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Psychiatry and Addictions Case Conference
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02/21/2019

WELCOME!

Today's Topic:

Opioids and Pain Conversations

How do I get past talking about treating their pain with opioids?

David Tauben, MD

PANELISTS:

BARB MCCANN, PHD AND JENNIFER ERICKSON, DO

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Opioids and Pain Conversations:
How Do I Get Past Talking About Treating Pain with Opioids?

David J. Tauben, MD, FACP
Chief, UW Division Of Pain Medicine
Hughes M & Katherine G Blake Endowed Professor
Depts of Medicine and Anesthesia & Pain Medicine
University of Washington, Seattle WA

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GENERAL DISCLOSURES

The University of Washington School of Medicine also gratefully acknowledges receipt of educational grant support for this activity from the Washington State Legislature through the Safety-Net Hospital Assessment, working to expand access to psychiatric services throughout Washington State.

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DISCLOSURES

- ✓ **No financial conflicts of interest**
- ✓ **Off-label use of Rx will be mentioned**

- ✓ Grant funding from:
  - NIH Pain Consortium award: UW Center of Excellence in Pain Education
  - AHRQ: Team-Based Safe Opioid Prescribing in Primary Care
  - Mayday Fund: "Tele-Coaching for Optimization of Pre- and Post-Operative Pain Management."
  - NIH STRR: Optimization of Pre- and Post-Operative Pain Management.
  - CDC Clinical Quality Improvement Implementation Package for Large Healthcare Systems: Activities to Support Guideline Dissemination and Implementation
  - CDC RFA-CE15- 15010201SUPP16 Oregon Health Authority: UW TelePain/Oregon Implementation Proposal for the Prevention for States Prescription Drug Overdose Supplement.

OBJECTIVES

1. More effectively broach the topic of weaning down or off opioids with your patients
2. Communicate value of non-opioid pharmacological and non-pharmacologic treatments for pain management
3. Improve negotiation strategies during difficult conversations

"Established patients already taking high dosages of opioids, as well as patients transferring from other clinicians…"

- "…tapering opioids can be especially challenging after years on high dosages because of physical and psychological dependence."
- Offer in a "nonjudgmental manner"… "the opportunity to re-evaluate their continued use of opioids at high dosages in light of recent evidence regarding the association of opioid dosage and overdose risk."
- "empathically review benefits and risks of continued high-dosage opioid therapy" and "offer to work with the patient to taper opioids to safer dosages"
- "very slow opioid tapers as well as pauses in the taper to allow gradual accommodation to lower opioid dosages."
- Be aware that anxiety, depression, and opioid use disorder "might be unmasked by an opioid taper"

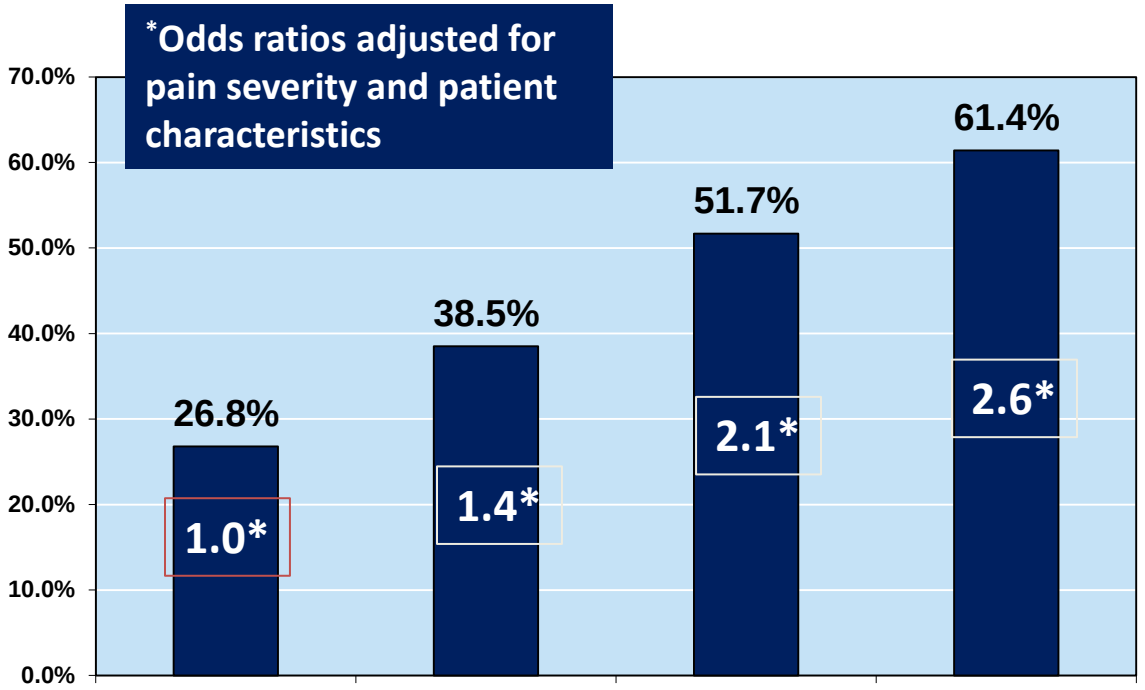
Centers for Disease Control and Prevention MMWR March 15, 2016; 65:23

