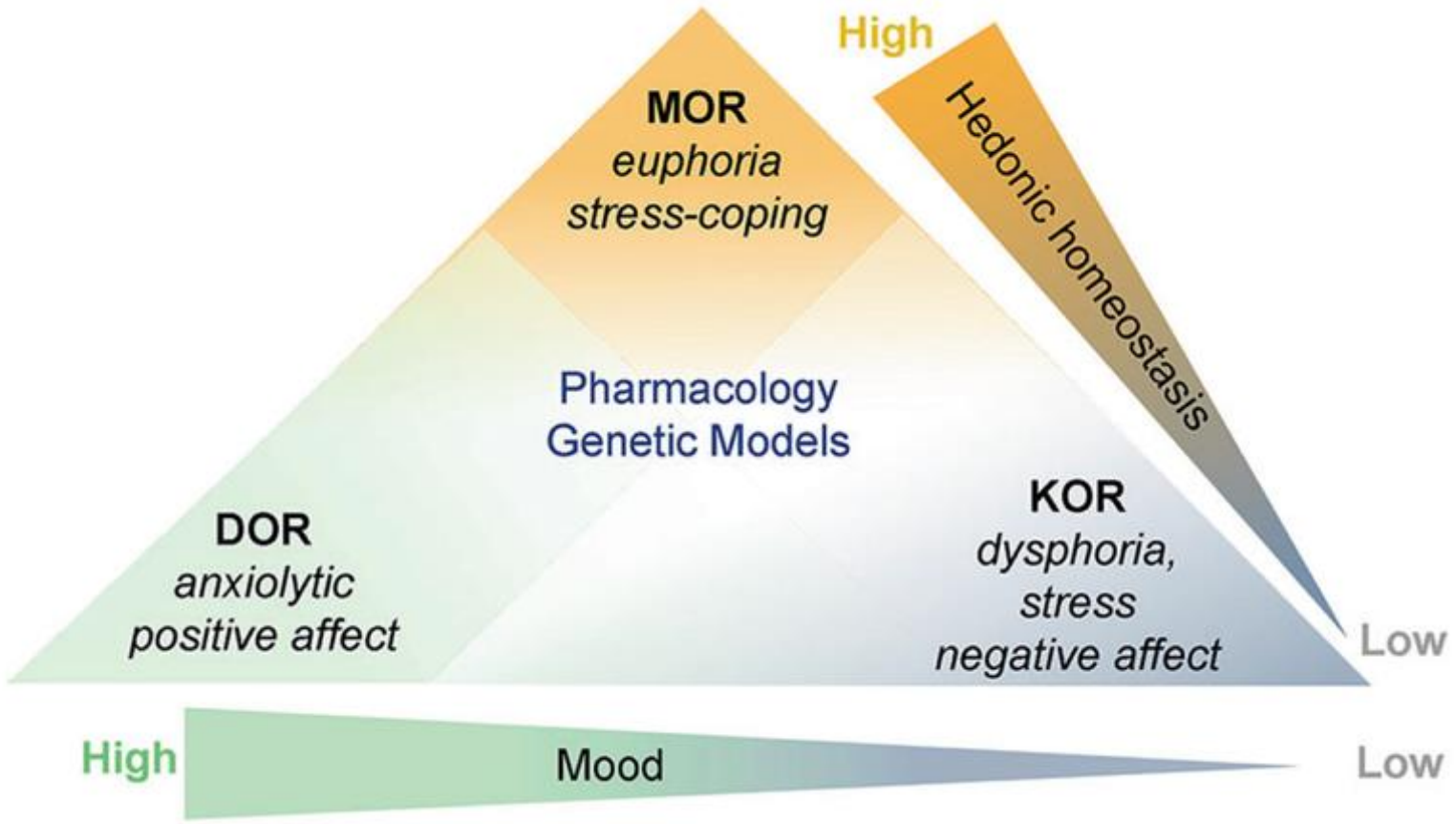
Opioid Receptor Activity
Mood, Euphoria, Reward Continuum



Valentino R Vokow N, *Neuropsychopharmacology* 2018;43:2514-2520.

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4. Unidimensional Pain Measures

Pain as Vital Sign

- Numeric Rating Scale (NRS) (0-10)
- Visual Analog Scale (0-10)

Multidimensional Pain Tools

- PEG_1
- BPI_2, SF-36 Bodily Pain, Roland Morris Disability Questionnaire
- PROMIS-PI_3
- Overall Benefit of Analgesic Score $(OBAS)_4$
- Clinically Aligned Pain Assessment Tool $(CAPA)_5$

1.Krebs E, et al. *J Gen Intern Med*. 2009; 24;733-738.
2.Cleeland C Ryan K. *Ann Acad Med Singapre* 1994;23:129-138.
3.Amtmann D, et al. *Pain* 2010;150:173-182.
4.Lehman N, et al. *British J Anaesthesia* 2010;105:511-518.
5.Donaldson and Chapmen. 2013: Univ Utah Dept Aneasthesiology.

