

NATIONAL REGISTER

CLINICAL WEBINARS

TRANSLATING RESEARCH TO PRACTICE

Patient-Centered Opioid De-prescribing in Low-Resource Care Settings

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Aram Mardian, MD



Aram Mardian, M.D. is clinical associate professor of Family, Community, and Preventive Medicine at the University of Arizona College of Medicine – Phoenix, is a board-certified family physician, and holds additional certifications in addiction medicine, pain medicine, and medical acupuncture. He is the founding Chief of the Chronic Pain Wellness Center at the Phoenix VA Health Care System, which has developed into a model for interprofessional whole person care for patients with pain and opioid use disorder. Dr. Mardian was a contributor for the Arizona Opioid Prescribing Guidelines published in 2014 and 2018 and a workgroup member for the VA/DoD Clinical Practice Guideline “Management of Opioid Therapy for Chronic Pain” published in February 2017. He serves as Co-Chair for the Health Care Advisory Team for the Arizona Prescription Drug Misuse & Abuse Initiative and Co-Chair for the Arizona Pain and Addiction Curriculum Workgroup.

Disclosures/Conflicts of Interest

Dr. Mardian has no disclosures or conflicts of interest.

Beth Darnall, PhD



 [@BethDarnall](https://twitter.com/BethDarnall)

Beth Darnall, PhD is Associate Professor at Stanford University School of Medicine, Department of Anesthesiology, Perioperative, and Pain Medicine.

She is principal investigator for large NIH and PCORI-funded multi-site clinical trials that broadly investigate behavioral medicine and self-management strategies for acute and chronic pain, and voluntary patient-centered prescription opioid reduction. She also creates and investigates scalable, accessible, low-cost and free pain treatments, including brief and digital pain treatments.

She has authored/co-authored 5 books for patients and clinicians.

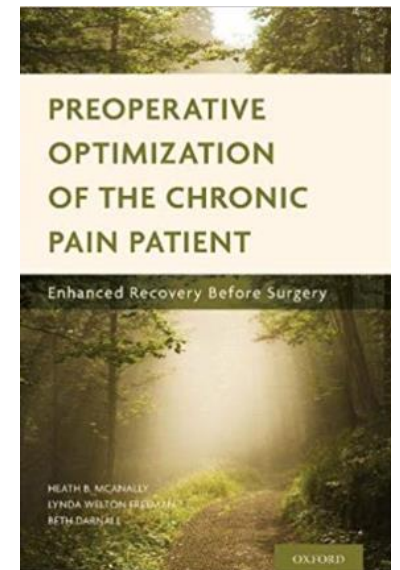
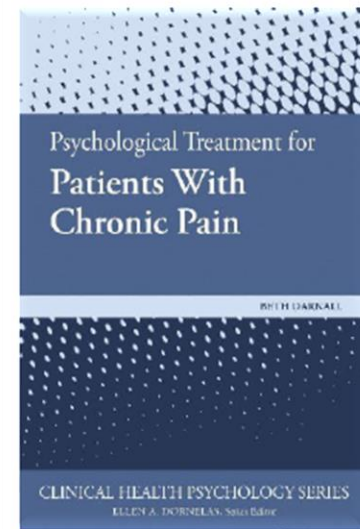
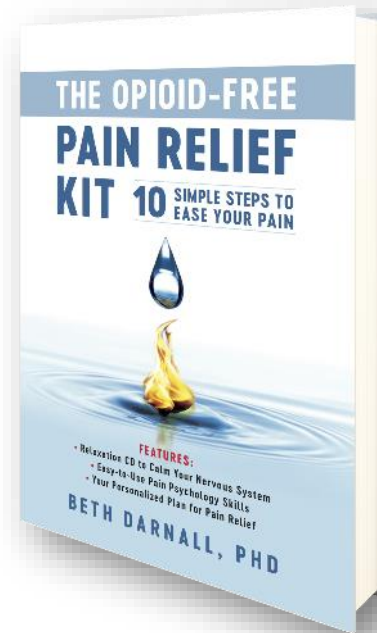
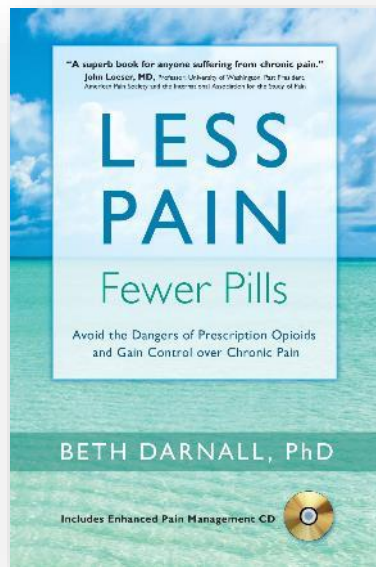
In 2018 she briefed the U.S. Congress on the opioid and pain crises, and in 2019 provided invited testimony to the FDA on iatrogenic harms from forced opioid tapering. Her work has been featured in *Scientific American*, *NPR Radio*, *BBC Radio*, and *Nature*. In 2018 she spoke on the psychology of pain relief at the World Economic Forum in Davos, Switzerland.

Contracts and Grants

- PCORI (PI) Patient-Centered Opioid and Pain Reduction
- NIH / NCCIH: R01 (Co-PI) Mechanisms & Efficacy of Pain Catastrophizing Treatment for Chronic Pain



Chief Scientific Advisor: appliedVR



Learning Objectives

- Apply strategies to determine which patients on opioid analgesic therapy might benefit from de-prescribing.
- Describe key behavioral strategies to help move patients along the pathway from resistance to readiness to engage with a tapering trial.
- List potential harms and benefits associated with opioid tapering and patient factors that may predispose to each
- List three strategies to enhance patient safety and comfort during opioid reduction.

Outline

- Background
- Risk: Benefit assessment
- Who is right for opioid tapering?
- Nuts and Bolts of patient-centering tapering
- Resources

