PCSS Providers Clinical Support System

# Navigating the Challenges in an Era of Opioid Deprescribing: *Behavioral Strategies for Patient Engagement and Success*

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**3 pm-4 pm EDT**
**Friday, July 12, 2019**

AAPM American Academy of Pain Medicine

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**Speakers:**

| | |
|---|---|
| **Beth Darnall, PhD**<br>appliedVR: Chief Science Officer<br>Axial Healthcare: Honorarium, Scientific Advisory Board<br>NIH/NCCIH #R01AT008561; Role: Co-Principal Investigator<br>PCORI #1610-3700; Role: Principal Investigator<br>NIH/NICHD Role: Site Principal Investigator | **Aram Mardian, MD**<br>PCORI funded study: Site Director and Investigator, no compensation received<br>EMPOWER Clinical Trial: Research Grant to my Institution, Investigator<br>*The views expressed in this presentation are the views of the presenter and do not reflect the official policy of the Department of Veterans Affairs or US Government* |

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## Target Audience

- The overarching goal of PCSS is to train a diverse range of healthcare professionals in the safe and effective prescribing of opioid medications for the treatment of pain, as well as the treatment of substance use disorders, particularly opioid use disorders, with medication-assisted treatments.



## Educational Objectives

- At the conclusion of this activity participants should be able to:
  - Apply strategies to determine which patients on opioid analgesic therapy might benefit from deprescribing.
  - Assess patient readiness to taper opioid analgesics (when opioid deprescribing is the goal).
  - Describe key behavioral strategies to help move patients along the pathway from resistance to readiness to engage with a tapering trial.
  - Distinguish between clinician behaviors and language that foster patient engagement versus those that foster separation or alienation.
  - Identify and address patient fears and negative expectations to enhance engagement during patient-centered opioid tapering and minimize nocebo effects.



## Introduction: *Directives and Challenges Around Opioid Prescribing*

**Beth Darnall, PhD**
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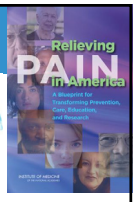
Stanford University School of Medicine,
Palo Alto, California

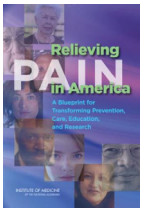
## 2011 IOM Report: *Relieving Pain in America*




- 100 million Americans have ongoing pain
- Costs $635 billion annually
- Erodes quality of life, confers suffering

Institute of Medicine. *Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education, and Research*. 2011; Washington, DC: The National Academies Press.

PCSS 7




The Interagency Pain Research Coordinating Committee
National Pain Strategy
A Comprehensive Population Health Level Strategy for Pain

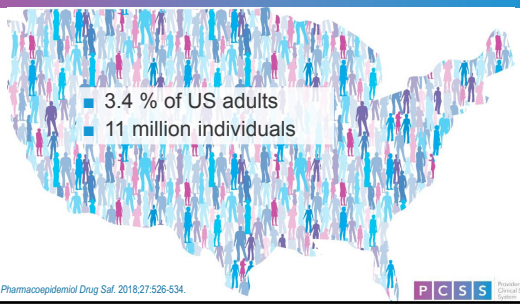
CDC
CENTERS FOR DISEASE CONTROL AND PREVENTION

PRESCRIBE RESPONSIBLY.
REDUCE OVERDOSE.
www.cdc.gov GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN

Institute of Medicine. *Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education, and Research*. 2011; Washington, DC: The National Academies Press. Interagency Pain Research Coordinating Committee. *National Pain Strategy. A Comprehensive Population Health-Level Strategy for Pain*. 2016; National Institutes of Health. Dowell D, et al. *MMWR Recomm Rep*. 2016;65:1-49.

PCSS 8

## Long-Term Use of Prescription Opioids



- 3.4 % of US adults
- 11 million individuals

Mojtabai R. *Pharmacoepidemiol Drug Saf*. 2018;27:526-534.

PCSS 9


The New York Times March 6, 2019

## *Good News: Opioid Prescribing Fell. The Bad? Pain Patients Suffer, Doctors Say.*

Doctors and insurers are using federal guidelines as cover to turn away patients, experts tell the C.D.C. and Congress.

Hoffman J, Goodnough A. *The New York Times*. March 6, 2019. Available at https://www.nytimes.com/2019/03/06/health/opioids-pain-cdc-guidelines.html. Accessed 6.17.2019.

PCSS 11

HUMAN RIGHTS WATCH

## "Not Allowed to Be Compassionate"

Chronic Pain, the Overdose Crisis, and Unintended Harms in the US

Human Rights Watch. *"Not Allowed to Be Compassionate" Chronic Pain, the Overdose Crisis, and Unintended Harms in the US*. Dec 2018. Available at www.hrw.org/sites/default/files/report_pdf/hhr1218_web.pdf

PCSS 12

THE HILL

## Addressing the dual crises of pain and opioids — a case for patient-centeredness

BY BETH DARNALL, OPINION CONTRIBUTOR — 10/31/18 06:00 PM EDT
THE VIEWS EXPRESSED BY CONTRIBUTORS ARE THEIR OWN AND NOT THE VIEW OF THE HILL

27 COMMENTS

HEALTHCARE

Darnall B. *The Hill*. Available at https://thehill.com/opinion/healthcare/414140-addressing-the-dual-crises-of-pain-and-opioids-a-case-for-patient. Accessed 6/18/2019.