Use tools in a patient-centered manner or don't use them at all !

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Follow Up Visits: Objective or Metrics

WAC 246-919-880; 885; WAC 246-853-700; WAC 246-840-470

Objectives or metrics to be used to determine treatment success if opioids are to be continued:

(a) Change in pain level (P)

(b) Change in psychosocial function (E)

(c) Change in physical function (G)

(d) Additional indicated diagnostic evaluations or other treatments

Pain, **E**njoyment in Life, **G**eneral Activity

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PEG 3

1 What number best describes your pain on average in the past week?

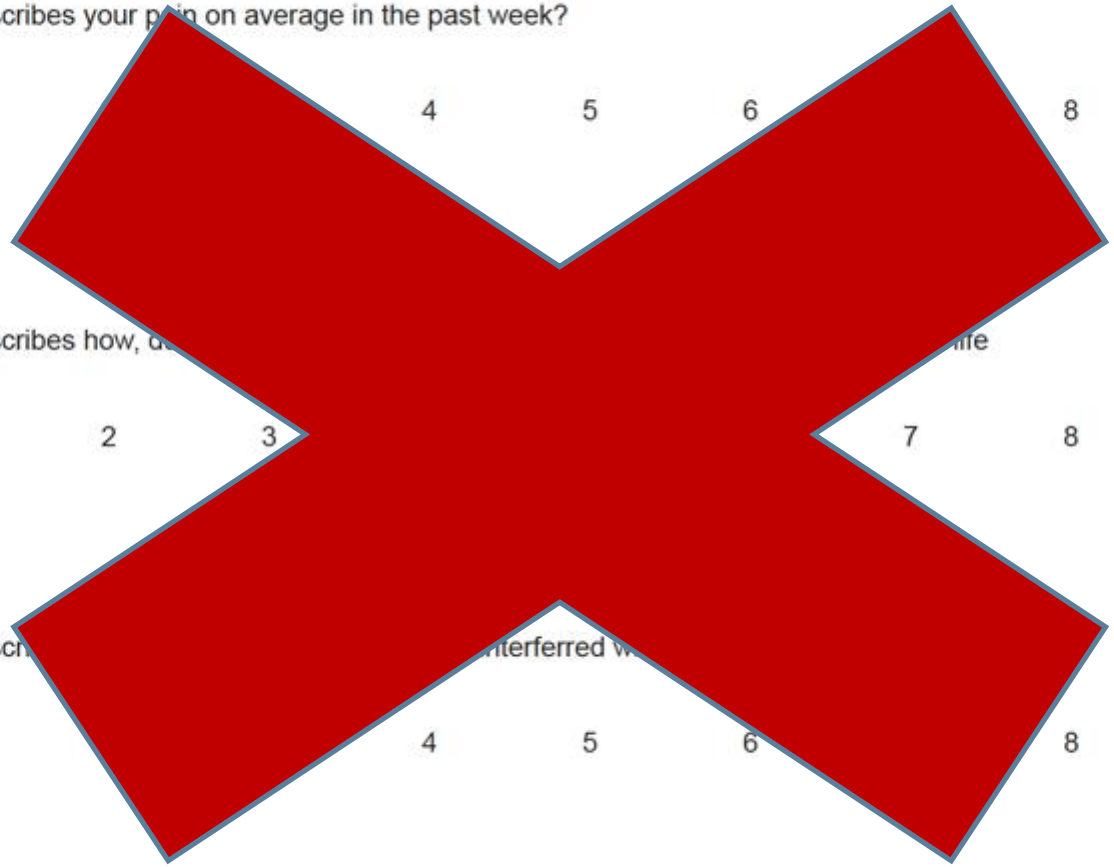
0	1	4	5	6	8	9	10
No Pain							Pain as bad as you can imagine

2 What number best describes how, d… life

0	1	2	3	7	8	9	10
No Pain							Pain as bad as you can imagine

3 What number best descr… interferred w…

0	1	4	5	6	8	9	10
No Pain							Pain as bad as you can imagine



Krebs E, et al. PEG Scale Development and Validation. *J Gen Intern Med* 2009;24(6):733-8.
Cleeland CS, Ryan K. *Ann Acad Med Singapore*. 1994;231:129-38.

