MANAGING OPIOID RISK AND CHRONIC PAIN IN CLINICAL SETTINGS

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Pain in Context

- IOM Report (2011)
  - Chronic pain affects approximately 100 million American adults
  - More than those affected by heart disease, cancer, and diabetes *combined*
  - Estimated annual cost of $500-600 billion in medical treatment and lost productivity

Pain Types

Acute Pain

- Hurt = Harm
  - Avoidance decreases damage
- Etiology:
  - Clear pathway
  - Often single cause
- Treatment Course
  - Fixed end point
  - Immobilization often essential for recovery
  - Medications

Chronic Pain

- Hurt ≠ Harm
  - Fear-avoidance cycle
- Etiology:
  - Many unknowns
  - Multifactorial
- Treatment Course
  - No fixed end point
  - Immobilization can worsen condition
  - Medications: Caution

Management Approach to Pain

- Similar to other chronic health conditions lacking a cure
- Focus on quality of life & functioning

Example: Diabetes

- Regulate diet
- Check blood sugars
- Exercise regularly
- Take insulin/medications
- Monitor wounds

Chronic Pain Management

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

Interdisciplinary Management

Diabetes

- Regulate diet
- Check blood sugars
- Exercise regularly
- Take insulin/medications
- Monitor wounds

Chronic Pain

- Medical optimization
- Physical reconditioning
- Behavioral/lifestyle modification

Chronic Pain Management

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

Chronic Pain Management Dilemma

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

Prescription Opioids

- Leading cause of overdose deaths in the U.S.
- Fatal prescription drug overdoses involving opioids increased ~ 4x from 1999 – 2011
- Rate of ED visits involving prescription drug misuse (opioids + others) doubled from 2004 – 2011

- Maxwell JC. The prescription drug epidemic in the United States: a perfect storm. Drug Alcohol Rev. 2011;30(3):264-70.
- Warner M, Hedegaard H, Chen LH. Trends in drug-poisoning deaths involving opioid analgesics and heroin. http://www.cdc.gov/nchs/data/hestat/drug_poisoning/drug_poisoning.htm.
- Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. The DAWN Report. http://archive.samhsa.gov/data/2k13/DAWN127/sr127-DAWN-highlights.htm.

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"

- 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.

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.

Stanford Comprehensive Interdisciplinary Pain Program (SCIPP)

- Typical patient
- Pain conditions accepted
- Admission criteria

Interdisciplinary Treatment

- Physical Therapy
- Occupational Therapy
- Medication Optimization (cocktail)
- Lifestyle/Behavioral Modification

Scheduled Activities

- AM Rounds
- Physical Therapy
- Occupational Therapy
- Pain Coping Skills Class
- Individual Provider Visits