PCSS 13

## Clinical Vignette


Portrayed by an actor

- 37-y/o male
  - Chronic low back pain and PTSD
  - Currently receiving prescriptions for oxycodone 10 mg 5 x daily (MEDD 75 mg)
- Now presents 2 days before his routine scheduled follow-up appointment stating that he is out of oxycodone because he had to take more after he strained his back while playing catch with his son

PCSS 14

## How Would You Approach This Patient?

a) Not refill the oxycodone
b) Assess for opioid use disorder
c) Use this as an opportunity to discuss whole-person pain care and optimize non-pharmacologic and non-opioid pharmacotherapies
d) Discharge the patient from your practice for noncompliance
e) A and D
f) B and C

PCSS 15

## Patient-Centered Opioid Desprescribing:
## *Patient Selection and Readiness for Taper*

**Aram Mardian, MD**
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Founding Chief,
Chronic Pain Wellness Center,
Phoenix VA Health Care System,
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## Knowledge Question

1. Current outpatient opioid tapering literature solidly supports mandated tapering and demonstrates good outcomes.
   a) True
   b) False

PCSS 17

## Knowledge Question

2. Core principles of patient-centered opioid tapering include:
   a) Proper patient selection
   b) Individualized taper plans
   c) Addressing patient concerns
   d) Optimizing patient control in the process
   e) A and B
   f) All of the above

PCSS 18

## Helpful to Consider 3 General Groups

**Engaged and open to tapering**
- Weak evidence to guide

**Opioid use disorder**
- Strong evidence to guide

**Not engaged and not open to tapering**
- No clear evidence to guide

PCSS 19

**Annals of Internal Medicine** REVIEW

## Patient Outcomes in Dose Reduction or Discontinuation of Long-Term Opioid Therapy

**A Systematic Review**

Joseph W. Frank, MD, MPH; Travis I. Lovejoy, PhD, MPH; William C. Becker, MD; Benjamin J. Morasco, PhD; Christopher J. Koenig, PhD; Lilian Hoffecker, PhD, MLS; Hannah R. Dischinger, BS; Steven K. Dobscha, MD; and Erin E. Krebs, MD, MPH

**Conclusion:** Very low quality evidence suggests that several types of interventions may be effective to reduce or discontinue long-term opioid therapy and that pain, function, and quality of life may improve with opioid dose reduction.

**Primary Funding Source:** Veterans Health Administration.
(PROSPERO: CRD42015020347)

Frank JW, et al. *Ann Intern Med*. 2017;167:181-191.

PCSS 20

Cochrane Library

Cochrane Database of Systematic Reviews

**Methadone maintenance therapy versus no opioid replacement therapy for opioid dependence (Review)**

Mattick RP, Breen C, Kimber J, Davoli M **2009**

**Buprenorphine maintenance versus placebo or methadone maintenance for opioid dependence (Review)**

Mattick RP, Breen C, Kimber J, Davoli M **2014**

Mattick RP, et al. *Cochrane Database Syst Rev*. 2009;(3):CD002209.
Mattick RP, et al. *Cochrane Database Syst Rev*. 2014;(2):CD002207.

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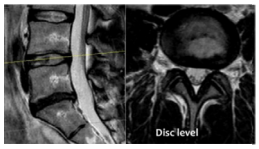
## Where is the Therapeutic Focus?

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## Goals of Treatment

- **Long-term positive health focus**
  - On improving physical, social, emotional functioning, health, and well-being
- **Minimize risk** of adverse events
- **Support self-management**

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## General Approach

- Develop a "**plan for the person with pain**" rather than a "pain treatment plan"
- Focus on **active treatments** that support self-management
  - eg, movement, psychological, diet therapies
- Use passive treatments as **bridging therapies** to support rehabilitation efforts
- Identify and treat medical, psychiatric, and SUD **co-morbidities**

SUD=substance use disorder

PCSS 24

## Engaged and Open to Tapering

EMPOWER

- Collaborative tapering process focusing on whole person
  - **Partnering** with patient
    - Treat the whole person
      - Optimize non-pharmacologic therapy (self-management, behavioral therapies, movement) and non-opioid pharmacotherapy
      - Identify and treat mental health, medical, and SUD comorbidities
    - **Gradual** taper (over months or years)
      - No set timeframe
  - **Routine risk mitigation**
    - Regular visits, UDS, PDMP, OEND
- **Vigilance for emergence of OUD**

OEND=overdose education and naloxone distribution; OUD=opioid use disorder; PDMP=prescription drug monitoring program; SUD=substance use disorder; UDS=urine drug screening

PCSS 25

## Opioid Use Disorder

- **Non-stigmatizing**
  - Of OUD and meds for OUD
- Reassure that **effective treatments are available**
- Offer and encourage **meds for OUD**
- **Whole-person** approach
- Higher intensity **risk mitigation**


PCSS 26

## Not Engaged and Not Open to Tapering

- **Most challenging group**
  - No clear evidence to guide treatment
- **Intensify team-based support**
- **Intensify risk mitigation**, including frequency of follow up

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## Not Engaged and Not Open to Tapering

- Consider DDX
  - Untreated underlying mental health condition
  - Unrecognized SUD/OUD
  - Chemical coping
  - Fear of change
  - Diversion

PCSS 28

## Not Engaged and Not Open to Tapering

- Assess risk vs risk
  - Psychosocial, mental health, SUD
- Timing and the "Now – Forever" Fallacy
- With additional time and support often:
  - Uncover and are able to treat underlying mental health condition and SUD, including OUD
  - Patient may become more engaged
- Consider buprenorphine for complex persistent opioid dependence

Manhapra A, et al. *Subst Abus*. 2018;39:152-161.