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PEG 3

1 What number best describes your pain on average in the past week?

0	1	2	3	4	5	6	7	8	9	10
No Pain										Pain as bad as you can imagine

2 What number best describes how, during the past week, pain has interferred with your enjoyment of life

0	1	2	3	4	5	6	7	8	9	10
No Pain										Pain as bad as you can imagine

3 What number best describes how, during past week pain has interferred with you general activity?

0	1	2	3	4	5	6	7	8	9	10
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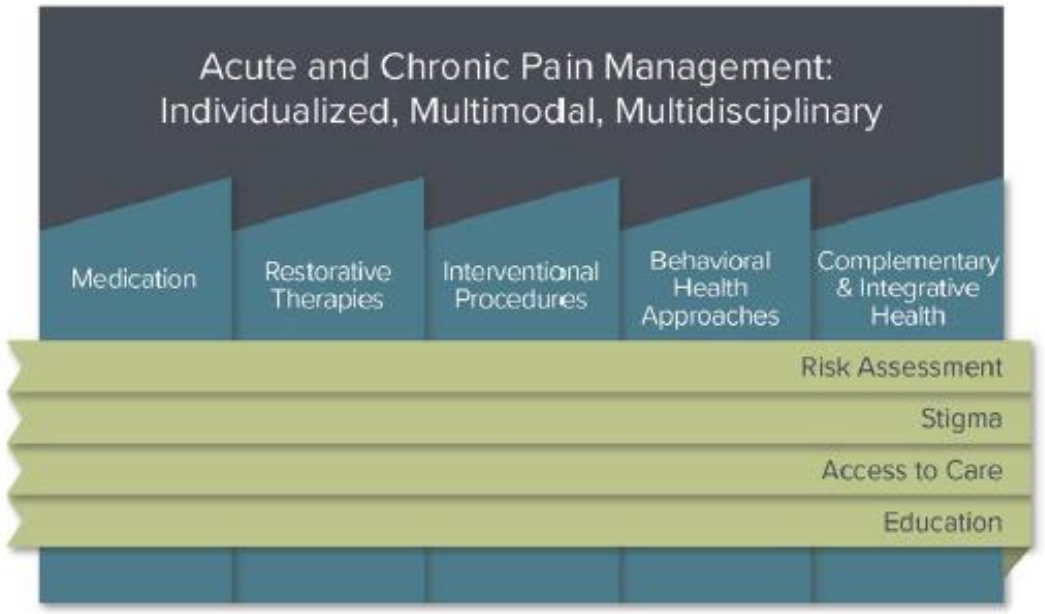
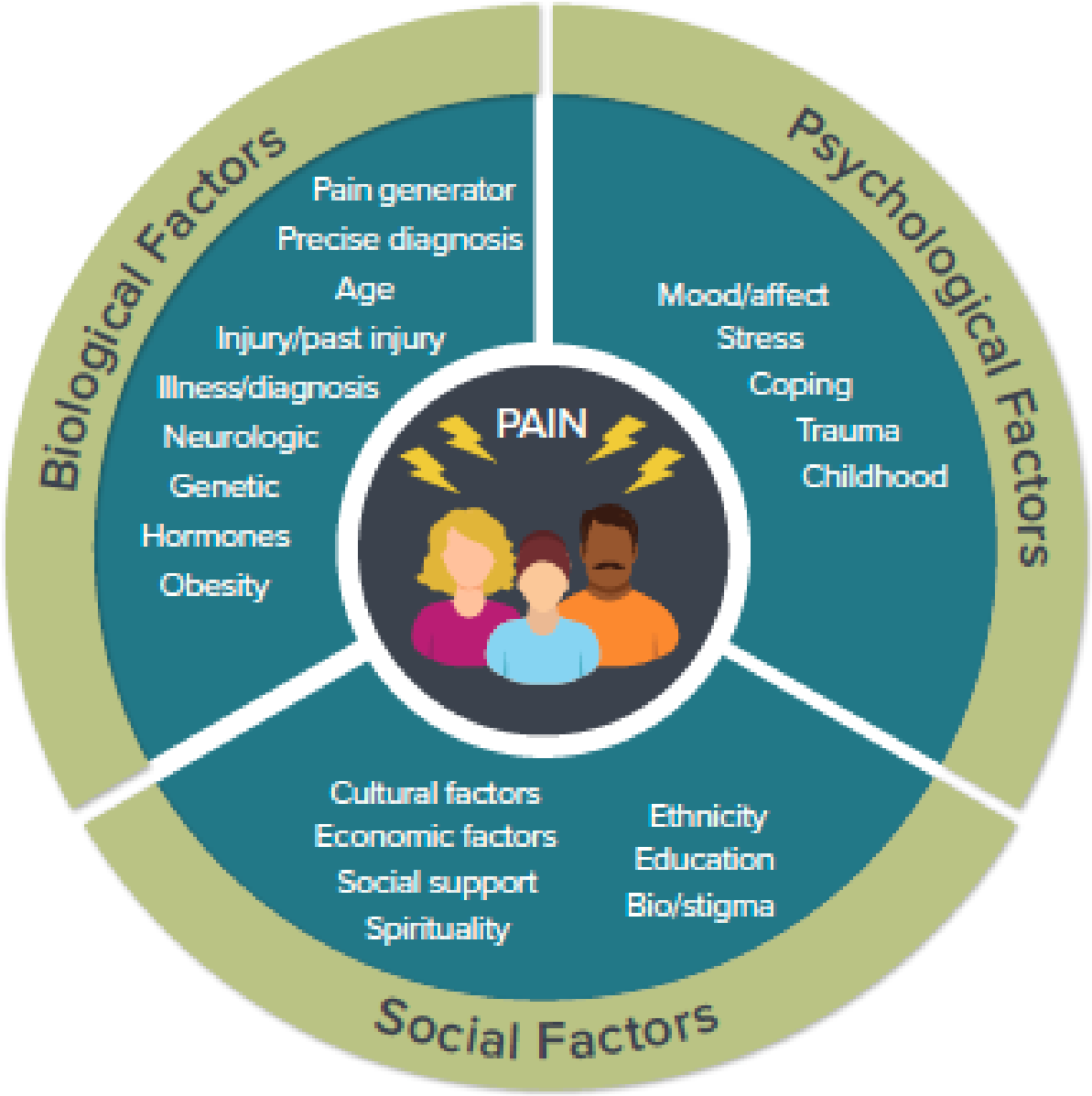
Cleeland CS, Ryan K. *Ann Acad Med Singapore*. 1994;231:129-38.