Adverse Outcomes and Adverse Selection

Highest Risk Patients* Receive Highest Opioid Dose

Co-occurring Psychiatric & Addiction Disorders

- *Depression: 50% mod/severe*
- *Anxiety: 25% mod/severe*
- *Childhood abuse/neglect: ≥ 50%*
- *Lifetime suicide attempt: 20%*
- *Alcohol use disorder: 30%*
- *Benzo + opioid Rx: 65%*



Ballantyne JC. Anesth Analg 2017; Rogers KD, et al. 2013; Merrill et al. 2011; Sullivan et al 2012; Gustavsson A, et al. 2012; Campbell et al. 2015

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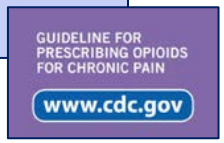
Be Aware that Anxiety, Depression, and
Opioid Use Disorder
"Might Be Unmasked by an Opioid Taper"



So:

- ***Not appropriate*** **to attempt complete opioid taper in patients with moderate to severe Opioid Use Disorder**

- ***Make the diagnosis*** **of OUD, and when present, to arrange for its treatment**
  - ***Be*** **Buprenorphine/Nlx "waivered"**
  - ***or if NOT (why?),*** ***Refer*** **to waivered PCPs or addiction specialty services**

Is it ***Opioid Use Disorder,*** *or* ***Complex Persistent Opioid Dependence?***

OUD

Meets DSM-5 Criteria

NOT OUD

- No lost prescriptions
- No ER visits
- No early prescriptions
- No requests for dose escalation
- No UDT aberrancies
- No doctor shopping (PMP)

Credit to Jane Ballantyne, MD

Managing Concerning Behaviors in Patients Prescribed Opioids for Chronic Pain: A Delphi Study

J Gen Intern Med. 2018 Feb;33:166-176

Jessica S. Merlin, MD, PhD, MBA[1,2], Sarah R. Young, PhD[1,3], Joanna L. Starrels, MD, MS[4], Soraya Azari, MD[5], E. Jennifer Edelman, MD, MHS[6], Jamie Pomeranz, PhD[7], Payel Roy, MD[8], Shalini Saini[9], William C. Becker, MD[6,10], and Jane M. Liebschutz, MD, MPH[8]

Consensus: ***Five Most Concerning Behaviors***

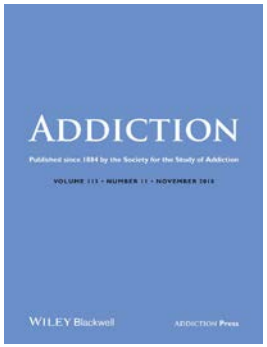
1. **Missing appointments**
2. **Taking opioids for symptoms other than pain**
3. **Using more opioid medication than prescribed**
4. **Asking for an increase in opioid dose**
5. **Aggressive behavior towards provider or staff**
6. **Alcohol and other substance use**

"The Drive To Taper Opioids: *Mind the Evidence, and the Ethics*"

Kertesz SG, Manhapra A. Spinal Cord Ser Cases/Nature Pub Grp 2018

"Forced tapers may destabilize patients and clinical evidence to support forced tapers is lacking."