Unscheduled Activities

- Independent practice
- Walking
- Activity tracking log

Behaviors Reinforced

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

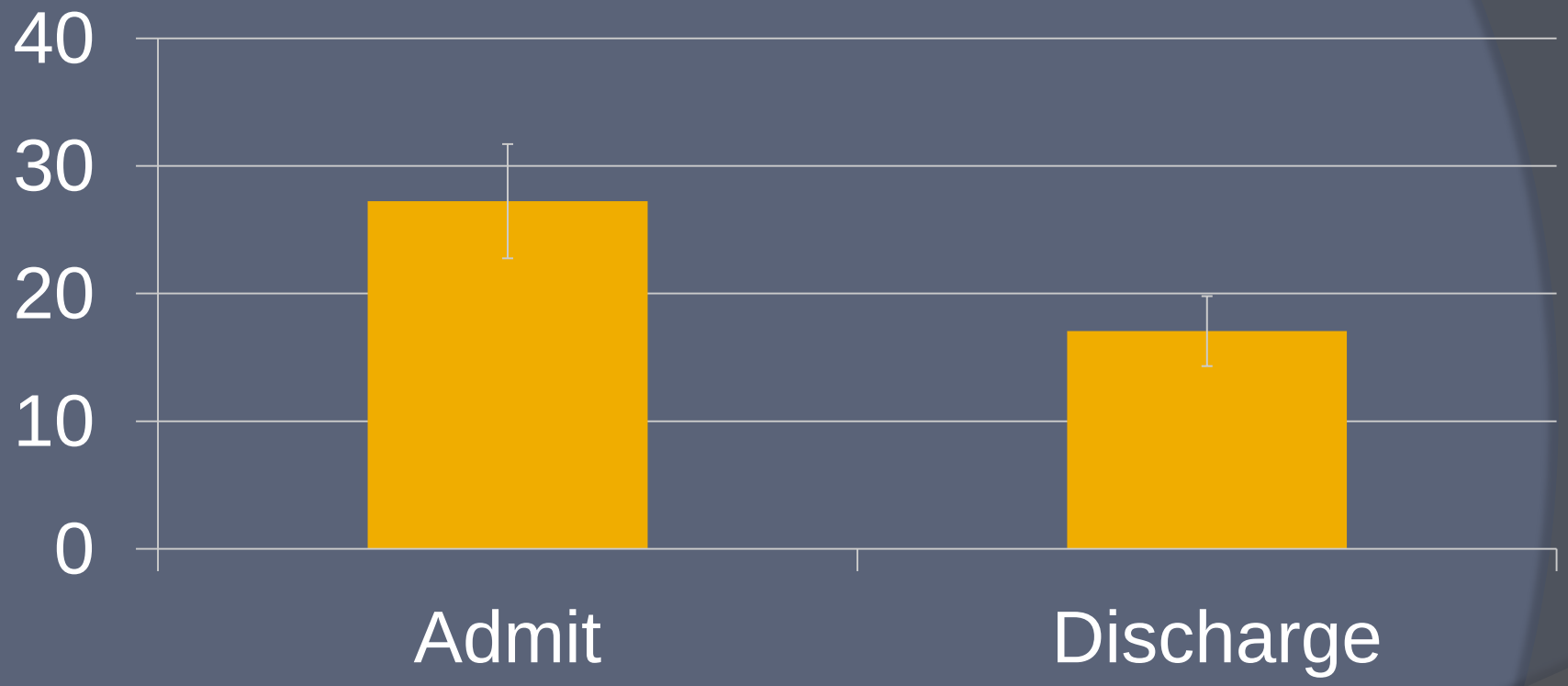
Behaviors not Reinforced

- Pain behavior
- Medication focus
- Somatic complaints