Clinical Vignettes

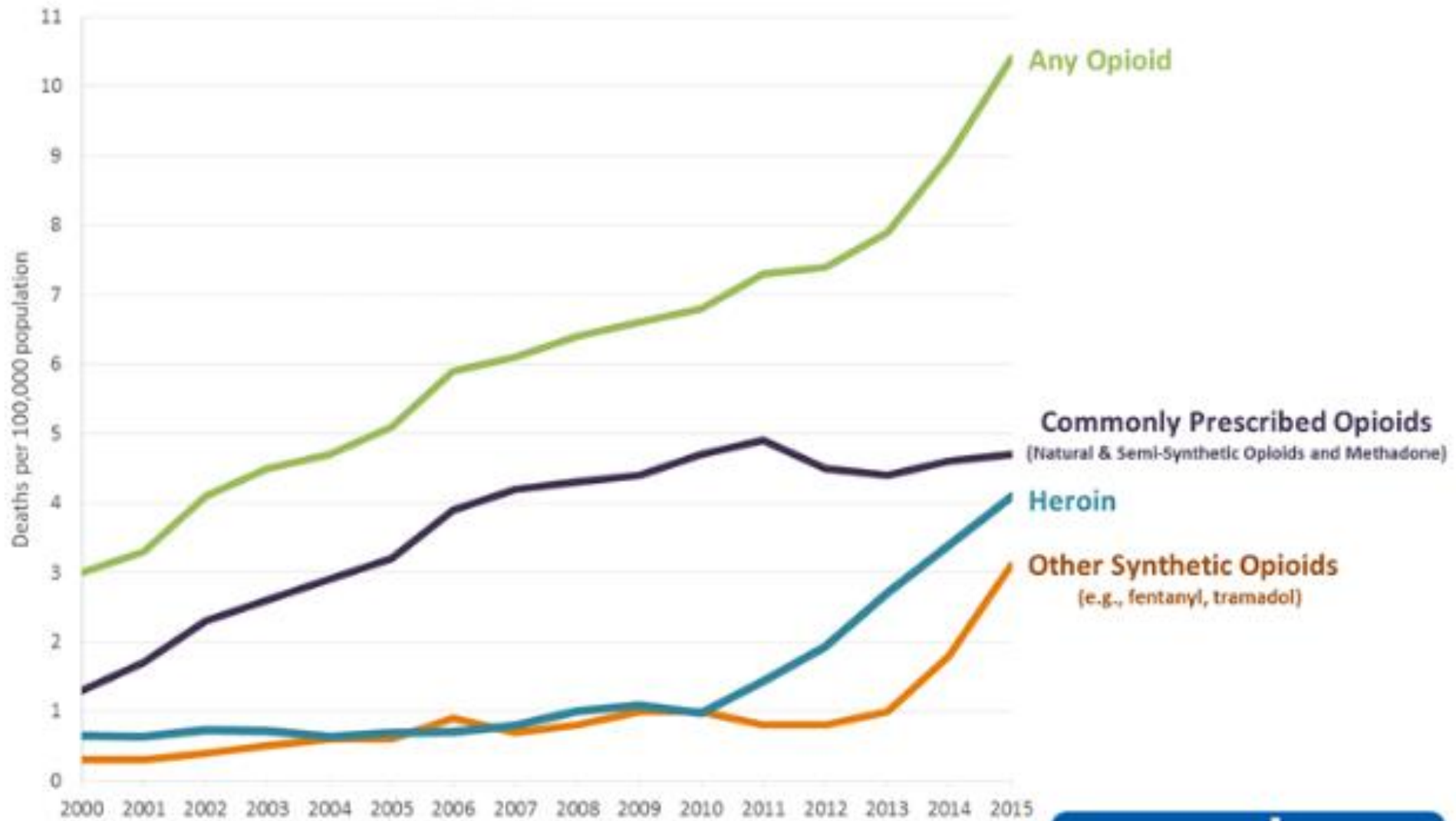


The background of the slide is a repeating pattern of blue silhouettes of people in various poses, creating a sense of a large crowd or community. The silhouettes are semi-transparent and overlap, giving a layered effect.

2011 IOM Report: *Relieving Pain in America*

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

Overdose Deaths Involving Opioids, United States, 2000-2015

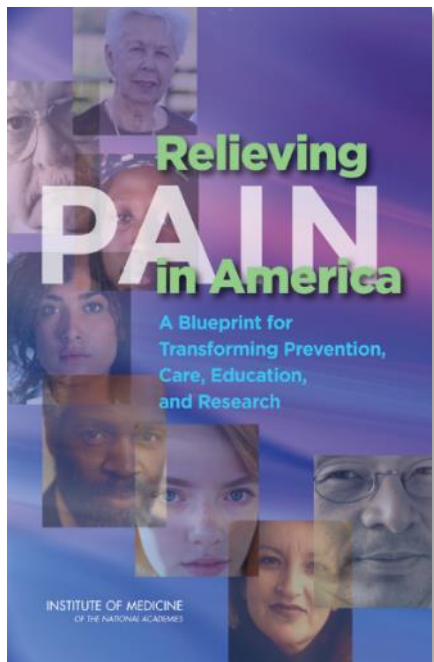


SOURCE: CDC/NCHS, National Vital Statistics System, Mortality. CDC WONDER, Atlanta, GA: US Department of Health and Human Services, CDC; 2016. <https://wonder.cdc.gov/>.

www.cdc.gov
Your Source for Credible Health Information

Long-Term Use of Daily Prescription Opioids

- 
- **3.4 % of US adults**
 - **11 million individuals**

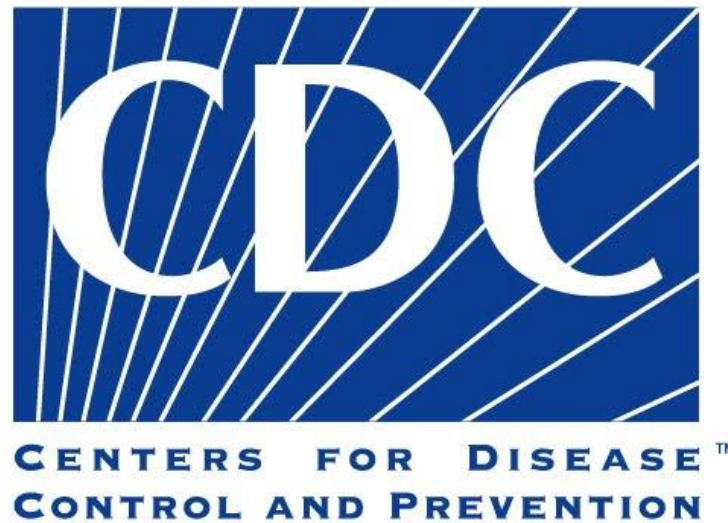


The
Interagency Pain Research Coordinating Committee



National Pain Strategy

A Comprehensive Population Health Level
Strategy for Pain



PRESCRIBE RESPONSIBLY.
REDUCE OVERDOSE.

www.cdc.gov

GUIDELINE FOR PRESCRIBING
OPIOIDS FOR CHRONIC PAIN



Susan

- Architect, working part-time
- Moderate depression
- Anxiety
- Insomnia
- Chronic neck and low back pain
- Taking 150 MEDD for 3 years
- Does not want to reduce her medication

Challenges for PCP

- Tension created by: Broad recommendations for deprescribing yet patient does not want to taper
 - Have not been trained in how to resolve this tension
- **PCPs have received conflicting messages** about the how to manage pain and patients on LTOT

Challenges for PCP

- In the last 30 years PCPs have been taught to:
 - Use the same approach to chronic pain as for acute pain (ie **find a “pain generator” and then try to numb, remove, eliminate** the diseased body part with pills, procedures, and surgeries). Works well for broken bone/abscess but not LBP
 - **Use opioids aggressively** to eliminate pain because the risks are minimal and opioids are effective for chronic pain
 - **Stop using opioids** because they are harmful and ineffective