Biopsychosocial Model of Pain Management





U.S. Department of Health and Human Services. Pain Management Best Practices Inter-Agency Task Force Report: Updates, Gaps, Inconsistencies, and Recommendations. Published May 9, 2019. Available at https://www.hhs.gov/sites/default/files/pmtf-final-report-2019-05-23.pdf. Accessed June 1, 2019.

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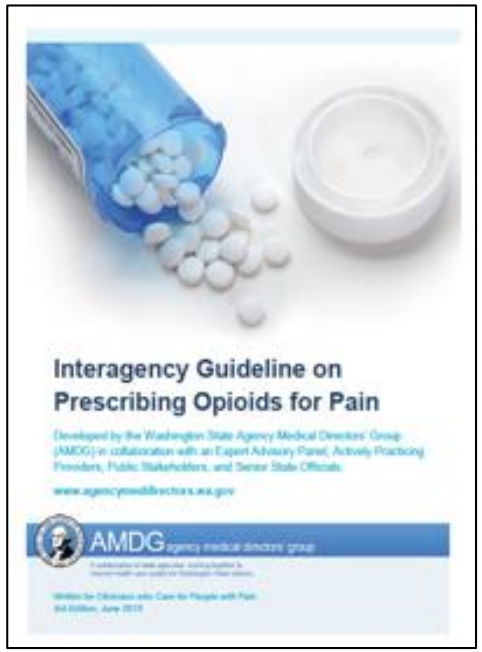
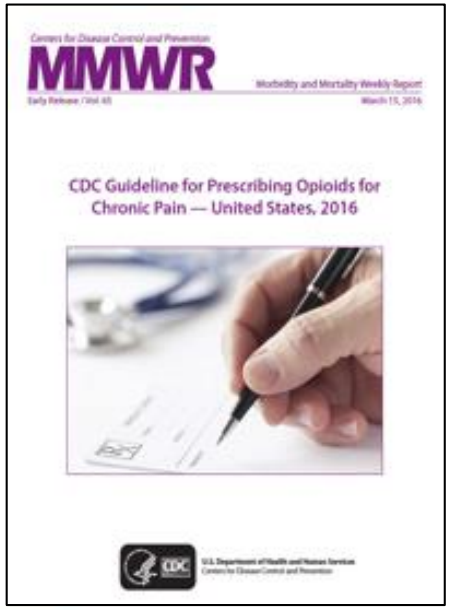
Best Practices for Opioid Prescribing

AMDG
agency medical directors' group



Washington State AMDG *Interagency Guideline on Prescribing Opioids for Pain.* 2015. Washington State Legislature. *WAC*



CDC
CENTERS FOR DISEASE CONTROL AND PREVENTION

MMWR, CDC Guideline for Prescribing Opioids. March 15, 2016, Vol. 65. 1-50.