We favor an ethic of informed consent when proposing changes to care involve meaningful risk, and suggest alternative approaches to optimizing safety."



"The imbalance between *strong prescription control and weak pain and addiction treatment expansion* exemplifies the... notion of 'bounded rationality."

Kertesz SG, Gordon AJ. A crisis of opioids and the limits of prescription control: United States. Addiction 2018

Broaching the "Taper": Preliminary Considerations

- **Many patients experience opioid related difficulties, say they are interested in opioid dose reduction or even discontinuation,**

…IF their pain does not increase

Fears of worsened pain & opioid withdrawal most often exceed actual pain & withdrawal experience

- ✓ ***Patients often feel overall better: social & functional domains***
- ✓ ***Pain is typically not worse, often better : less "bothersome"***
- ✓ ***Symptoms of withdrawal can be effectively managed***

Mark D. Sullivan, Judith A. Turner, Cory DiLodovico, Angela D'Appolonio, Kari Stephens, Ya-Fen Chan Prescription Opioid Taper Support for Outpatients with Chronic Pain: A Randomized Controlled Trial. J Pain. 2017

WHEN Are Long-term Opioid Analgesics *NOT* Recommended

Very Common Primary Care Painful Conditions, e.g., …

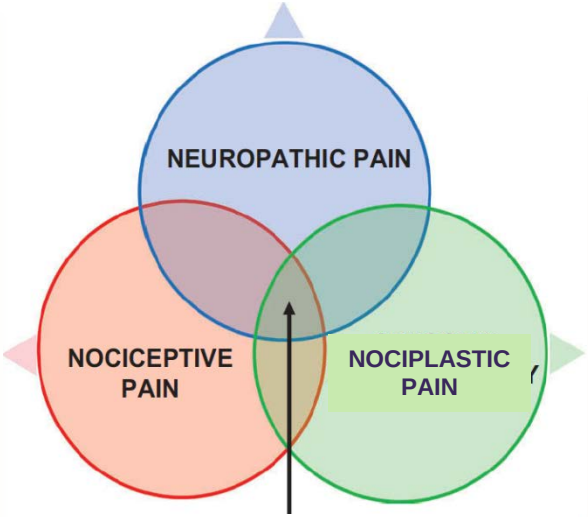
- ☒ *Headache*
- ☒ *Non-specific chronic low back pain*
- ☒ *Fibromyalgia*
- ☒ *Irritable bowel syndrome*
- ☒ *Chronic (male and female) pelvic pain without specific identifiable cause*

PREDOMINANTLY NEUROPATHIC

- PHN
- pDPN
- Lumbar or cervical radiculopathy
- Stenosis
- Tumor-related neuropathy
- Chemotherapy-induced neuropathy
- Small fiber neuropathy
- Persistent postoperative pain
- Multiple sclerosis pain
- Post-stroke pain
- Pain associated with spinal cord injury

PREDOMINANTLY NOCICEPTIVE

- Osteoarthritis
- Rheumatoid arthritis
- Tendonitis, bursitis
- Ankylosing spondylitis
- Gout
- Neck and back pain with structural pathology
- Tumor-related nociceptive pain
- Sickle-cell disease
- Inflammatory bowel disease



Mixed pain conditions frequently associated with multiple pain patho-physiologies once pain becomes chronic

PREDOMINANTLY NOCIPLASTIC

- Fibromyalgia
- Irritable bowel syndrome
- Tension-type headaches
- Interstitial cystitis/pelvic pain syndrome
- Tempo-mandibular joint disorder
- Chronic fatigue syndrome
- Restless leg syndrome
- Neck and back pain without structural pathology

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Modified from: Stanos et al. Postgraduate Medicine 2016

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Taper *To* & *Onto* What?

What opioid dose?

- < 90 mg MED?
- < 50 mg MED?
- No opioids?
- PRN opioids?
- Rotate onto buprenorphine?

What non-drug therapies?