The biopsychosocial model of pain





International Association for the Study of Pain

IASP

Working together for pain relief

Pain Definition: A noxious sensory and emotional experience

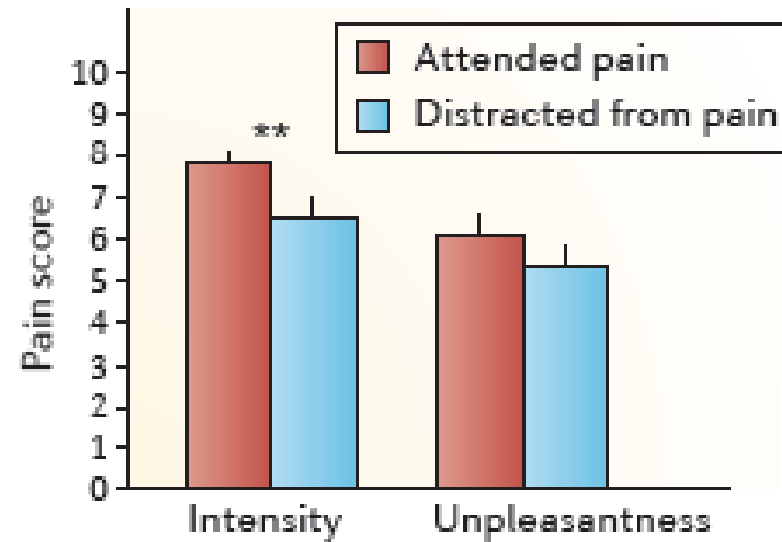


Pain is Complex

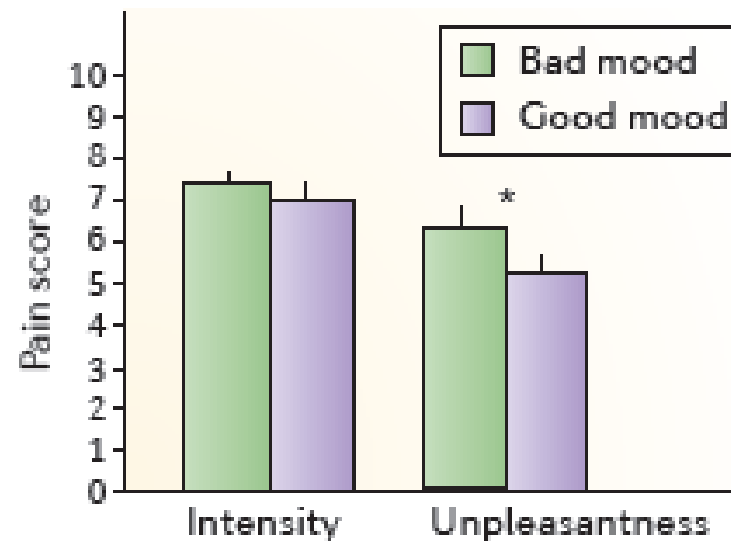
- Context
- Meaning
- Cognition
- Emotion
- Affect
- Mood
- Attention
- Social factors

Villemure C & Bushnell MC. Cognitive modulation of pain: how do attention and emotion influence pain processing? *Pain* (2002).

Attentional modulation



Emotional modulation



DRUG EFFICACY

The Effect of Treatment Expectation on Drug Efficacy: Imaging the Analgesic Benefit of the Opioid Remifentanil

Ulrike Bingel,^{1,2*} Vishvarani Wanigasekera,¹ Katja Wiech,¹ Roisin Ni Mhuirheartaigh,¹ Michael C. Lee,³ Markus Ploner,⁴ Irene Tracey¹

Evidence from behavioral and self-reported data suggests that the patients' beliefs and expectations can shape both therapeutic and adverse effects of any given drug. We investigated how divergent expectancies alter the analgesic efficacy of a potent opioid in healthy volunteers by using brain imaging. The effect of a fixed concentration of the μ -opioid agonist remifentanil on constant heat pain was assessed under three experimental conditions using a within-subject design: with no expectation of analgesia, with expectancy of a positive analgesic effect, and with negative expectancy of analgesia (that is, expectation of hyperalgesia or exacerbation of pain). We used functional magnetic resonance imaging to record brain activity to corroborate the effects of expectations on the analgesic efficacy of the opioid and to elucidate the underlying neural mechanisms. Positive treatment expectancy substantially enhanced (doubled) the analgesic benefit of remifentanil. In contrast, negative treatment expectancy abolished remifentanil analgesia. These subjective effects were substantiated by significant changes in the neural activity in brain regions involved with the coding of pain intensity. The positive expectancy effects were associated

EXPECTATIONS

- Analgesic (Pollo, Amanzio, et al 2001)
- Amplify pain (Benedetti, Lanotte, Lupiano, Colloca 2007)

Published in final edited form as:

Pain. 2014 January ; 155(1): 129–136. doi:10.1016/j.pain.2013.09.014.

From cue to meaning: Brain mechanisms supporting the construction of expectations of pain