DR. ROBERT BREE COLLABORATIVE

Adopted July 17, 2018

Prescribing Opioids for Postoperative Pain

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High dose low function, psychosocial distress

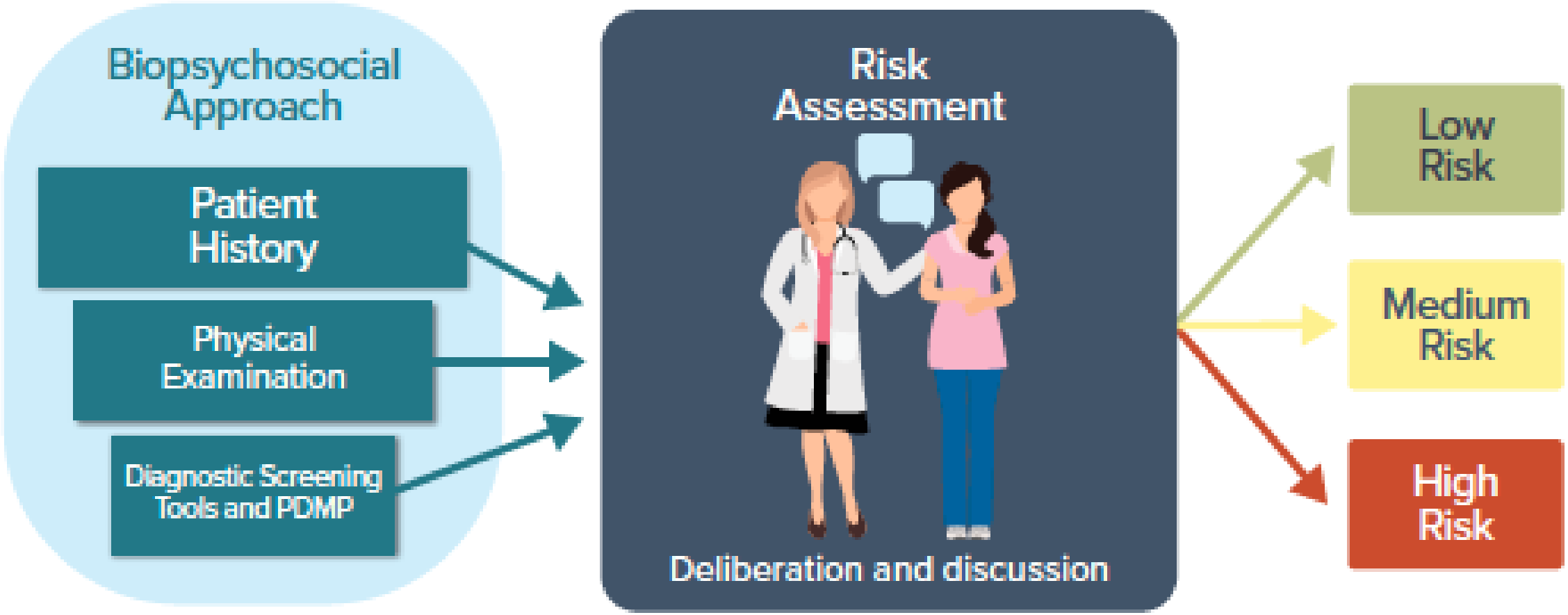
Recreational User

Moderate dose, pain, & function stable

Low dose compliant, high risk

Rewarding and anxiolytic properties of opioids

Putting It All Together



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Opioids MAY be part of a treatment plan, but not THE plan.

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CDC Opioid Guideline

Determining need for opioids

- Opioids are not first-line or routine therapy for chronic pain.
- Establish and measure goals for pain and function.
- Discuss benefits and risks of opioid therapy and availability of nonopioid therapies.

Opioid selection, dosage, and duration of therapy

- Use immediate-release opioids when starting treatment.
- Start low and go slow.
- Reassess pain and function when doses reach >50 mg of morphine equivalents a day and avoid increasing doses to >90 mg a day without justification
- Follow-up and re-evaluate risk of harm; reduce dose or taper and discontinue if needed.

Assessing risk and addressing harm

- Evaluate risk factors for opioid-related harms.
- Check PDMP for high dosages and prescriptions from other providers.
- Use urine drug testing to identify prescribed substances and undisclosed use.
- Avoid concurrent benzodiazepine and opioid prescribing.
- Arrange treatment for OUD if needed.

Dowell D, et al. *MMWR Recomm Rep* 2016;65(1):1-49.

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MAY
Identifying Patient Who Benefit from Chronic Opioid Therapy

- 63 yr. old, rheumatoid arthritis, lumbar spondylosis, s/p L3-sacrum fusion
- Chronic renal disease, COPD, chronic prednisone
- Retired ”lumbar jack”
- Oxycodone 15 mg, 1 TID, MED: 60
- GAD-7, PHQ-9 elevated
- Physical Exam:

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DON'S ASSESSMENT

Determining need for opioids

- Opioids are not first-line or routine therapy for chronic pain.
- Establish and measure goals for pain and function.
- Discuss benefits and risks of opioid therapy and availability of nonopioid therapies.

- Patient-centered history
- Functional goals (3)
- Patient expectations
- Risk

Dowell D, et al. *MMWR Recomm Rep* 2016;65(1):1-49.