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## Avoid Fallacies in Reasoning

**The Now – Forever Fallacy**

When making a treatment decision (eg, to taper or not taper), the decision matches a patient's situation at a single point in time and is Not a Forever Decision

**The Black – White Fallacy**

When making a treatment decision (eg, to taper or not taper), individualize and offer multiple choice points for the patient; recognize shades of grey and avoid seeing only binary categories

**The Accept – Fix Fallacy**

When formulating a treatment plan recognize that accepting present reality is paradoxically required before action towards goals and change is possible

PCSS 30

## Neurobehavioral Adaptations to Opioids

- Simple opioid dependence
  - Short-lived and self-limited withdrawal symptoms after opioids are discontinued
- Complex persistent opioid dependence
  - Worsening pain, function, affective symptoms and sleep disturbance in response to opioid tapering or cessation
- Opioid use disorder
  - DSM 5 diagnostic criteria (3 Cs)

Manhapra A, et al. *Subst Abus*. 2018;39:152-161.

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## Conundrum of Opioid Tapering in Long-Term Opioid Therapy for Chronic Pain

- Long-term opioid therapy can worsen pain and associated psychological symptoms
  - Each dose of opioid provides **lower** but **very salient** pain relief
- Long-standing **dependence** (not necessarily addiction) interacts **bidirectionally and dynamically** with pain, other symptoms, stress, sleep, and psychological distress, causing significant **lability** of all these, **increasing the perceived need for opioids**
- **Opioid tapering/cessation seems** like a **logical** solution in those with well-established opioid dependence (not necessarily addiction), but can **often result in significantly worsened pain, mood, sleep, and distress** that persist for months or weeks beyond acute withdrawals
  - Due to persistent neuroadaptations

Manhapra A, et al. *Subst Abus*. 2018;39:152-161.

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## Protracted Opioid Withdrawal

- Worsening **pain**
- **Anxiety**, **irritability**, hostility
- **Depression**, mood instability
- **Fatigue, insomnia**
- Difficulty concentrating
- Unexplained physical symptoms

Manhapra A, et al. *Subst Abus*. 2018;39:152-161.

PCSS 33

## Distinguishing Requires Assessment for OUD

- Requires knowledge about diagnosis of OUD
  - DSM-5 criteria
  - 3 Cs:
    - Loss of **C**ontrol
    - **C**raving
    - Use despite **C**onsequences


American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM-5). 2013: American Psychiatric Publishing: Washington, DC.

PCSS 34

## DSM 5 Criteria for OUD

| | | |
|---|---|---|
| LOSS OF CONTROL | Using larger amounts of opioids or over a longer period than initially intended | eg: taking more than prescribed (eg, repeated requests for early refills) |
| | Persistent desire or inability to cut down on or control opioid use | eg: tried to reduce dose/quit opioid because of family's concerns about use, but unable to |
| | Spending a lot of time to obtain, use, or recover from opioids | eg: driving to different doctors' offices to get renewals for various opioid prescriptions |
| CRAVING | Craving, or strong desire or urge to use opioids | eg: describe constantly thinking about or needing opioid |
| USE DESPITE NEGATIVE CONSEQUENCES | Failure to fulfill obligations at work, school, or home due to use | eg: not finishing tasks due to effect of taking opioids; getting fired from jobs |
| | Continued use despite persistent or recurrent social/interpersonal problems related to opioids | eg: spouse or family member worried or critical about patient's opioid use |
| | Activities given up or reduced because of use | eg: no longer participating in weekly softball league despite no additional injury or reason for additional pain |
| | Recurrent use in physically hazardous situations | eg: repeatedly driving under the influence |
| | Continued use despite physical or psychological problems related to opioids | eg: unwilling to discontinue or reduce opioid dose despite non-fatal accidental overdose |
| PHYSIOLOGIC CRITERIA | Tolerance* | eg: needing to take more to achieve the same effect |
| | Withdrawal* | eg: feeling sick if opioid not taken on time or exhibiting withdrawal effects |

2-3: Mild OUD
4-5: Moderate OUD
≥6: Severe OUD

*Tolerance and withdrawal not counted as DSM-5 criteria for OUD when the patient is taking opioid medications as prescribed

American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM-5). 2013: American Psychiatric Publishing: Washington, DC.

PCSS 35

## OUD Screening Options

- **No universally accepted and quick way** to screen for OUD in primary care or pain medicine
- **Validated screening tools** (eg, NIDA Quick Screen or TAPS)
  - Limitations: initial portion is quick (NIDA Quick Screen and TAPS-1), but requires more extensive follow-up if positive (NIDA-Modified ASSIST and TAPS-2 respectively)
- ORT and SOAPP-R **limitations**:
  - Low sensitivity or time consuming
  - **NOT screens for OUD**—rather "aberrant use"

NIDA=National Institute on Drug Abuse; ORT=Opioid Risk Tool; SOAPP-R=Screener and Opioid Assessment for Patients with Pain-Revised; TAPS=Tobacco, Alcohol, Prescription medication, and other Substance use Tool

www.drugabuse.gov/publications/resource-guide-screening-drug-use-in-general-medical-settings/nida-quick-screen
www.drugabuse.gov/nmassist/ www.drugabuse.gov/taps/#/

PCSS 36

## OUD Screening Options

EMPOWER

- EMPOWER Study consensus method for screening
  - 3 opiate questions from the TAPS-2 and if any positive, query for presence of DSM-5 criteria
  - Limitations: not validated
- Clinical gestalt
  - Awareness of 3 Cs
  - Identification of high-risk behaviors
  - Application of DSM-5