- Inactivity

SCIPP Outcomes

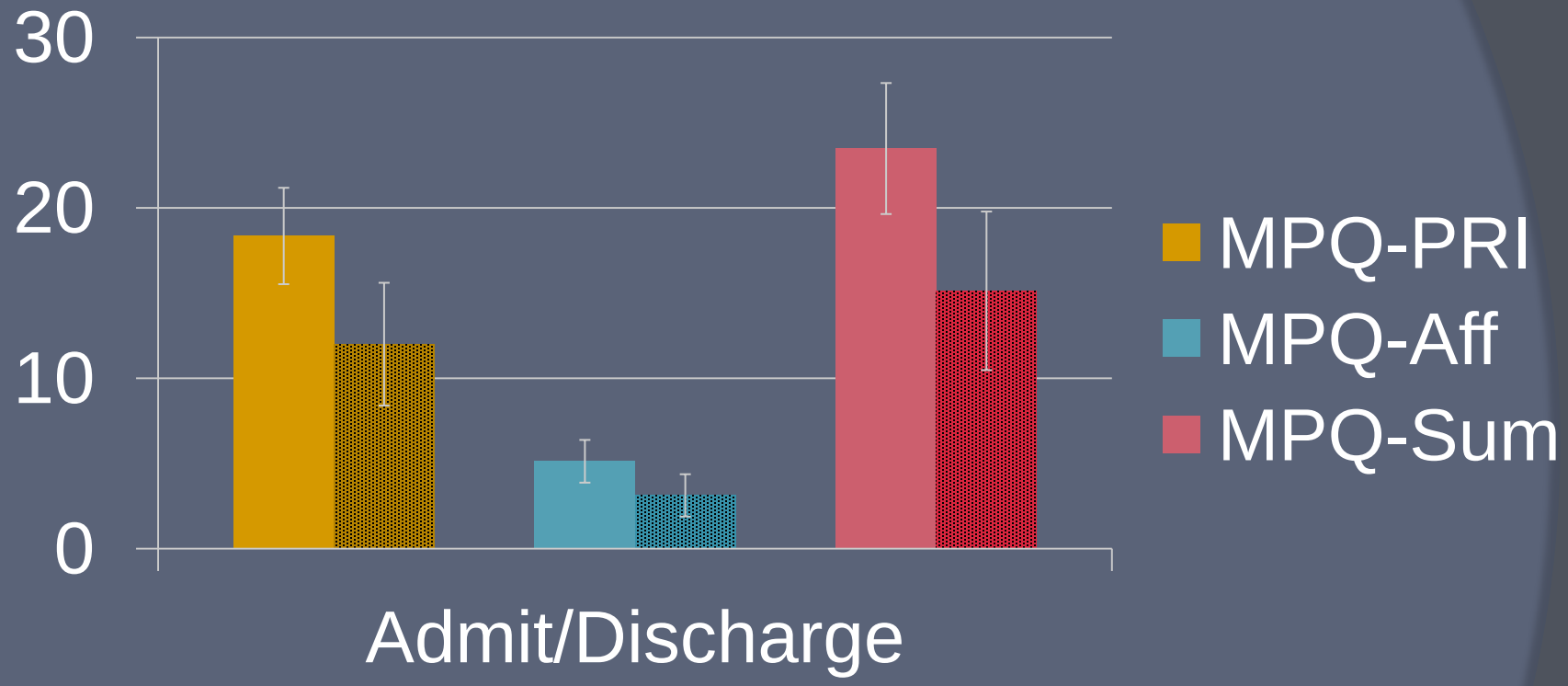
- n = 44 (19 male, 25 female)
- Minimum of 1 pain diagnosis
- Assessments:
  - Center for Epidemiologic Study of Diseases—Depression Scale (CESD)
  - McGill Pain Questionnaire (MPQ)