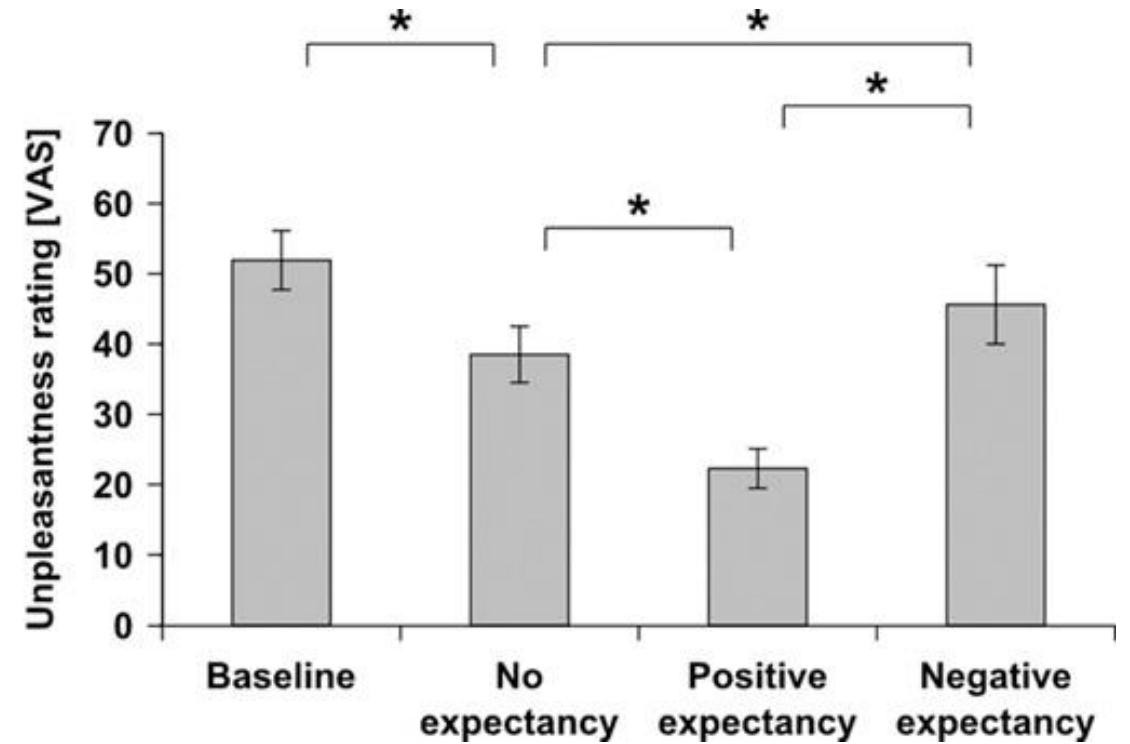
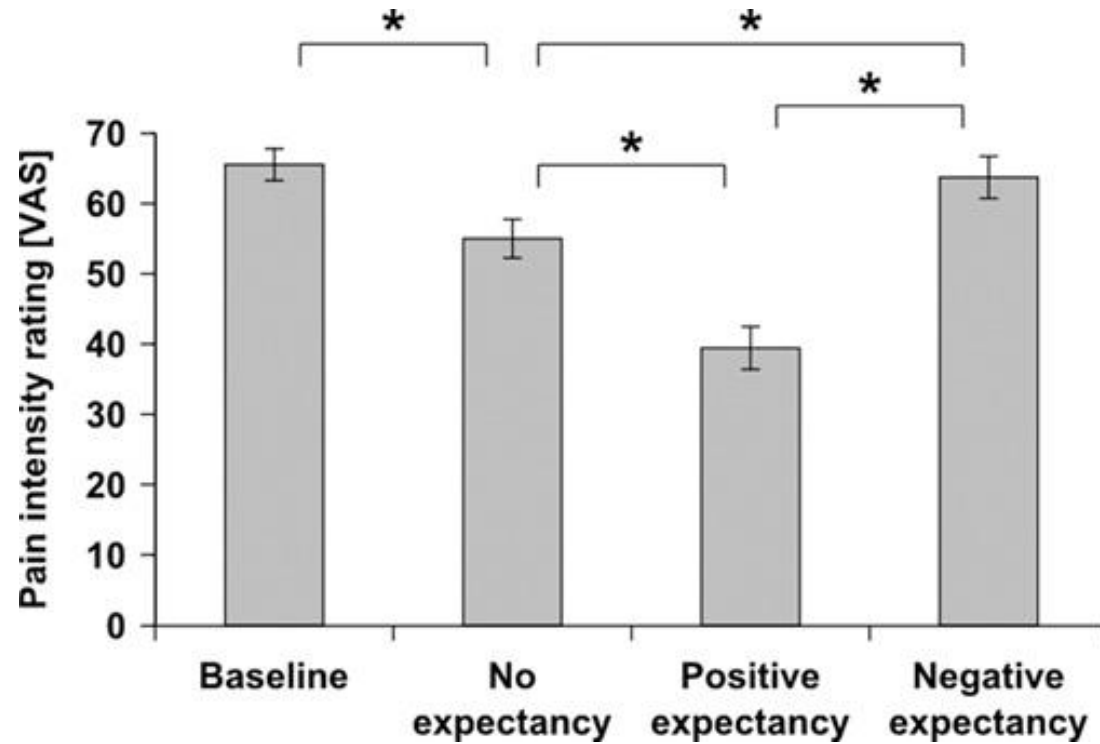
Oleg V. Lobanov^{1,2}, Fadel Zeidan², John G. McHaffie², Robert A. Kraft³, and Robert C. Coghill^{1,2}

¹Neuroscience Program, Wake Forest University School of Medicine, 1 Medical Center Boulevard, Winston-Salem, NC 27157-1010, USA

²Department of Neurobiology and Anatomy, Wake Forest University School of Medicine, 1 Medical Center Boulevard, Winston-Salem, NC 27157-1010, USA

³Department of Biomedical Engineering, Wake Forest University School of Medicine, Medical Center Boulevard, Winston-Salem, NC 27157-1022, USA

Psychological Modulation of Opioid Analgesia



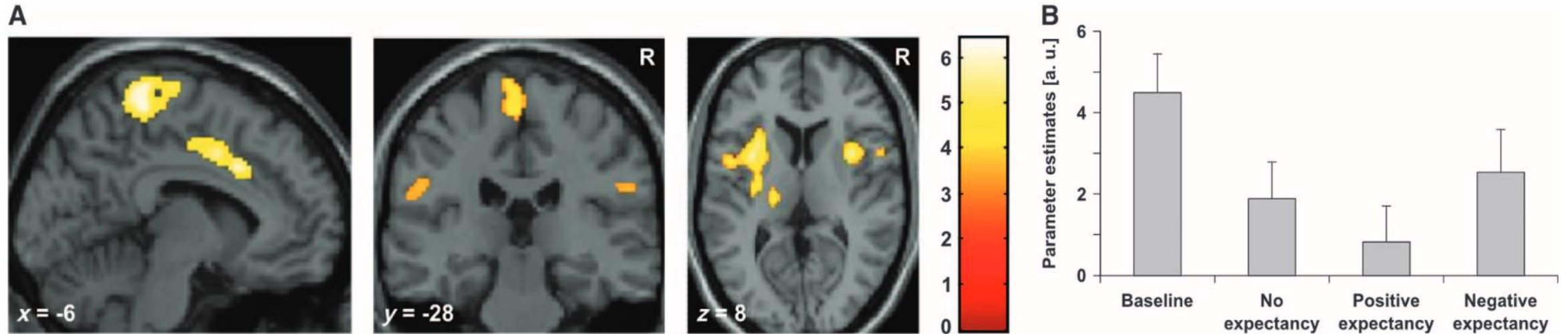


Fig. 5. Effect of expectancy modulation of opioid analgesia in the core regions of the pain neuromatrix. **(A)** Brain activity correlating with the changes in behavioral analgesia in the four experimental conditions. These correlations were identified with z-transformed mean ratings from the four experimental runs as contrast weights. The images are thresholded at

$P < 0.001$ uncorrected. **(B)** Parameter estimates of pain-related BOLD responses averaged across the above shown brain regions for each of the experimental runs plotted for visualization purposes (extracted from a 6-mm sphere around the peak voxels of activation; for details, see Table 1). a.u., arbitrary units. Color bar indicates t score.





How Do We Treat Susan as a Whole Person?

Start by Transforming our Evaluation

“I have pain in my L5 vertebrae.”



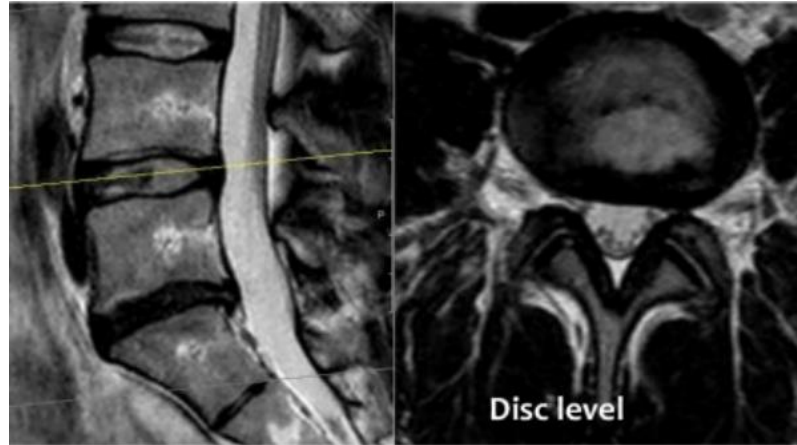
Instead of Focusing on a Body Part, Focus on the Whole Person



Instead of Focusing on a Body Part, Focus on the Whole Person



Where is the Therapeutic Focus?