PCSS 37

## Cautions

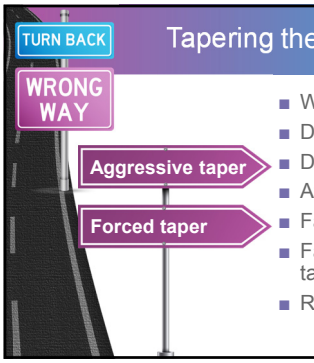
- Whole person approach requires keen attention to mental health and SUD comorbidities
- Assessing for suicidality and changes in mood should be routine
  - Readiness to intensify team-based support as needed
- Err on side of giving more time and working with patients unless acute danger
- Continue to closely engage with patients in the post-taper period
  - At least 6-12 months

PCSS 38

## Threading the Needle: *Patient-Centered Opioid Deprescribing*

**Beth Darnall, PhD**
Associate Professor,
Department of Anesthesiology, Perioperative, and Pain Medicine,
Stanford University School of Medicine,
Palo Alto, California

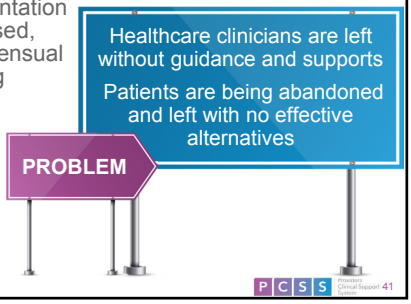
## Tapering the Wrong Way




- Withdrawal symptoms
- Discomfort
- Distress
- Attrition
- Failed tapers
- False belief that outpatient tapering is impossible
- Remaining on opioids indefinitely

PCSS 40

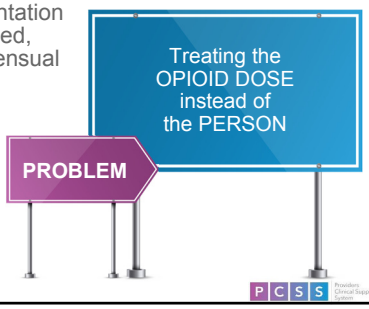
No evidence exists to support the implementation of community-based, outpatient non-consensual opioid tapering




Darnall BD, et al. *Pain Med.* 2019;20:429-433.

PCSS 41

No evidence exists to support the implementation of community-based, outpatient non-consensual opioid tapering




Darnall BD, et al. *Pain Med.* 2019;20:429-433.

PCSS 42

WORLD VIEW *A personal take on events*

IAN MACKEY

# To treat pain, study people in all their complexity

**TOO OFTEN,** PAIN IS **TREATED** AS A PURELY **BIOMEDICAL** PROBLEM.

*Clinical research needs to investigate not simply drugs, but the psychology of why and how individuals experience pain, says* **Beth Darnall.**

Darnall B. *Nature*. 2018;557:7.

PCSS 43

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**The biopsychosocial model of pain**


PCSS

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PCSS 45

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## Opioid Tapering: Address Patient Needs and Wants


PCSS 46

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SPECIAL TOPIC SERIES

*Clin J Pain* • Volume 29, Number 2, February 2013

## Opioid Cessation and Multidimensional Outcomes After Interdisciplinary Chronic Pain Treatment

*Jennifer L. Murphy, PhD,* Michael E. Clark, PhD,*† and Evangelia Banou, PhD**

| Outcome Variables | OP (n = 221) Mean (SD) | NOP (n = 379) Mean (SD) |
|---|---|---|
| Pain intensity | | |
| Admission | 7.01 (1.77) | 6.91 (1.58) |
| Discharge | 6.46 (1.74) | 6.14 (1.79) |

OP group: patients using opioid analgesics before admission (typically daily, sustained use) and required opioid taper
NOP group: patients not using opioid analgesics before admission and/or did not require any taper

Murphy JL, et al. *Clin J Pain*. 2013;29:109-117.

PCSS 47

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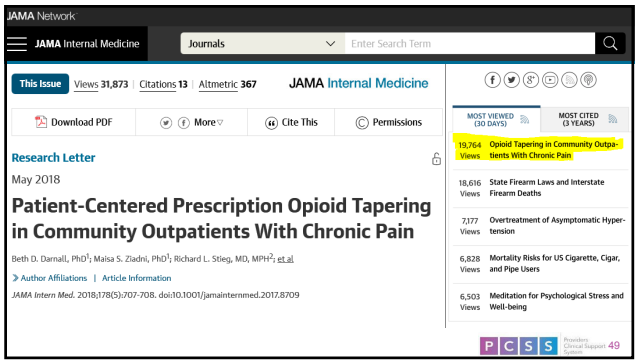
## Community-Based Solutions are Needed

- Low-cost
- Low-risk
- Scalable
- Effectively reduces health risks
- Provides education and support
- Structured
- Addresses anxiety of patients and prescribers alike
- Promotes trust and a good doctor-patient bond