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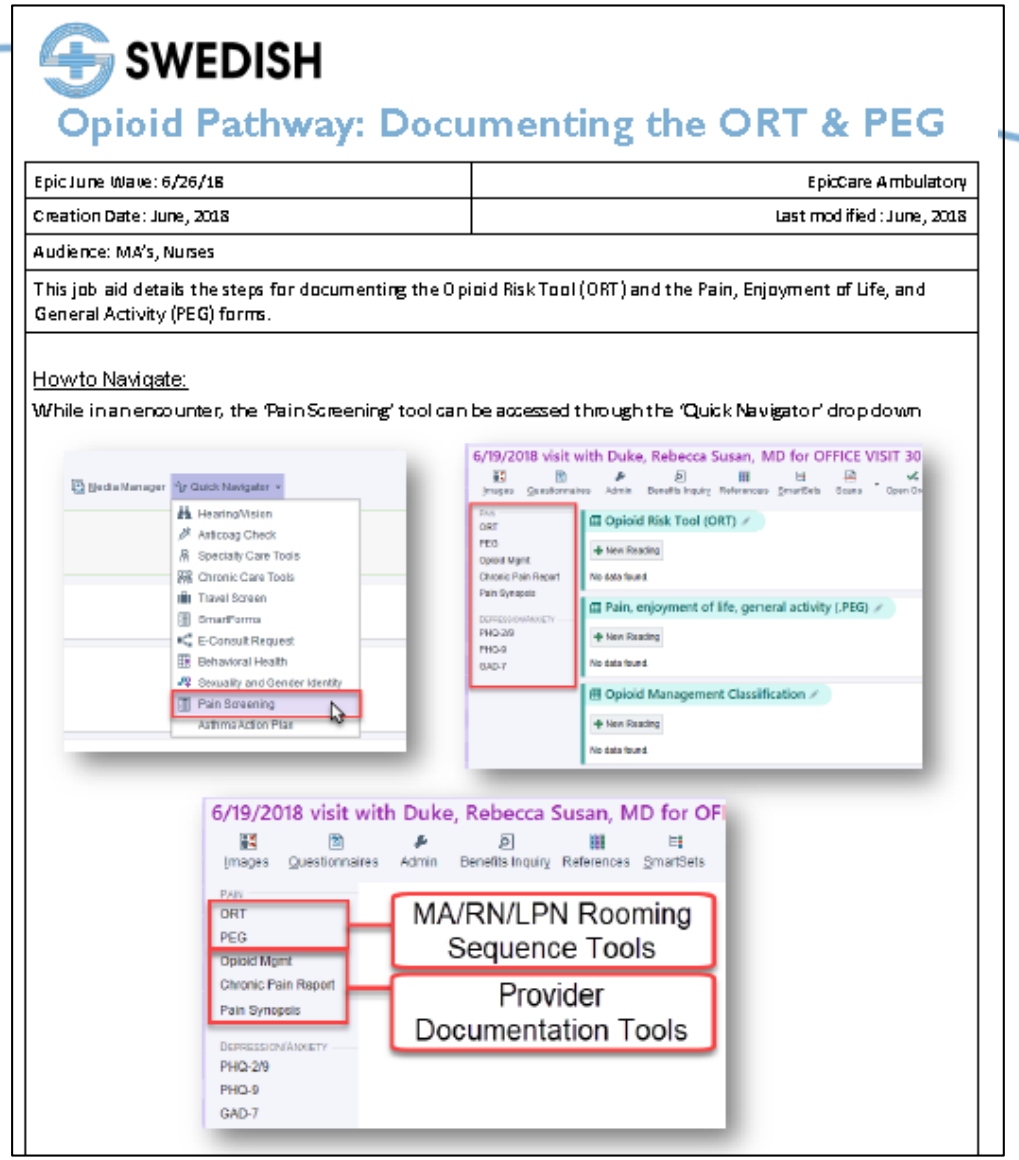
Pain Navigator

- PEG
- MED
- Opioid Risk Tool (ORT)
- Urine Screen
- Treatment Agreements
- Risk Stratification Tool
  - MED / ORT
  - Adjust for Medical Comorbidities (1)
  - Adjust for Medications at Greater Risk of Overdose (2)
  - Final “Management Classification”
    - **Low, Medium, High**



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Don's: Opioid Risk Tool (ORT)

Mark each box that applies		Female	Male
1.	**Family Hx of substance abuse**		
	Alcohol	☐ 1	☒ 3
	Illegal drugs	☐ 2	☐ 3
	Prescription drugs	☐ 4	☐ 4
2.	**Personal Hx of substance abuse**		
	Alcohol	☐ 3	☒ 3
	Illegal drugs	☐ 4	☐ 4
	Prescription drugs	☐ 5	☐ 5
3.	**Age between 16 & 45 yrs**	☐ 1	☐ 1
4.	**Hx of preadolescent sexual abuse**	☐ 3	☐ 0
5.	**Psychologic disease**		
	ADD, OCD, bipolar, schizophrenia	☐ 2	☐ 2
	Depression	☐ 1	☐ 1