How do we treat Susan as a whole person?

- Start with focus on **therapeutic alliance**
 - Validate her experience of pain/suffering
 - Learn about her health/life goals
- Therapeutic approach on **treating comorbidities and building health**
 - Treatment of insomnia, depression, and anxiety and improve pain and function



Lancet Low Back Pain Series: Called for Transformation of care for LBP

Low back pain 1

What low back pain is and why we need to pay attention

Jan Hartvigsen, Mark J Hancock*, Alice Kongsted, Quinette Louw, Manuela L Ferreira, Stéphane Genevay, Damian Hoy, Jaro Karppinen, Glenn Pransky, Joachim Sieper, Rob J Smeets, Martin Underwood, on behalf of the Lancet Low Back Pain Series Working Group†*

Low back pain 2

Prevention and treatment of low back pain: evidence, challenges, and promising directions

*Nadine E Foster, Johannes R Anema, Dan Cherkin, Roger Chou, Steven P Cohen, Douglas P Gross, Paulo H Ferreira, Julie M Fritz, Bart W Koes, Wilco Peul, Judith A Turner, Chris G Maher, on behalf of the Lancet Low Back Pain Series Working Group**

Low back pain: a call for action

*Rachelle Buchbinder, Maurits van Tulder, Birgitta Öberg, Lucíola Menezes Costa, Anthony Woolf, Mark Schoene, Peter Croft, on behalf of the Lancet Low Back Pain Series Working Group**

Key Messages

- Low back pain is a **complex condition** with **multiple contributors** to both the pain and associated disability, including psychological factors, social factors, biophysical factors, comorbidities, and pain-processing mechanisms
- For the vast majority of people with low back pain, it is currently **not possible to accurately identify the specific nociceptive source**

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Key Messages

- Use biopsychosocial framework to guide management with **initial non-pharmacological treatment**
 - **Education** that supports **self-management** and **resumption of normal activities**
 - **Exercise**
 - **Psychological programs** for those with persistent symptoms
- **Avoid harmful and useless treatments** by adopting a framework similar to that used in drug regulation—ie, only include if evidence shows that they are safe, effective, and cost-effective
- **Non-evidence-based practice is common**
 - **Including inappropriately high use of imaging, rest, opioids, spinal injections, and surgery**

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Key Messages

- Use the notion of **positive health**—the **ability to adapt and to self-manage** in the face of social, physical and emotional challenges—for the treatment of non-specific low back pain
- **Address widespread misconceptions** in the population and among health professionals about the causes, prognosis, and effectiveness of different treatments for low back pain, and deal fragmented and outdated models of care

How do we treat Susan as a whole person?

- Provide **education about potential harms of opioids** (including worsening mood, irritability, and sleep disruption)
- Assess risks/benefits of current opioid therapy vs risks/benefits of opioid deprescribing
- Introduce **long term goal of minimizing opioid use**



Fewer new starts is the best way to decrease opioid prescriptions

Patients taking long-term prescription opioids require careful considerations

- Physiological and **neuropsychological adaptations** occurred over time
- Reducing opioid doses creates **new risks**
- Right methodology can be applied to **minimize iatrogenic risks** from de-prescribing



Growing Outcry Against Iatrogenic Opioid Reduction Risks and Harms



International Stakeholder Letter publishes

- Darnall BD, Juurlink D, Kerns R, et al.
- Reuters Wire service
 - 45 news outlets worldwide

Human Rights Watch

- Declares the issue a “human rights violation”
- Laura Mills

HP3 Letter

- Kertesz, Satel, et al.
- 300+ signatories
 - 3 former U.S. Drug Czars
 - AMA signs support

FDA

Clarifies labeling and cautions against abrupt discontinuation

CDC

Dowell et al. Clarification of opioid prescribing guidelines publish in *NEJM*.

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

23 (



HEALTHCARE

Original Investigation | Pharmacy and Clinical Pharmacology

Trends and Rapidity of Dose Tapering Among Patients Prescribed Long-term Opioid Therapy, 2008-2017

Joshua J. Fenton, MD, MPH; Alicia L. Agnoli, MD, MPH, MHS; Guibo Xing, PhD; Lillian Hang, MBA, MPH; Aylin E. Altan, PhD; Daniel J. Tancredi, PhD; Anthony Jerant, MD; Elizabeth Magnan, MD, PhD

Mortality After Discontinuation of Primary Care–Based Chronic Opioid Therapy for Pain: a Retrospective Cohort Study



Jocelyn R. James, MD¹, JoAnna M. Scott, PhD², Jared W. Klein, MD, MPH¹, Sara Jackson, MD, MPH¹, Christy McKinney, PhD, MPH³, Matthew Novack, MS³, Lisa Chew, MD, MPH¹, and Joseph O. Merrill, MD, MPH¹

¹Department of Medicine, Division of General Internal Medicine, Harborview Medical Center, University of Washington School of Medicine, Seattle, WA, USA; ²University of Missouri – Kansas City School of Dentistry, Kansas City, MO, USA; ³Tacoma Family Medicine, Multicare, Tacoma, WA, USA.

J Gen Intern Med 34(12):2749–55

DOI: 10.1007/s11606-019-05301-2

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Opioid Taper Is Associated with Subsequent Termination of Care: a Retrospective Cohort Study

Hector R. Perez, MD, MS¹, Michele Buonora, MD, MS¹,
Chinazo O. Cunningham, MD, MS¹, Moonseong Heo, PhD², and
Joanna L. Starrels, MD, MS¹

General Hospital Psychiatry 47 (2017) 29–35



Contents lists available at [ScienceDirect](#)

General Hospital Psychiatry

journal homepage: www.elsevier.com/locate/genhospsych

Suicidal ideation and suicidal self-directed violence following clinician-initiated prescription opioid discontinuation among long-term opioid users

Michael I. Demidenko^a, Steven K. Dobscha^{a,b}, Benjamin J. Morasco^{a,b}, Thomas H.A. Meath^{a,c},
Mark A. Ilgen^{d,e}, Travis I. Lovejoy^{a,b,f,*}

JAMA
Network | **Open**[™]

Original Investigation | Substance Use and Addiction

Association Between Opioid Dose Variability and Opioid Overdose Among Adults Prescribed Long-term Opioid Therapy

Jason M. Glanz, PhD; Ingrid A. Binswanger, MD; Susan M. Shetterly, MS; Komal J. Narwaney, PhD; Stan Xu, PhD