PCSS 48



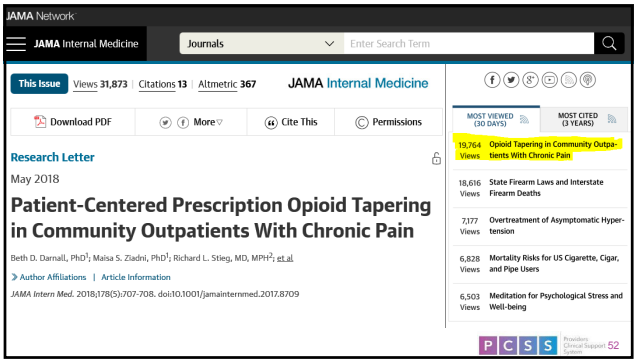

## Guiding Principles for Patient Engagement

- Voluntary
- Describe the evidence for tapering
- Make it relevant to the patient you are treating: why do you think it is important?
- Listen: answer all of their questions
- Explain the goals of going very slow, keeping them comfortable
- Monitor closely
- Offer patients control to reduce pace or pause
- Appreciate that it may take a few visits to gain their buy-in and trust
- Taper very slowly to prevent withdrawal symptoms

PCSS 50

## Opioid Reduction vs. Opioid Cessation


PCSS 51




## Study Variables

- Demographics (gender, age)
- Pain treatment history (pain diagnosis, duration of opioid use)

- Opioid dose (MEDD)
- Average Pain Intensity (0-10 NRS)
- Pain Catastrophizing Scale
- PROMIS Measures
- Marijuana use (Y/N)

→ 16 weeks

Darnall BD, et al. *JAMA Intern Med.* 2018;178:707-708.

PCSS 53

## Baseline Sample Characteristics

| Variable | Baseline |
|---|---|
| Female | 55% |
| Median age | 52 years (range 25-72) |
| Median duration of opioid use | 6 years (range 1-38) |
| Median pain intensity (NRS) | Moderate (5/10) |
| Marijuana use | 37% (18) |
| Median opioid MEDD | 288 mg (60, 1005) |

MEDD=morphine equivalent daily dose; NRS=Numeric Rating Scale

Darnall BD, et al. *JAMA Intern Med.* 2018;178:707-708.

PCSS 54

## Outcomes: Change From Baseline to Month 4

| Variable | Completers (n=51) | | *P*-value |
|---|---|---|---|
| | Baseline | 16 weeks | |
| | Median (IQR) | | |
| Opioid dose (MEDD) | 288 (153, 587) | 150 (54, 248) | 0.002 |
| Pain intensity (NRS) | 5.0 (3.0, 7.0) | 4.5 (3.0, 7.0) | 0.29 |
| PCS (catastrophizing) | 22 (10, 30) | 15 (7, 23) | 0.04 |
| Fatigue* | 61 (54, 65) | 59 (51, 65) | 0.64 |
| Anxiety* | 60 (53, 64) | 54 (46, 62) | 0.06 |
| Depression* | 56 (49, 64) | 55 (48, 61) | 0.31 |
| Sleep disturbance* | 59 (54, 70) | 56 (50, 64) | 0.13 |
| Pain interference* | 63 (58, 67) | 63 (57, 67) | 0.44 |
| Pain behavior* | 60 (57, 63) | 59 (56, 64) | 0.47 |
| Physical function*† | 39 (34, 41) | 39 (34, 43) | 0.78 |

IQR=interquartile range; MEDD=morphine equivalent daily dose; NRS=Numeric Rating Scale; PCS=PAIN Catastrophizing Scale
*Patient Reported Outcomes Information System (PROMIS) measure
†Lower scores reflect worse function, pain (numeric rating scale)

Darnall BD, et al. *JAMA Intern Med*. 2018;178:707-708.

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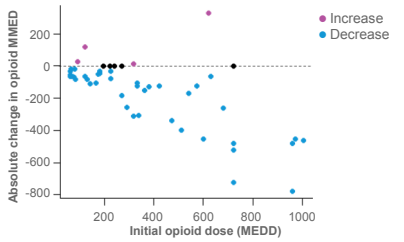
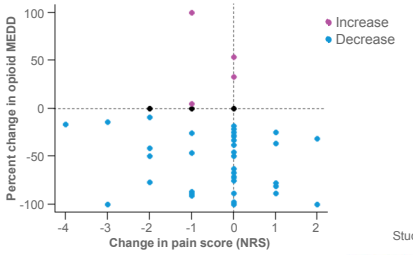
## Change in Opioid MEDD by Initial Opioid Dose: Baseline to Month 4




Darnall BD, et al. *JAMA Intern Med*. 2018;178:707-708.

PCSS 56

## Change in Opioid MEDD and Pain Intensity Score: Baseline to Month 4

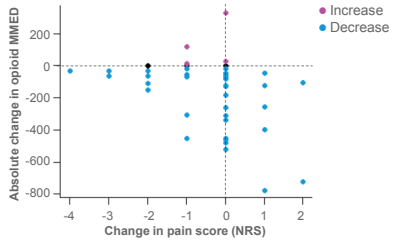



Study completers

Darnall BD, et al. *JAMA Intern Med*. 2018;178:707-708.

PCSS 57

## Change in Opioid MEDD and Pain Intensity Score: Baseline to Month 4




Darnall BD, et al. *JAMA Intern Med*. 2018;178:707-708.

PCSS 58

## Not Just About Opioids or No Opioids

How do we help patients live better, doing more of what's most meaningful to them?