  - McGill Pain Questionnaire-Visual-Analog Scale (MPQ-VAS)
  - Profile of Mood States (POMS)
- Administered within 24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

CESD



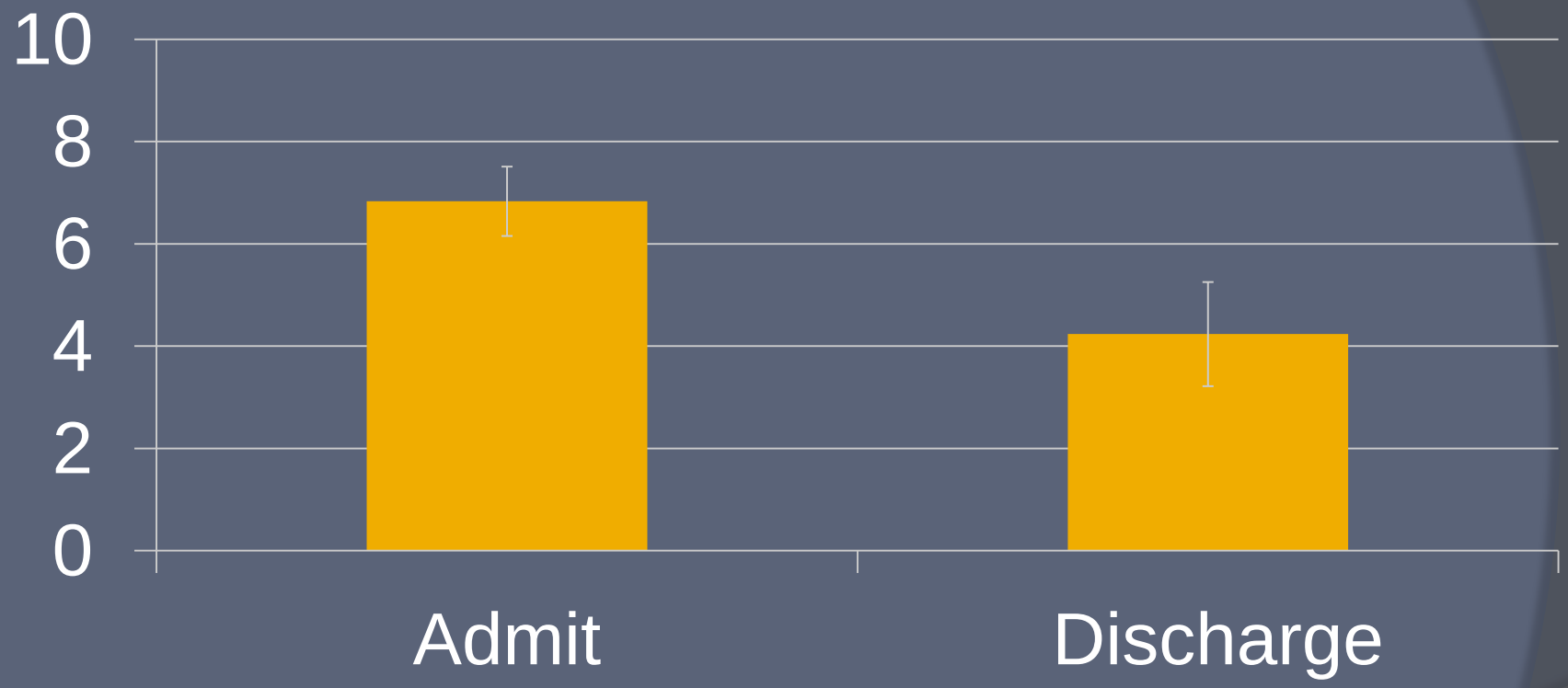
Total CESD score was significantly lower at discharge than at admission ($p<.001$).