- Co-occurring behavioral health diagnoses

(Depression, Anxiety, PTSD)

  - Cognitive-Behavioral Therapy/ACT
  - Trauma-based therapies

- Mind-Body (MBSR, Yoga, Tai-Chi)
- Acupuncture

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"Adjuvant" R_x *instead* of Opioids

- **Melatonin**
  - Sleep initiation
- **Antidepressants***

  ***Analgesia better with TCAs and SNRIs; TCAs are sedating; all can help mood**
  - Analgesia, Sleep, Mood
- **"Gabapentinoids"** ***(gabapentin or pregabalin)***
  - Nociplastic pain syndromes ***(aka "central sensitization")***
- **Prazosin**
  - PTSD

Chronic Pain Treatments

"Comparing Effectiveness"

Reductions in range of effect size ± pain measures
≥3- 6 months across **range of conditions**

Analgesic Drugs

- **Opioids** ≤ 30%*
  *(*No long-term benefits)*
- **Tricyclics/SNRIs:** 30%
- **Gabapentinoids:** 30%
- **Cannabis:** ?10-30%
- **Muscle Relaxants:** "modest"
  *(*No long-term benefits)*
- **NSAIDs:** <7 % for CLBP
  Risks often > Benefits

Non-Drug Treatments

CBT/Mindfulness	≤ 50%
Exercise	15%
TENS	5-12%
Acupuncture	*10-80%*
Sleep restoration	> 40%
Hypnosis	"modest"
Manual therapies	"Slight"
Yoga	12%
Tai Chi	15%

AHRQ 2018; Turk, D. et al. Lancet 2011; Davies KA, et al. Rheum. 2008; Koes BW, et al. 2018; Kroenke K. et al. Gen Hosp Psych. 2009; Morley S Pain 2011; Shaheed CA, et al. 2016; Moore R, et al. Cochrane 2012; Elkins G, et al. Int J Clin Exp Hypnosis 2007.

Broaching the "Taper": Patient Mindset

"I don't think people in chronic pain think about long-term.

We are basically: how do I get through today.

***I gotta get through today**."*

Patient's quote from, Frank JW, et al. Pain Med 2010

Effectively Communicating With Patients About Opioid Therapy

"But doc, I can't even manage on my current dose; I need more, not less!"

- **Identify "Resistance Talk:" pushing hard will lead to…**
  - **"No way I can taper!"**
  - **"My pain is as bad as it can be"**
  - **"What do you want me to do, lay in bed all day?"**
  - **"What do you want me to do, have to go get stuff off the street instead?"**
  - **"What do you want me to do, kill myself?"**

Dowell D, Tauben D, Merrill J. CDC Clinician Outreach and Communication Activity (COCA) 12/2016 accessed 10/2018: https://emergency.cdc.gov/coca/calls/2016

Effectively Communicating With Patients About Opioid Therapy

"Well, you're not just going to take away my pain pills, …are you?"

'Our shared goal is for you to be active and recover your quality of life.'

'What are you concerned might happen if we reduced them very slowly?'

'Would you mind if I told you what my concerns are?'

'We are both looking at this together: the up sides and the down-sides together.'

Dowell D, Tauben D, Merrill J. CDC Clinician Outreach and Communication Activity (COCA) 12/2016 accessed 10/2018: https://emergency.cdc.gov/coca/calls/2016

Some Communication Tips:
Alternatives to Opioids

Own it Together

"It's about what's best for you."

"It's about your benefits and risks."

"You'll have a say in the rate and timing of your taper."

"It's about how new scientific data applies to you."

"We'll work together on this."

Don't Abandon & Deflect

"It's about those guidelines!"

"It's because my clinic says I can't prescribe narcotics anymore."

"I'm afraid I'll lose my license."

"Don't worry, it's not that hard!"

"I don't care*, I'm not going to prescribe you opioids anymore."

(*…about you)

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Skillful Empathic Communication

GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN
www.cdc.gov

1. **Reflective listening**

… an opportunity for understanding your patient's story/concerns.

2. **Non-judgmental language**

… supports collaborative treatment planning.