PCSS 59

## Voluntary vs. Involuntary

- Patient readiness exists on a continuum
- Expect early resistance
- How YOU engage with patients will determine how well they engage with you
- In the next segment we will describe some tools (also downloads)
- Clinician behaviors that foster patient engagement
- How can you reduce the patient's perception of "risk"?
- Timing is key

PCSS 60

## Comparative Effectiveness Study: Patient-Centered Opioid Tapering

Comparing **pain cognitive behavioral therapy (CBT)** with **peer-led chronic pain self-management** for patients with chronic pain who want to **reduce opioid use**—the **EMPOWER** Study

Darnall BD (Principal Investigator)
Mardian A (Co-Investigator)

EMPOWER
EFFECTIVE MANAGEMENT OF PAIN AND OPIOID-FREE WAYS TO ENHANCE RELIEF

Multi-state study funded by:

pcori
PATIENT-CENTERED OUTCOMES RESEARCH INSTITUTE

https://empower.stanford.edu/
www.pcori.org/research-results/2017/comparing-cognitive-behavioral-therapy-peer-led-support-groups-patients#/

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## EMPOWER Study Design

- Population
  - 1365 patients taking long-term opioids for chronic pain in primary care and pain clinics
- 4-state, 5-clinic, pragmatic clinical trial
  - Study clinics
    - Stanford Pain Management Center (CA)
    - Stanford Primary Care (CA)
    - Intermountain Health (Salt Lake City, UT)
    - Phoenix VA Health Care System (Phoenix, AZ)
    - Richard Stieg, MD, LLC (Frisco, CO)

CHOIR Collaborative Health Outcomes Information Registry

www.pcori.org/research-results/2017/comparing-cognitive-behavioral-therapy-peer-led-support-groups-patients#/
https://empower.stanford.edu/

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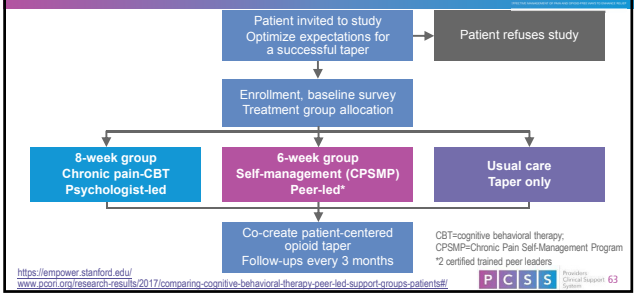
## EMPOWER Study Design




https://empower.stanford.edu/
www.pcori.org/research-results/2017/comparing-cognitive-behavioral-therapy-peer-led-support-groups-patients#/

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## EMPOWER Guiding Principles

- Patient safety and comfort is paramount
- Patient-centeredness
  - Integration of the patient voice into the study design and conduct
- Opioid tapering is not right for everyone
  - Careful patient selection
- Monitor closely to identify and mitigate opioid tapering health risks
  - Near real-time feedback to prescribing clinicians
- Flexible systems attend to the individual patient's needs and wants

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## Patient-Centered Opioid Tapering Methods

- **VOLUNTARY** participation
- Patients may control the pace of their taper
- No stipulation of unidirectionality
- Patients may pause their taper
- Patients may drop out of the study at any time
- The taper goal is not zero unless the patient chooses that goal
- The taper is **NOT** to a pre-defined opioid dose
- Patients partner with their clinician to achieve their lowest comfortable dose over **12 months**

Darnall BD, Colloca L. *Int Rev Neurobiol*. 2018;139:129-157.

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## Patient Engagement and Strategies for Success

- **VALIDATE** fear, anger, stigmatization, fighting with pharmacies etc.
- Patients tend to reject "one-size-fits-all" mandates
- Use peer-to-peer communication
  - eg, www.empower.Stanford.edu
- Provide the scientific evidence on tapering
- **PARTNER** with patients
  - Provide them with options
  - Help them feel more in control
- Patient-centeredness means putting the patient's personal wellbeing above all else

All these strategies **optimize placebo** and **minimize nocebo**

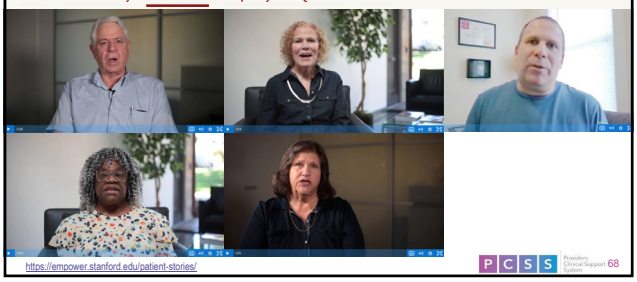
Darnall BD, Colloca L. *Int Rev Neurobiol*. 2018;139:129-157

PCSS 67

## EMPOWER Study

*Effective Management of Pain and Opioid-Free Ways to Enhance Relief*

Home | About the Study | Patient Stories | Frequently Asked Questions | Contact



https://empower.stanford.edu/patient-stories/

PCSS 68

## Opioid Tapering is **Not** For Everyone

- Patient selection
  - eg, OUD, medical conditions
- Patient willingness
  - Offer choices

PCSS 69

## Not Just About Opioids or No Opioids

How do we help patients live better, doing more of what's most meaningful to them?