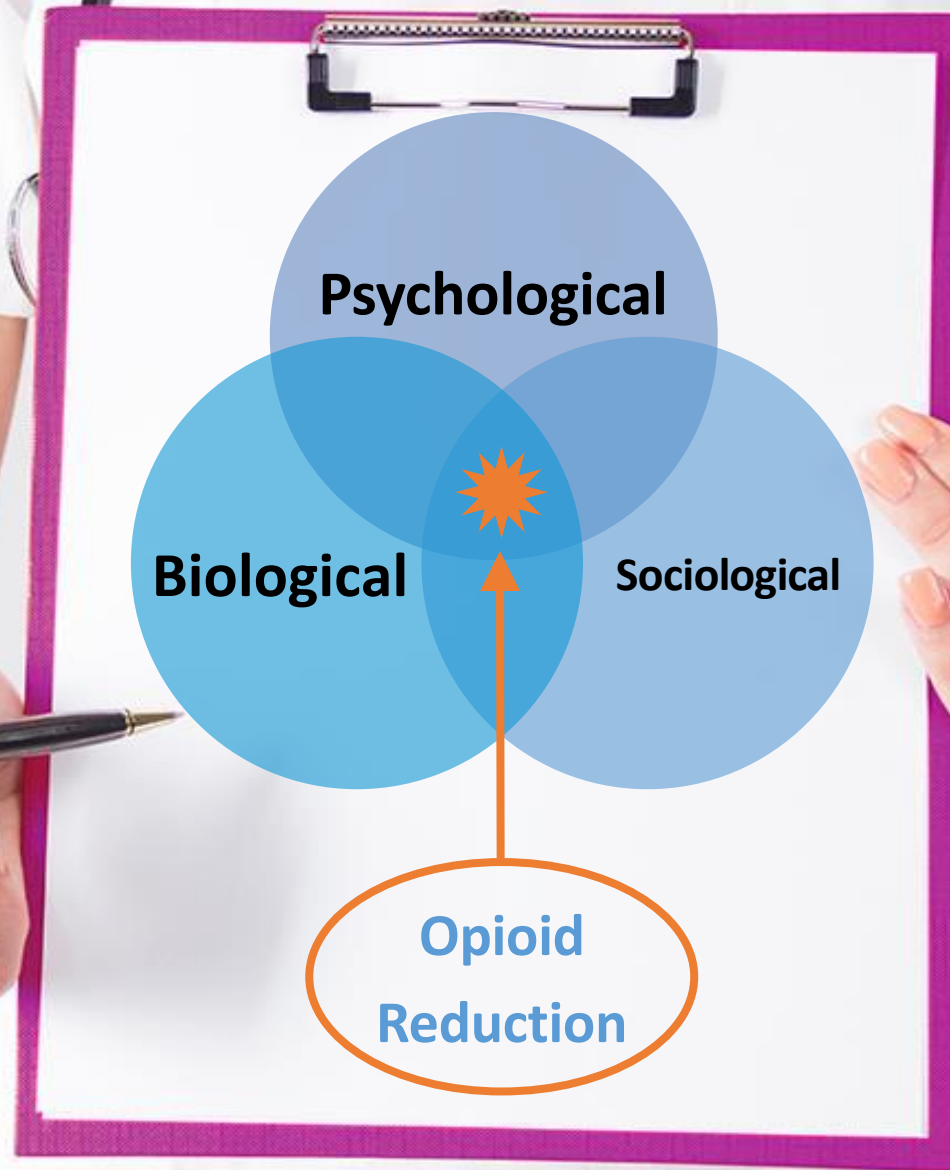
Tapering Methods Matter Greatly

- The health of the patient is paramount
- Rigid dose-based policies violates patient-centeredness, exposes patients to health risks and is unsupported by the CDC and the AMA
- Dose changes are associated with health risks
- Patient-centered methods enhance patient engagement, safety and outcomes
- Imperative to screen prior to tapering, emphasize voluntary tapering, carefully monitor patient response during the taper and adjust accordingly
- Provide psychological support

Change Confers Risk

How do we minimize risks and create a sense of safety for our patients?

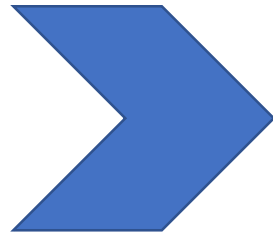
The biopsychosocial model of **tapering**





Tapering the Wrong Way

Aggressive
Taper



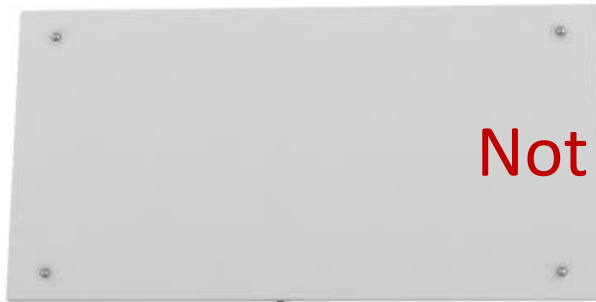
Forced
Taper

- Withdrawal Symptoms
- Discomfort
- Distress
- Failed tapers
- False belief that outpatient tapering is impossible
- Remaining on high doses
- Overdose (in SUD)
- Suicidal ideation
- Suicide

Tapering Opioids

Patients' number one concern/fear?

Not Interested!



Opioid Cessation and Multidimensional Outcomes After Interdisciplinary Chronic Pain Treatment

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

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

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)

Community-Based Solutions are Needed

- Low-cost
- Low-risk
- Scalable
- Effectively reduce health risks
- Provide education and support
- Structured
- Address anxiety of patients and prescribers alike
- Promote patient trust and a good doctor-patient bond
- **Enhance patient willingness to try a gentle opioid taper**

New Online

Views **31,655** | Citations **10** | Altmetric **365**

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 Permissions

Research Letter

February 19, 2018

ONLINE FIRST



Patient-Centered Prescription Opioid Tapering in Community Outpatients With Chronic Pain

Beth D. Darnall, PhD¹; Maisa S. Ziadni, PhD¹; Richard L. Stieg, MD, MPH²; [et al](#)

[» Author Affiliations](#) | [Article Information](#)

JAMA Intern Med. Published online February 19, 2018. doi:10.1001/jamainternmed.2017.8709

The risks associated with prescription opioids are well described.^{1,2} Although reducing opioid use is a national priority, existing opioid tapering models use costly interdisciplinary teams that are largely inaccessible to patients and their physicians.^{3,4} Patients and physicians need solutions to successfully reduce long-term prescription opioid dosages in settings without behavioral services. We conducted a study of voluntary, patient-centered opioid tapering in outpatients with chronic pain without behavioral treatment.

JAMA Network

JAMA Internal Medicine



MOST VIEWED
(30 DAYS)

MOST CITED
(3 YEARS)

19,764 Views Opioid Tapering in Community Outpatients With Chronic Pain

18,616 Views State Firearm Laws and Interstate Firearm Deaths

7,177 Views Overtreatment of Asymptomatic Hypertension

6,828 Views Mortality Risks for US Cigarette, Cigar, and Pipe Users

6,503 Views Meditation for Psychological Stress and Well-being

Opioid Cessation vs. Opioid Reduction



VS.



