Date: September 20, 2018
Title of Talk: Integrating Alternative Pain Management Techniques, Opioid Tapering and MAT into Practice
CME DISCLAIMER

- In support of improving patient care, this activity has been planned and implemented by the Robert Larner College of Medicine at the University of Vermont and the Vermont Medical Society. The University of Vermont is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC), to provide continuing education for the healthcare team.

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VMS Third Thursday Webinar Series
Integrating Pain Management Alternatives, Opioid Tapering & MAT into Practice

Speakers:
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John Brooklyn, M.D.

Planning Committee Members:
Jessa Barnard, ESQ, Stephanie Winters, Deputy Executive Director & Dr. Carl Dobson, M.D., Southwestern Vermont Medical Center

Purpose Statement/Goal of This Activity:
Integrating Alternative Pain Management Techniques, Opioid Tapering, and MAT into Practice

Learning Objectives:
To learn how to use alternative pain management techniques and opioid tapering to reduce opioid prescribing, and how to integrate Medication Assisted Treatment into practice.

Disclosures:
Is there anything to Disclose? Yes  No
Did this activity receive any commercial support? Yes  No

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An Integrative Approach to Treating Chronic Pain

Jon Porter, MD
University of Vermont Medical Center
Comprehensive Pain Program
Takeaways

- Our current approach to addressing chronic pain does not serve patients or clinicians well
  - Patients may find themselves labeled ‘difficult’ and experience the clinician-patient relationship as adversarial.
  - Clinicians may feel daunted by the challenges presented by these patients and their inability to resolve a chronic condition

- Integrative, team-based, patient-centered approaches using integrative therapies offer hope for better outcomes for patients and clinicians
The Problem of Chronic Pain
Society and Economics

Prevalence 11-47%, over 6 Million Individuals in the US

Low Back Pain, Neck Pain, OA, Headache Most Common Conditions in US

Morbidity, Disability, Economic Costs: $500-$600 Million Annually
  (Exceeds the annual expenditures for hear disease, cancer, diabetes combined.)

(Institute of Medicine, 2011)
The Challenge of Chronic Pain
The Individual

Chronic Pain as Personal Redefinition and Core Identity

Physical
Psychological
Social
Economic
Sense of Self
Spiritual
Mrs. S

- 58 year old female with a 20 year history of low back pain and pain in both lower extremities. She has been married for thirty years, has been unable to work for the last fifteen years. She finds it difficult to stand for any length of time because of her pain. She spends much her day in a recliner watching television. Her sleep is disrupted by pain, and she reports an average of 3-4 hours at night and occasional naps during the day.

- She has three grown children and four grandchildren “who I live for.” She is Catholic and attends mass when she feels up to it. She reports a tumultuous childhood marked her mother’s suicide when she was five years old.
Mrs. S

- She presents today with increased pain to 10/10 over the past two months (up from 8/10 baseline). Her current medications include Oxycodone ER 200 mg morning and evening, Oxycodone ER 180 mg at noon, hydromorphone 8 mg 1-2 tabs q 4h prn pain (maximum 9 tabs/day), diazepam 10 mg tid prn anxiety and venlafaxine.

- She is seeking something to help her with her worsening pain.
Comorbidities

16% of Americans with mental health disorders receive over 50% of opioid prescriptions (Davis, 2017)

Increased prevalence of depression, anxiety

Trauma
Comorbidities

50-80% prevalence of insomnia warranting clinical attention in chronic pain patients (Tang et al., 2015)

Social isolation

Multiple previous procedures/surgeries

Negative interactions with the medical system
Race/Ethnicity, Gender, Age

The strongest predictor of back pain in African American women: perceived/experienced day-to-day discrimination (Edwards 2008)

Women are more likely to report chronic pain than men in every racial/ethnic category (IOM 2011)

Severe pain interfering with life activities increases with age (IOM 2011)
Factors Informing Our Present Context
THE NEW YORKER

A REPORTER AT LARGE  OCTOBER 30, 2017 ISSUE

THE FAMILY THAT BUILT AN EMPIRE OF PAIN

The Sackler dynasty’s ruthless marketing of painkillers has generated billions of dollars—and millions of addicts.

By Patrick Radden Keefe
“The Fifth Vital Sign”
Outcomes

Manage the Score
   How to get to zero?

Long-term opiate prescription and use

Minimal focus on
   Quality of life
   Functional Status
Opiates

Frustrated Patients and Fearful Physicians

Henry (2017), Unger (2017)

Patients

- Shifting norms - LTOT
- Tapering of a medication believed useful
- Expectations of compliance
- Stigma

Clinicians

- Shifting norms - LTOT
- Concern about patient safety with new understanding of risks associated with LtOT
- Expectations of compliance
- Time and Schedule
“We just haven’t been flapping them hard enough.”
Integrative Health

“Integrative Health affirms the importance of the relationship between practitioner and patient, focuses on the whole person, is informed by evidence, and makes use of all appropriate therapeutic disciplines and lifestyle approaches to achieve optimal health, function, and healing.”