MPQ

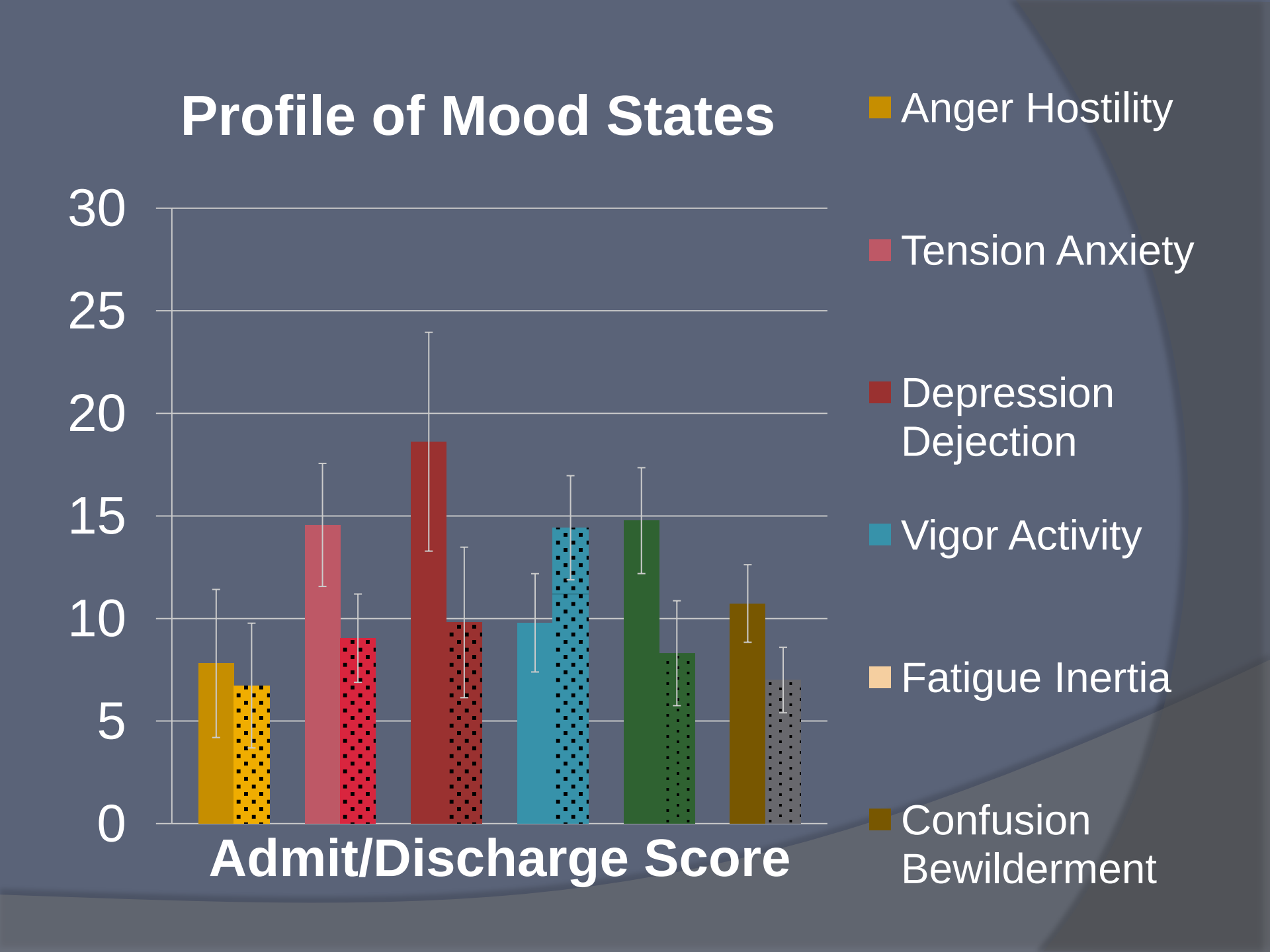


Significant reductions were detected on the MPQ sum score (p=.005) and each of the MPQ subscales – PRI (single item pain rating index; p=.007) and Affective (p=.01).

MPQ-VAS



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


Profile of Mood States
30
25
20
15
10
5
0
Admit/Discharge Score
Anger Hostility
Tension Anxiety
Depression Dejection
Vigor Activity
Fatigue Inertia
Confusion Bewilderment

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-Intertia ($p=.002$)
  - POMS Confusion-Bewilderment ($p=.003$)
  - POMS Total Mood Disturbance ($p=.01$)
- No significant difference on
  - POMS Anger-Hostility

Other Literature Findings

- 373 CPRP participants (3 week)
- ~57% on opioids at admission
- Assessments at admission, discharge, and 6-month (70% return rate; pain severity, depression, psychosocial functioning, health status, pain catastrophizing)
- Pain severity and depression higher in opioid users at admission
- Significant improvement on all variables at discharge, 6-month follow-up regardless of opioid status

Townsend, CO, Kerkvliet, JL, Bruce, BK, Rome, JD, Hooten, WM, Luedtke, CA, Hodgson, JE. (2008). A Longitudinal Study of the Efficacy of a Comprehensive Pain Rehabilitation Program with Opioid Withdrawal: Comparison of Treatment Outcomes Based on Opioid Use Status at Admission. Pain, 140(1): 177-189.

Other Literature Findings

- 705 (600 completed) outpatient interdisciplinary program participants
- Opioid group tapered with cocktail
- Opioid group improved same as more than non-opioid group (pain severity, catastrophizing, sleep, treatment satisfaction, pain-related functioning domains)

Murphy, JL, Clark, ME, Banou, E (2013). Opioid Cessation and Multidimensional Outcomes After Interdisciplinary Chronic Pain Treatment. Clin J Pain, 29(2): 109-17.

Outpatient Application

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

Addressing Chronic Pain in the Context of Substance Use Disorders

- Employ use of a biopsychosocial formulation of the patient's predicament versus focusing solely on a biomedical model
- Emphasize focus on function versus pain elimination: Set functional goals (resumption of normal activities, RTW) and use activity tracking sheets

Addressing Chronic Pain in the Context of Substance Use Disorders

- Medication reduction can improve functional outcomes
- Interdisciplinary care enhances results and can lead to decreased medical utilization

Lambeek, Van Mechelen, Knol, Loisel, Anema (2010); Flor, Fydrich, Turk (1992)

Buchner, Zahlten-Hinguranage, Schiltenwolf, Neubauer (2006); Linton & Ryberg (2001)

Risk Evaluation and Mitigation Strategy (REMS)

- Safety education for prescribers & patients
- Multiple possibilities
  - Prescription Drug Monitoring Programs (PDMPs)
  - UDS
  - Risk assessment tools (ORT, SOAPP, etc.)
  - Individual evaluation(s)
  - Visit frequency
  - Treatment plan components

Psychology in REMS

- Guidance re: creation
- Service delivery