Administer

On initial visit

Prior to opioid therapy

Scoring *(RISK)*

0-3: low

4-7: moderate

≥8: high

Webster LR, Webster RM. *Pain Med.* 2005;6:432-42
Link http://www.opioidrisk.com/node/887

Scoring Totals: **6, moderate RISK**

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Assessment and Risk Stratify

Medications:

Oxycodone 15 mg Q 4-5 hrs (60 MED)

Gabapentin 200 mg QHS

Amitriptyline 25 mg QHS

Robaxin 750 mg PRN

Screening

PHQ-9

GAD-7

Opioid Risk Tool: moderate

Monitoring

Urine monitoring

PMP: consistent w/prescribers

Management Classification

Step #1 Adjustment

MED (Morphine Equiv. Dose)	Opioid Risk Tool (ORT)
Low: < 50	Low risk = neutral risk
Medium: 50-90	Moderate risk = at least "medium" risk
High: > 90	High risk = at least "high" risk

Consider higher of the two categories

MED	ORT	Step 1 Adjustment
Low	Medium	Medium
Medium	Low	Medium
High	Low	High

Step #2 Adjustment — **Medical comorbidities and concurrent meds (add "A" and "B")**

A. Medical comorbidities (1 point per) impaired respiratory function, COPD, CHF, untreated sleep apnea, high fall risk, altered drug metabolism, advanced age/ frail, impaired renal or hepatic dysfunction, unstable psychiatric condition (i.e., depression, anxiety), other

Subtotal A: _____

B. Concurrent high risk co-prescriptions: (1 point per) Benzodiazepines, barbiturates, carisoprodol, non-benzodiazepine hypnotics, stimulant medications, other

Subtotal B: _____

Add subtotals "A" and "B" for total adjustment score: _____

If > 2 points = Consider grade UP
If 1 point = Maintain classification
If 0 points = Consider grade DOWN

Final "management classification" score

"Low"
"Medium"
"High"

- **Use the management classification score for ongoing monitoring.**
- **Risk factors may change over time. Reassess regularly.**
- **Methadone MED classification is limited by unique qualities of the drug.**

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Cleeland CS, Ryan K. *Ann Acad Med Singapore*. 1994;231:129-38.

Ongoing Patient-Centered (PC) Assessment

PEG

Analgesic Response

Mood

Sleep

Patient Goals & Expectations

Daily Routine

Compliance Monitoring

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Clinicians are pretty good at identifying when a patient “didn’t do well” on opioids.

But many times it’s too late.

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Opioid Therapy: Risk Factors

Aberrant behaviors

- Family and personal history of substance misuse, abuse
- Psychiatric comorbidity
- Age
- Trauma

Poor analgesic response

- Psychosocial, negative affect
- Genetic characteristics
- Incomplete assessment
- Lack of knowledge
- Incongruent expectations
- Diversion

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Tapering Considerations

WAC 246-919-950

- **Consider tapering or referral for substance abuse disorder evaluation if:**
  - Patient requests;
  - **Patient experiences a deterioration in function or pain;**
  - Patient is noncompliant with the written agreement;
  - Other treatment modalities are indicated;
  - There is evidence of misuse, abuse, substance use disorder or diversion
  - Patient experiences a severe adverse event or overdose;
  - **Patient is receiving escalation in opioid dosage with no improvement in pain or function.**

WAC, Medical Commission Pain Rules, 2019.
Bema C. et al. *Mayo Clin Proc* 2015;90:828-842.

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DO ✓ Identifying Patient Who Benefit from Chronic Opioid Therapy

- 71 yr old retired nurse
- Severe low back and leg pain
- Spinal stenosis, kyphoscoliosis
- Myofascial pain, obesity
- Rheumatoid arthritis
- Depression
- “failed multiple opioids”

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Interdisciplinary Approach: 4 week Program

Treatment Team

- **Pain medicine**
- **Physical therapy (PT)**
- **Occupational therapy (OT)**
- **Relaxation training**
- **Pain Psychology**
- **Nursing Education**

	Monday		Wednesday	Friday
Noon	**Nursing Lecture**		**Group Stretching Class**	**Nursing Lecture**
1:00	**Physical Therapy**		**Physical Therapy Group**	**Physical Therapy**
2:00	**OT**	**Medical Visit**	**OT Group: Tai Chi**	**Occupational Therapy**
3:00	**Psychology**		**Psychology Group**	**Psychology**
4:00	**Relaxation Training**		**Relaxation Group**	**Relaxation Training**
5:00	**Team Conference**: Physician, Nurse, PT, OT, Psych, Relax Therapist			

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So, who does benefit?