Adapted from the Academic Consortium for Integrative Medicine and Health (2015)
Chronic Pain is really about suffering
Curing versus Healing
Comprehensive Pain Program - UVMMC

Mission

- to engage those experiencing chronic pain and their family/support system in a holistic and patient-centered manner using a biopsychosocial lens.

- to support participants in achieving optimal comfort and function in the service of fulfilling their own self-articulated goals.

- to optimize participants’ sense of agency and self-efficacy in managing their condition
Comprehensive Pain Program - UVMMC

Mission

- to provide participants with the best and safest therapies available
- to avoid and mitigate the adverse impacts of over-reliance on the prescription of opiate medications on patients and by extension the larger community.
- to benefit the care of participants by maintaining a healthy work environment for staff, allowing them to model balance and self-care in their work day
Comprehensive Pain Program Phases

I  Existing Cohort

II  Primary Care Faculty Practices

III Inpatient Service
Comprehensive Pain Program - UVMMC

- Transdisciplinary Team
- Group Format, including medical group visit
- "Episode of Care" - Tiered
- Primary Caregiver track
- Maintenance Phase
- Collaborative/Supportive Relationship with Primary Care
Flipping the Paradigm

Patient

Trauma
Mental Health
Identities
Family
SES
Vocation
Genome

Expressed Concern

“Do Something”

20 Minutes

8 Weeks

More Understanding
More Skills
Empowerment
Comprehensive Pain Program - UVMCC

Transdisciplinary Approach

- Acupuncture
- Massage Therapy
- Mindfulness
- Movement
- Nutrition
- Reiki
- Physical Therapy/Occupational Therapy
- Allopathy
Comprehensive Care Program Team
Traditional Therapies

Psychiatrist 0.5 FTE
Psychologist - 1.0 FTE
LADC - 1.0 FTE
Caseworker - 1.0 FTE

NP/PA - 2.0 FTE
RN - 1.0 FTE
Interventional Anesthesiologist - 0.1 FTE
Medical Director - 1.0 FTE
“Gesundheit.”
Appropriate tapering of opioids and management of opioid use disorder in the office

John Brooklyn, MD
Clinical Assistant Professor of Family Practice and Psychiatry
University of Vermont College of Medicine
Medical Director of Howard Center Chittenden Clinic
Medical Director BAART St. Albans Hub
Current Vt Pain prescribing guidelines

- Went into effect on July 1, 2017
- Expected to be the standard
- Evidence based recommendations from diverse groups
- Prior to prescribing an opioid, a prescriber shall have an in-person discussion with the patient regarding potential side effects, risks of dependence and overdose, alternative treatments, appropriate tapering and safe storage and disposal.
- Informed consent
Informed Consent

- Information regarding:
  - The drug’s potential for misuse, abuse, diversion, and addiction
  - Potential side effects
  - Tolerance
  - The risks associated with the drug for life-threatening respiratory depression; potentially fatal overdose as a result of accidental exposure, especially in children; neonatal opioid withdrawal syndrome; and potentially fatal overdose when combining with alcohol and/or other psychoactive medication including but not limited to benzodiazepines and barbiturates
Tolerance

- The physiological state that occurs when
  - 1) the person becomes either acclimated to the current dose and needs more for the same effect to control pain
  - 2) the person takes more for purposes of euphoria that is no longer occurring
Neurophysiology of opioids

- Diverse group of opioid receptor activities genetically coded with individual variations- OPRDelta, OPRMu, OPRKappa
- Dopamine receptor activity variations-D2,3,4
- Dopamine transport activity genetically coded
- Endorphin, enkephalin, dynorphin molecule production and activity
Effects of opioids

- Exogenous opioids can induce changes in as few as 3 days that move people from pain to euphoria through mediated changes in endogenous opioids and their receptors and increases in dopamine.
- “Reward deficiency syndrome” or “hypodopaminergic” state can be enhanced by taking opioids and people can quickly escalate doses for pleasure.
- Does not occur for most people initially however many do not realize they are at risk.
Dopamine pathways in the Ventral Tegmentum (VT) to the Nucleus Accumbens (NA) and Medial Frontal Cortex (MFC) are activated during rewarding behaviors. Mu receptors in the VT, NA, MFC, and Locus Coeruleus (LC). Chronic opiates cause LC inhibition and stopping them causes excitation in the LC and withdrawal symptoms. Opiates also reduce glucose metabolism globally in the brain. GABA receptors are scattered throughout this area and are involved with reward for ethanol, BZD, and opiates.
Acute pain

- The current guidelines provide prescribers with a framework for prescribing opioids in the smallest doses for the shortest periods of time to be effective in the management of pain.