PCSS 70

## Wrap-Up

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## Clinical Vignette


- 37-y/o male
  - Chronic low back pain and PTSD
  - Currently receiving prescriptions for oxycodone 10 mg 5 x daily (MEDD 75 mg)
- Now presents 2 days before his routine scheduled follow-up appointment
  - States that he is out of oxycodone because he had to take more after he strained his back while playing catch with his son

PCSS 72

## How Would You NOW Approach This Patient?

a) Not refill the oxycodone
b) Assess for opioid use disorder
c) Use this as an opportunity to discuss whole person pain care and optimize non-pharmacologic and non-opioid pharmacotherapies
d) Discharge the patient from your practice for noncompliance
e) A and D
f) B and C



## Clinical Vignette


- Patient commended for engaging in important life activities
- Assessment
  - Assessed for OUD: 0 of 9 criteria present
    - → No diagnosis of OUD
  - Assessed for PTSD symptoms
    - → Experiencing poor sleep due to frequent nightmares and hypervigilance
  - Chemical coping suspected
- Treatment
  - Oxycodone refilled at current dose
  - Patient agreed to evidence-based psychotherapy for PTSD
  - SNRI initiated
  - After 2 months, collaborative opioid taper started



## Final Thoughts

- Connection between the clinician and patient is the foundation to successful pain and opioid management
- Psychological strategies are key to enhancing patient engagement and may help support patient during a collaborative opioid taper
- Familiarity with the diagnosis and management of OUD is critical when managing patients on long-term opioid therapy



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- The Empower Study. https://empower.stanford.edu/


## PCSS Mentoring Program

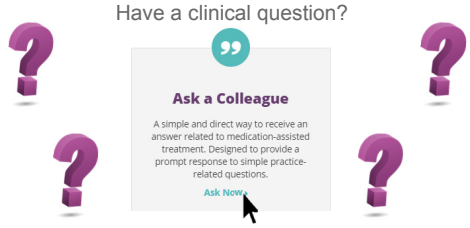
- PCSS Mentor Program is designed to offer general information to clinicians about evidence-based clinical practices in prescribing medications for opioid addiction.
- PCSS Mentors are a national network of providers with expertise in **addictions, pain, evidence-based treatment including medication-assisted treatment**.
- 3-tiered approach allows every mentor/mentee relationship to be unique and catered to the specific needs of the mentee.
- No cost.

**For more information visit:**
**https://pcssNOW.org/mentoring/**



## PCSS Discussion Forum

Have a clinical question?




**http://pcss.invisionzone.com/register**

PCSS Providers Clinical Support System

**PCSS** is a collaborative effort led by the
American Academy of Addiction Psychiatry (AAAP) in partnership with:

| | |
|---|---|
| Addiction Technology Transfer Center | American Osteopathic Academy of Addiction Medicine |
| American Academy of Family Physicians | American Psychiatric Association |
| American Academy of Neurology | American Psychiatric Nurses Association |
| American Academy of Pain Medicine | American Society for Pain Management Nursing |
| American Academy of Pediatrics | American Society of Addiction Medicine |
| American College of Emergency Physicians | Association for Multidisciplinary Education and Research in Substance Use and Addiction |
| American College of Physicians | International Nurses Society on Addictions |
| American Dental Association | National Association of Community Health Centers |
| American Medical Association | National Association of Drug Court Professionals |

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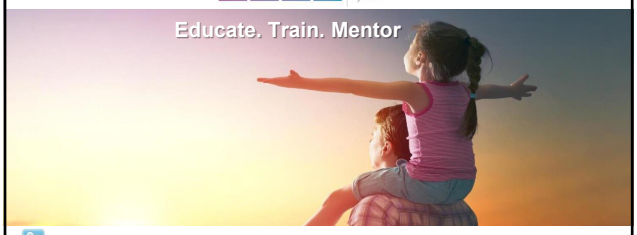


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PCSS Providers Clinical Support System

# Questions & Answers

**Please type your questions into the text chat box**

# Patient-Centered Opioid Tapering

- Opioid tapering is NOT for everyone. Patients with Moderate to Severe Opioid Use Disorder require different care pathways.
- Caution against forced opioid tapering. Work to partner with patients on *voluntary* opioid tapering.
- Recognize that most patients are fearful.
- Don't take it personally. Patients may resist a treatment plan; it's not about you.
- Explain the health benefits of reducing medications. Patients need to know why reducing opioids is good vs. likely to leave with suffering. (provide a handout)
- Highlight why reducing medications will specifically help *them.* Tailor a personalized, conversation for each individual patient.
- Anxiety about reducing medications undermines patient engagement and patient response to the taper. Helping allay patient concerns is paramount to success.
- Forced tapers yield suboptimal results. Focus on building partnership.
- Avoid talking about ZERO opioids. Help them be willing to try a gentle reduction toward less opioids.
- Connect. Validate patients' concerns. Feeling heard is the foundation for patients to trust you.
- Share the data on opioid tapering results: pain does not typically increase when done the right way; for many, pain improves.
- Explain how you will partner with them (follow-up schedule, dose decrements)
- Explain that the goal is to *prevent withdrawals*.
- Help them feel in control (consider micro dose decrements to start, ability to pause)
- Give them support (pain psychology resources, clinic staff support)
- Provide a patient resource reading list for opioid tapering and a relaxation tool.

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# Addressing Opioids

When opioid reduction is the goal:

- **Assess motivation** and readiness to reduce opioids.
- **Assess any/all negative impacts** from opioid use (e.g., cognitive effects, fatigue, poor sleep, effort to obtain scripts, stigma, etc).
- **Shift paternalistic dialog**. Help patients understand the long term risks of opioids and why using less medication is in their best interests. Doing so will minimize perceptions of injustice and blame.
- **Ask**: What are your concerns about reducing your opioids?
- **Set positive expectations**. The biggest patient fear is greater pain. Review the data that when opioids are reduced slowly and sensibly, pain intensity tends to remain constant or improve. Sleep improves with opioid reduction and that facilitates reduced pain.
- **Assess and provide education** for how psychosocial factors can maintain greater use of opioids

  poor pacing → greater pain → opioids

  anxiety → greater pain → opioids

- **Provide specific resources** (e.g., books on opioid reduction).
- **Declare your philosophy:** Opioids may be *one part* of an overall care plan-- not the whole story. And for many, long term opioids may be contraindicated.
- **Emphasize self-management**. Partner with patients in reducing their opioids risks by emphasizing behavioral medicine. Doing so yields the best outcomes.