3. **Affirmative statements**

… enable change by persuasion, not by argument.

4. **An agreed upon opioid taper or non-opioid plan**

…for your patient can result from shared medical decision-making.

Dowell D, Tauben D, Merrill J. CDC Clinician Outreach and Communication Activity (COCA) 12/2016 accessed 10/2018: https://emergency.cdc.gov/coca/calls/2016

Broaching the Topic:
Role of a Skilled and Trusted Clinician

- Need for a therapeutic alliance with "trusted provider"
- Establish the importance of taper
- Build patient confidence
- Focus on patient skills
- Identify value and availability of social support
  - ***Bring in family members or close friends***

Sullivan M, et al. J Pain. 2017

The “BRAVO” Approach

- **B**roaching the subject
- **R**isk/Benefit
- **A**ddiction happens
- **V**elocity (and Validate)
- **O**ther treatments

Anna Lembke linesforlife.org/wp-content/uploads/5.19.18-Keynote-Lembke.pdf

Take-Aways

Achieving Transition to Non-Opioids, Non-Drug, & Tapers

1. Voluntary & supported non-opioid treatments are most effective
2. Possible *without increasing pain &* with improved social & emotional function
3. Behavioral health issues need be identified and treated
4. Empathic listening & motivational techniques are key!
5. Skills for patient self-management are needed
6. Option to pace and/or pause *("definitely", <u>not</u> "indefinitely")*

UW TelePain

A service for community-practice providers to increase knowledge and skills in chronic pain management

UW TelePain sessions are collegial, audio/video-based conferences that include:

1. **Didactic presentations** from the UW Pain Medicine curriculum for primary care providers.
2. Case presentations from community clinicians.
3. Interactive consultations for providers with a multi-disciplinary panel of specialists.
4. Education in use of guideline-recommended measurement-based clinical tools to improve diagnosis and treatment effectiveness.
5. Follow-up case presentations to track outcomes and optimize treatments for ongoing care of your patients.

UW TelePain sessions for community health care providers are held each Wednesday, noon to 1:30 p.m.

You are invited to present your difficult chronic pain cases or ask questions, even if you don't present a case.

The expertise of the UW TelePain Panel spans pain medicine, internal medicine, anesthesiology, rehabilitation medicine, psychiatry, addiction medicine, and nursing care coordination.

Learn more about these sessions on the UW TelePain website
http://depts.washington.edu/anesth/care/pain/telepain/

Questions?
telepain@uw.edu

To register:
Download and complete the registration form and fax it to 206-221-8259. Form location **http://depts.washington.edu/anesth/care/pain/telepain/TelePain-Participant-Reg-Form.pdf**

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Washington State Health Care Authority

Are CME credits available? Yes.
The University of Washington School of Medicin
Education to provide continuing medical educat
The University of Washington School of Medicin
Category 1 Credits™. Physicians should claim o
the activity. (Each session 1.5 credits)

Clinicians: caring for patients with complex pain medication regimens? We're behind you.

UW Medicine
Pain and Opioid Consult Hotline for Clinicians
1-844-520-PAIN (7246)

UW Medicine pain pharmacists and physicians are available Monday through Friday, 8:30 a.m. to 4:30 p.m. (excluding holidays) to provide clinical advice at no charge to you.

Consultations for clinicians treating patients with complex pain medication regimens, particularly high dose opioids:

- Interpret Washington State Prescription Monitoring Program record to guide you on dosing
- Individualized opioid taper plans
- Systematic management of withdrawal syndrome
- Evaluate/recommend non-opioid/adjuvant analgesic treatment
- Triage and risk screening
- Individualized case consultation for client care and medication management
- Explain/review Center for Disease Control and Prevention (CDC) opioid guidelines: **https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm**
- Will help identify and refer to other resources:
  - Evaluation of Substance Use Disorder, Washington Recovery Help Line 1-866-789-1511
  - Local pain clinics for patient referrals: **www.doh.wa.gov/Emergencies/PainClinicClosures/PainClinicAvailability**
  - UW TelePain Services: Available Wednesdays noon to 1:30 p.m. **http://depts.washington.edu/anesth/care/pain/telepain**

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