- In the past the lack of this guideline led to an extremely common situation for people seen in the Opioid Treatment Programs with long durations of opioids that led to problems.
Screening, evaluating and risk assessment for Chronic pain treatment

- Tools are available
- People are not forthcoming
- Many providers don’t have the time in a 15 minute visit
- Make the time and don’t feel rushed as this can be a lifetime of trouble for the patient if mistreated by either prescribing when not appropriate or losing treatment when it is appropriate
Ongoing Care

- Schedule and undertake periodic follow-up visits and evaluations at a frequency determined by the patient’s risk factors, the medication dose and other clinical indicators.

- Patients who are stable in terms of the medication dose and its effectiveness in managing chronic pain must be reevaluated no less than once every 90 days.
Tapering

- This is one of the most frightening concepts to patients as they associate it with abandonment.
- Start with giving people information about the concept of lowering the dose to try to get closer to the recommended target of 90 MME and stating the current evidence.
- State that you want the person’s health to be the most important consideration.
- Relate that we know more about the harms from opioids than we did and they most likely have heard reports about the current problems with opioids in this country.
Tapering

- Assess the person’s readiness for change
  - 1) Precontemplative
  - 2) Contemplative
  - 3) Preparedness
  - 4) Action
  - 5) Maintenance
- Determine how much resistance there is and why to the concept of taper
- Understand that a taper can make things worse for people who are long term stable
- Even a 1% reduction in a dose is a start
Tapering

- Make sure to let the person know this will be a team effort
- See if there is a need for a pain psychologist
- See if there is a need for a pharmacy consult
- See if there is a need for a physical therapy consult
- See if there is a need for a physiatry consult
- See if you need to speak with a colleague
Tapering

- Agree that once a taper begins you will see the patient back soon and every dose reduction will be done after a face to face meeting.
- If the person does not want to taper, consider why and explore if there is an underlying OUD that needs to be diagnosed.
- Realize that there is always a spectrum of behaviors in people on opioids and some may be “coping chemically”, mood-wise.
- The slower the taper the better.
- Avoid the 10% per week or other protocols you see. It has to be individualized.
- It can take years to reduce doses in some people.
Consultation

- It is recommended that a provider consult with a pain specialist or addiction specialist if there is concern about the patient’s use of opioids.
- It is considered the standard of care, even though it is listed as a “shall” and “may” as the Committee did not want to be prescriptive.
Referral

- Concerns for patient abandonment given that anyone tolerant to opioids will go through withdrawal and many times seek additional opioids and cause significant disruptions to the health system by “doctor shopping”, frequenting the emergency departments, relying on friends or family for drugs, and/or buying illicitly and risking overdose
- Hub and Spoke model for opioid use disorder
  - Some people would benefit from Hub referral for methadone treatment
  - Some people would benefit from being diagnosed with opioid use disorder and treatment with buprenorphine/naloxone in a spoke
  - Some people would benefit from a pain management consultation
Opioid Use Disorder

- Consider the person now has DSM-5 criteria for opioid use disorder and needs treatment.
- Some people benefit from being started on buprenorphine/naloxone by the same provider, a provider in the same office, or a referral to another provider be it in a hub or spoke.
- Try to establish the diagnosis first and then discuss with the person the referral.
- If there is concern about diversion, one is still obligated to not abandon the person and to refer for further evaluation.
**DSM-5 criteria for OUD**

- **These criteria not considered to be met for those individuals taking opioids solely under appropriate medical supervision**

- **Tolerance, as defined by either of the following:**
  - (a) a need for markedly increased amounts of opioids to achieve intoxication or desired effect
  - (b) markedly diminished effect with continued use of the same amount of an opioid

- **Withdrawal, as manifested by either of the following:**
  - (a) the characteristic opioid withdrawal syndrome
  - (b) the same (or a closely related) substance are taken to relieve or avoid withdrawal symptoms
DSM-5 criteria for OUD

- Opioids are often taken in larger amounts or over a longer period of time than intended.
- There is a persistent desire or unsuccessful efforts to cut down or control opioid use.
- A great deal of time is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects.
- Craving, or a strong desire to use opioids.
- Recurrent opioid use resulting in failure to fulfill major role obligations at work, school or home.
- Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids.
- Important social, occupational or recreational activities are given up or reduced because of opioid use.
- Recurrent opioid use in situations in which it is physically hazardous
- Continued use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by opioids.
- Mild 2-3, moderate 4-5, severe 6 or more
Summary

- Tapering is done collaboratively with the patient and a team
- Tapers need to occur slowly and may not be successful
- Patient education and discussions are key
- Patients may worsen with a taper
- Feel free to get consultation and if needed a referral to a spoke or a hub
Summary

- Chronic and permanent changes can occur in the brain after short exposure to opioids and lead to opioid use disorder in some but not all.
- Don’t confuse this with tolerance and stability.
- Don’t abandon the patient.
- Learn how to interpret urine testing.
- “One strike you are out” policies are harmful. Check your reaction before reacting!