Nationalpainreport.com

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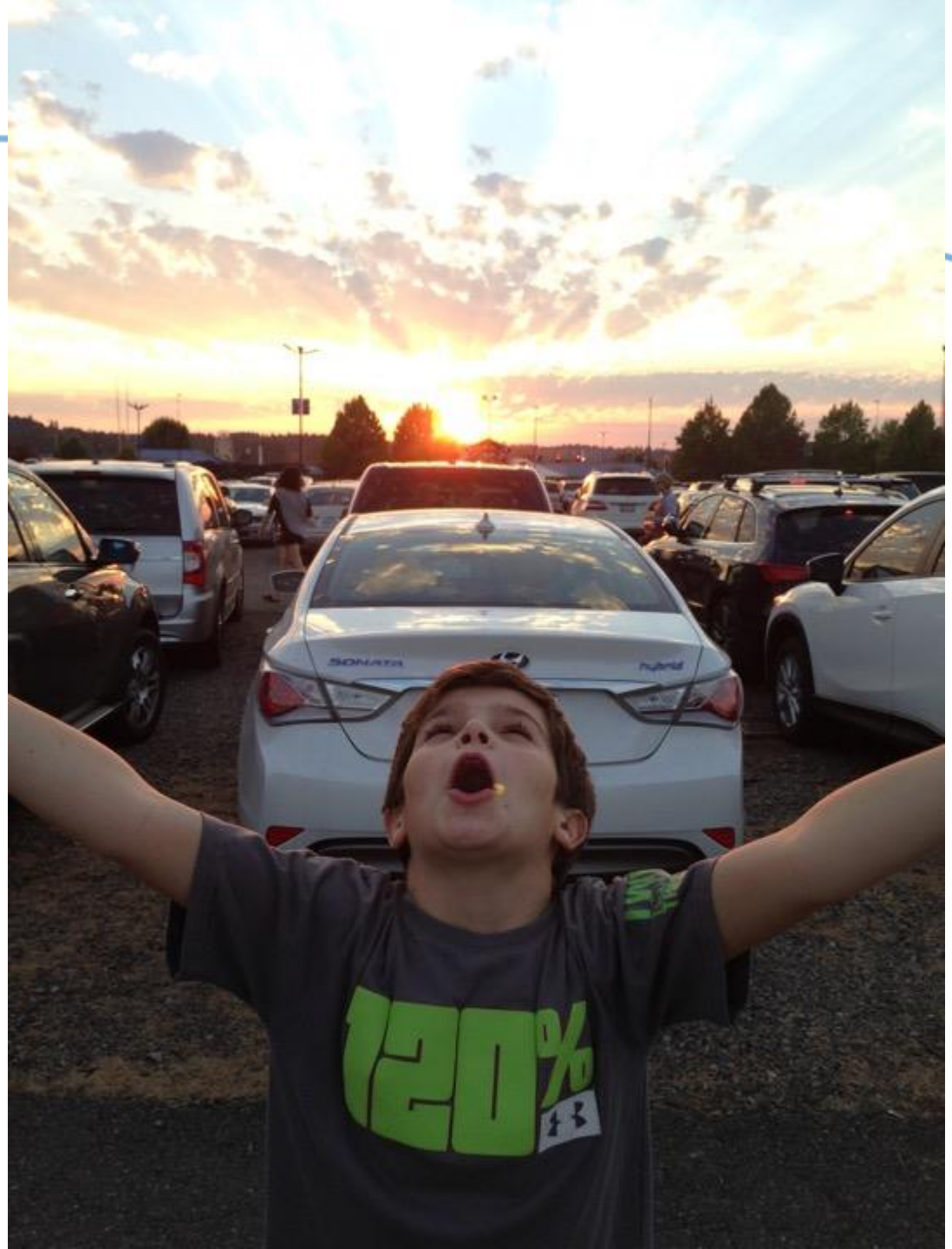
“ Repent ”

Change your mind

Change your thinking



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Opioid Therapy

- Future state of integrating opioid therapy as an option is here.
- Pain uniformity myth, negative affect . . .
- Analgesia: mood, euphoria, reward continuum
- Multidimensional tools and patient-centered approach.
- Biopsychosocial assessment and getting back to the basics.
- Selection of opioids as part of treatment plan, not THE plan.
- Moving beyond the 5th vital sign to a “PC Assessment”
- Use tools and guidelines.

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Pain Management & Pharmacovigilance

Community Education & Support

Inpatient: Transitions of Care

Interventional Procedures

Medical Management, Complimentary

Emergency Department

Primary Care: Patient Centered Medical Home

Interdisciplinary Care: Functional Restoration

Complimentary and Integrative Care

Integrated Behavioral Health in Primary Care

Addiction Medicine and Behavioral Medicine

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Thank you! steven.stanos@swedish.org