**Provide ongoing support**. Classes, self-management groups, support groups.

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# Tips for Physicians / Prescribers

**Remind Your Patients About the Benefits of Opioid Tapering**: Studies suggest that on average patients get better with a VERY SLOW opioid taper. Many people report having less pain and feeling better overall. On top of that, they will enjoy fewer side effects and greatly reduced health risks.

**Reassure your patients.** Your patients are scared because they tried and failed before. Most patients have failed because they went too fast with their taper and had withdrawals. Remind them that the VERY SLOW taper will prevent withdrawals and keep them comfortable. Everyone can wean down on opioids but the trick is to go very slowly and use skills to keep yourself calm as your body adjusts. If you use adjuvants, tell them other medications may be used to help them reduce opioids more comfortably.

**GO SLOW**. Most taper guidelines suggest taper schedules that are too aggressive for the real-world chronic pain patient on multiple meds and high opioid doses. We do not recommend a specific taper schedule to you, but if a patient has been on opioids for years and decades, consider taking about 6 months for cessation or getting to the lowest possible dose. A good target is substantial reduction at 4 months, as low as possible at 10 months.

**Not Everyone Will Taper Completely**. The goal is to get patients as low as possible in 10 months.

**Check in With Your Patients**. Monitor closely, especially for discomfort and mood changes. At each follow-up, ask how they are doing. Ask if they are ready to go down on *one* of their doses.

**Engage Them in Their Pain Care**. Ask if they have read the book that was mailed to them. Ask them what they are learning about how to best keep their pain low so they naturally need less medication.

**Not everyone benefits from opioid reduction**. Despite what the data tell us about patient outcomes with opioid reduction, some patients do not experience pain relief. Patient-centeredness encourages us to treat each patient as an individual, taking into account their complexities and response. *Some patients need opioids as one component of their pain care.* Ideally, if it is discovered that patients have poor outcomes with opioid reduction, they should be allowed to return to their therapeutic dose, within the context of multidisciplinary care.

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# Tips & Scripts for Communicating with Patients

- "It's not about taking something away from you. It's about treating your pain better, with lower risks."
- Understand their concerns. Ask them if they are interested in reducing opioids. If not, why.
- Assess history of withdrawal symptoms. Patients often believe that they will experience withdrawals and increased pain if medications are reduced. "Have you ever missed a dose of medication, or had withdrawal symptoms before?"
- Educate patients about the distinction between withdrawal symptoms, "baseline pain", and what they can expect from a very slow opioid taper.
- "We can partner together and reduce your medications so slowly your body doesn't notice it. This keeps you comfortable and prevents withdrawal symptoms."
- "When done right, most people who reduce opioids do not have increased pain. In fact, pain actually improves for many people."
- Patient videos can be a valuable tool.
- Offer flexibilities: "We can pause the taper if we need to."
- Assure patients they will still have access to acute pain care as needed, but the long-term goal may be to resume the opioid taper afterward.
- Consider reassuring patients that if they do not experience benefit over 5 months they can return to a previous opioid dose. The goal is to help them be comfortable during the taper so they agree to continue. This point stands in recognition that not all patients benefit from opioid reduction.

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# Communication Examples:

- **PATIENT: "I tried stopping once and my pain was terrible."**

  YOU: "That's a common experience that usually happens when medications are reduced too quickly and it triggers withdrawals. Our goal will be to prevent you from having negative symptoms. To address this, we begin with such a slow reduction that your body will not notice the difference and will not react to it. This sets you up for success."

- **PATIENT: "I don't want to reduce my opioids because if my pain is worse I will want them back and you won't give them to me."**

  YOU: "When done very, very slowly most people do not have more pain – and studies show that many find their pain actually gets *better*. Reducing opioids can be an effective way to actually reduce your pain; it's just got to be done the right way.

  Would you be willing to partner on a very, very slow reduction to see if we can get you reductions in your pain? For instance, we might try reducing (by 5%) over the course of a month or more. Meanwhile, we will focus on giving you other tools that will help all areas of your life that are impacted by pain."

- **PATIENT: "What if I find my pain gets worse. Then what?"**

  YOU: "Our goal is to prevent this scenario. We can prevent it by going super slow. But, chronic pain does flare from time to time, even with opioids. We will stay in close communication so in the unlikely event your pain increases we can learn from it and understand why it's happening. We can also pause the taper and work with your body."

- **PATIENT: "I'm really scared about this."**

  YOU: "You are not alone. It is common for patients to fear opioid reduction, even though most say that they would like to take less opioid medication. Our plan will set you up for success. We will go slow, communicate with each other, and I will help address your needs. Your job will be to help yourself be calm because that will help our plan work better. Let me connect you with some resources and tools to help you feel less anxious about this."

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## Print Resources

Books that address opioid tapering:

- *The Opioid-Free Pain Relief Kit* ©2016 (Bull Publishing)
- *Less Pain, Fewer Pills: Avoid the dangers of prescription opioids and gain control over chronic pain* ©2014 (Bull Publishing)

Overview of Evidence-Based Behavioral Treatments for Chronic Pain

Includes clinician and patient free resources.

- *Psychological Treatment for Patients with Chronic Pain* ©2018 (APA Press)