We Optimized Patient Choice and Control in Their Taper

- Participation was VOLUNTARY
- Patients could control the pace of their taper
- Patients could pause their taper
- Patients were free to drop out of the study at any time
- The taper goal was not zero unless the patient chose that goal
- The taper was NOT to a pre-defined opioid dose
- Patients partnered with their doctor to achieve their *lowest comfortable dose* over 4 months
- The taper was NOT unidirectional

Study Variables

- Demographics (Gender, Age)
- Pain Treatment History (Pain Dx, Duration of Opioid Use)
- Opioid Dose (MEDD)
- Average Pain Intensity (0-10)
- Pain Catastrophizing Scale
- PROMIS Measures
- Marijuana use (Y/N)



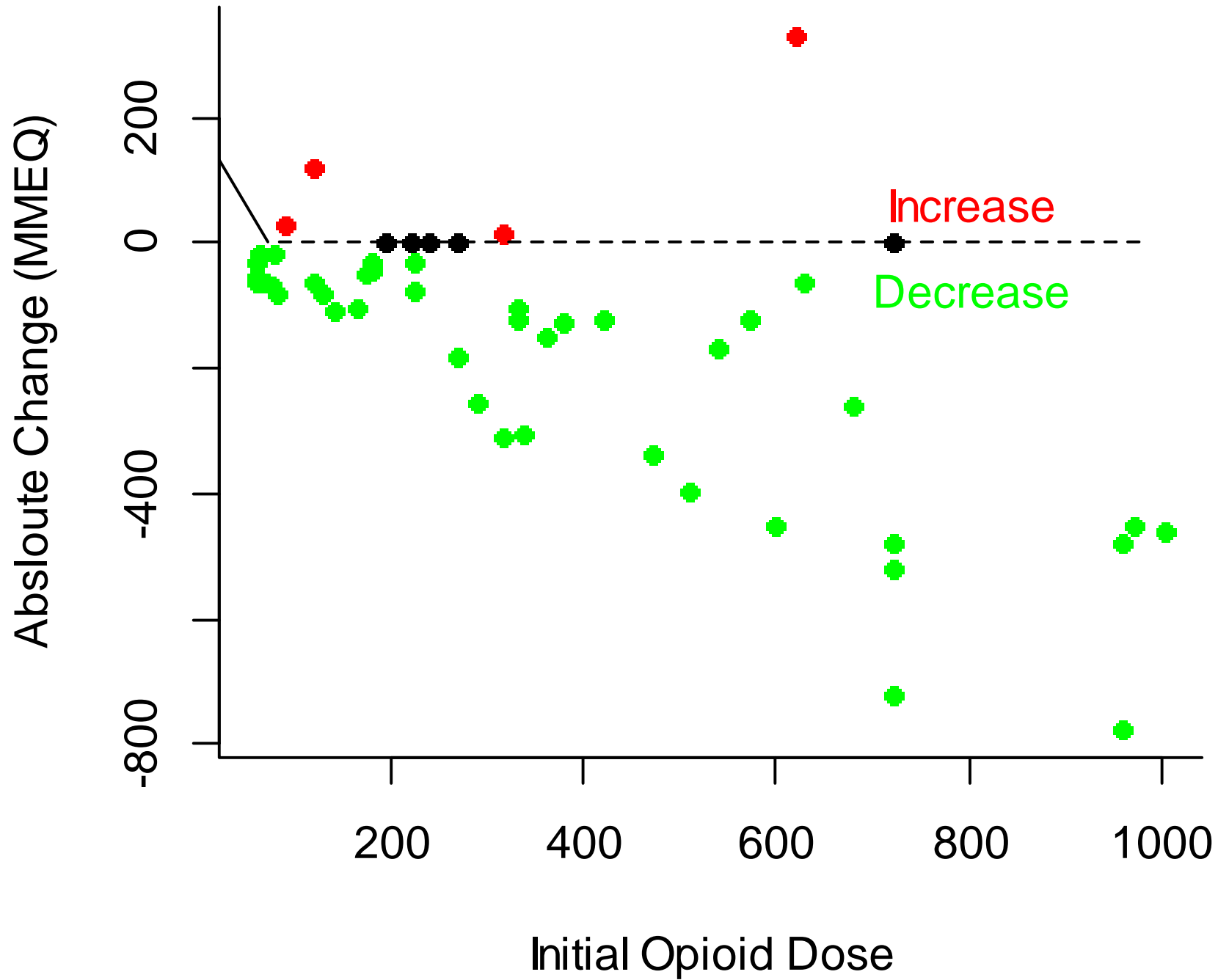
Sample Characteristics (N=51)

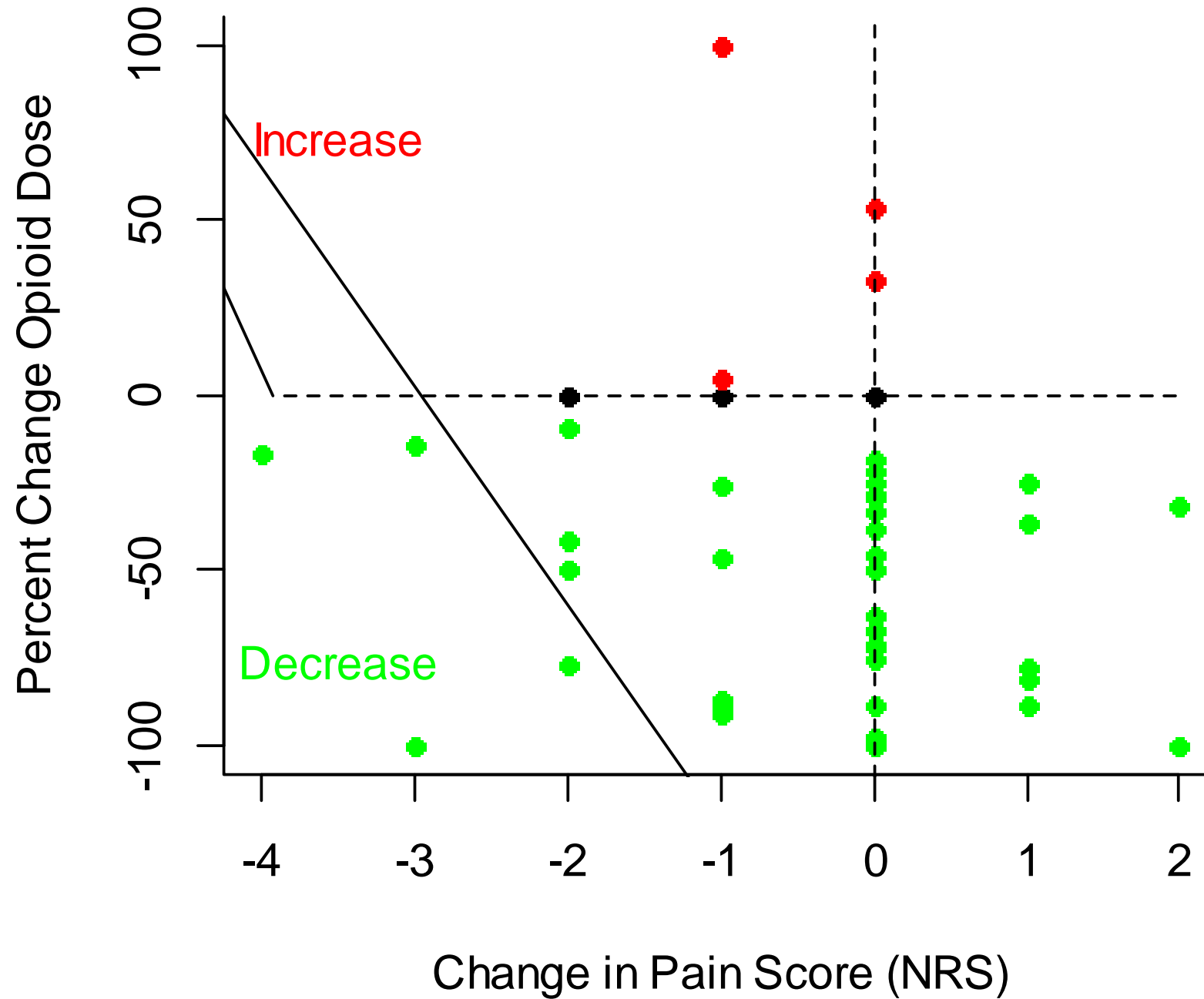
- 55% female
- 52 years of age (range = 25 – 72)
- 6 years on opioids (range = 1 – 38)
- Moderate pain intensity
- Marijuana: 37% (18)
- Opioid MEDD = 288 (60, 1005)

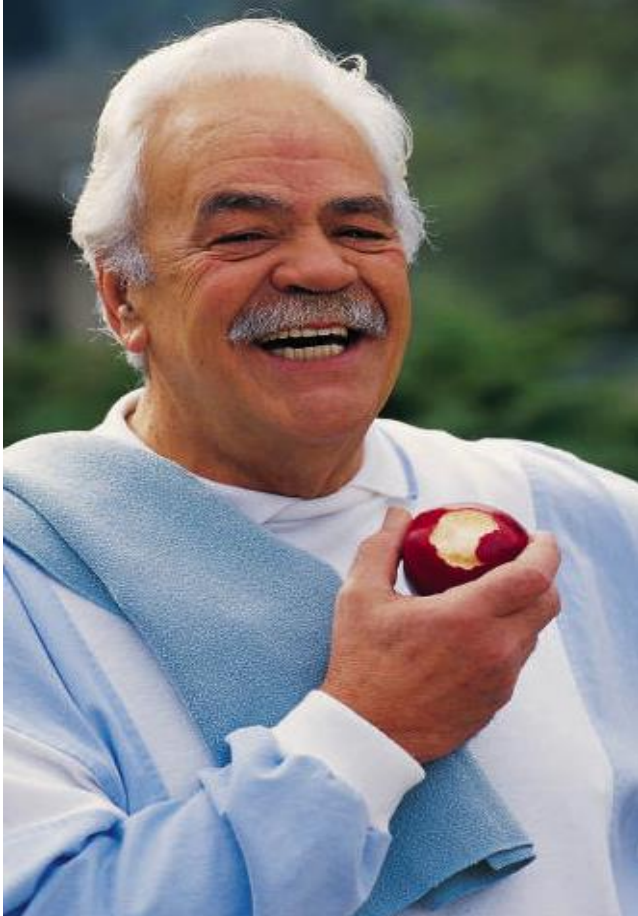
Darnall BD, Ziadni MS, Mackey IG, Kao MC, Flood P (FEB 2018; *JAMA Int Med*)

	Baseline	16 weeks	
Variable	Median (IQR)		P-val
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

Kruskal-Wallis rank sum test







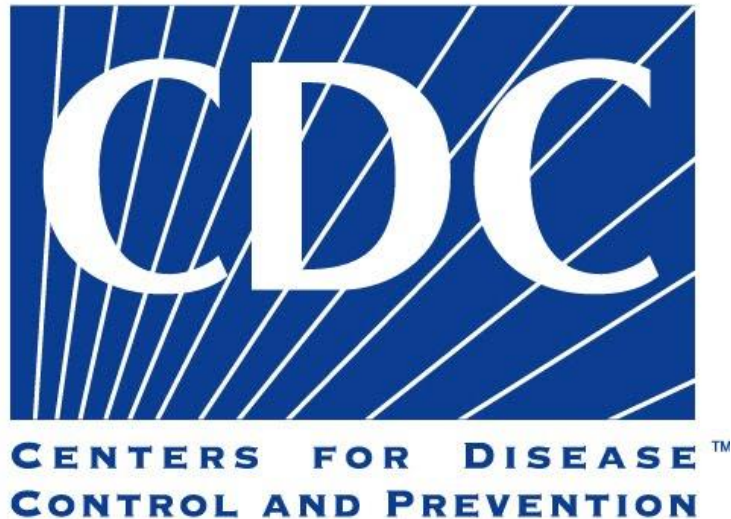
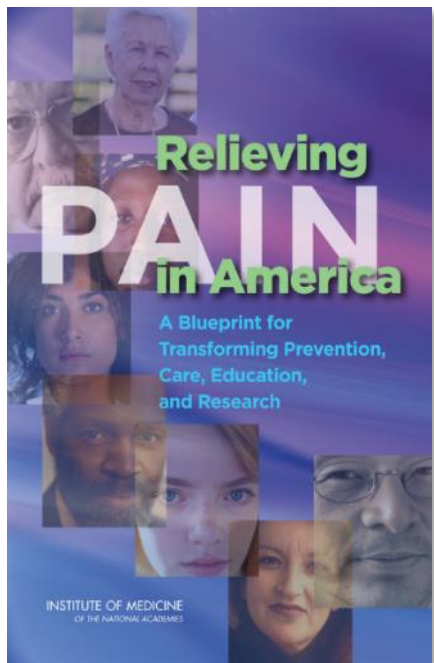
Tomas

Retired teacher

Continued opioids after his first knee replacement surgery

Fearful of tapering but willing to try





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GUIDELINE FOR PRESCRIBING
OPIOIDS FOR CHRONIC PAIN

Comparative Effectiveness of Pain Cognitive Behavioral Therapy and Chronic Pain Self-Management Within the Context of Voluntary Opioid Reduction

Darnall BD (PI)

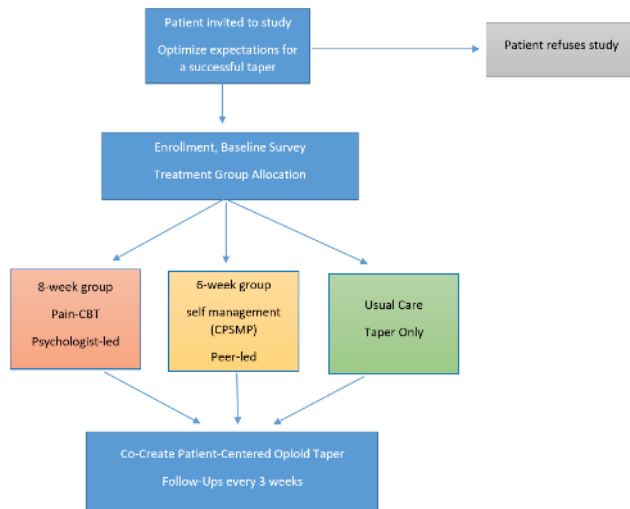
<https://empower.stanford.edu/>



EMPOWER

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

Funded by the Patient-Centered Outcomes Research Institute®



Chronic Pain
Self-Management Program

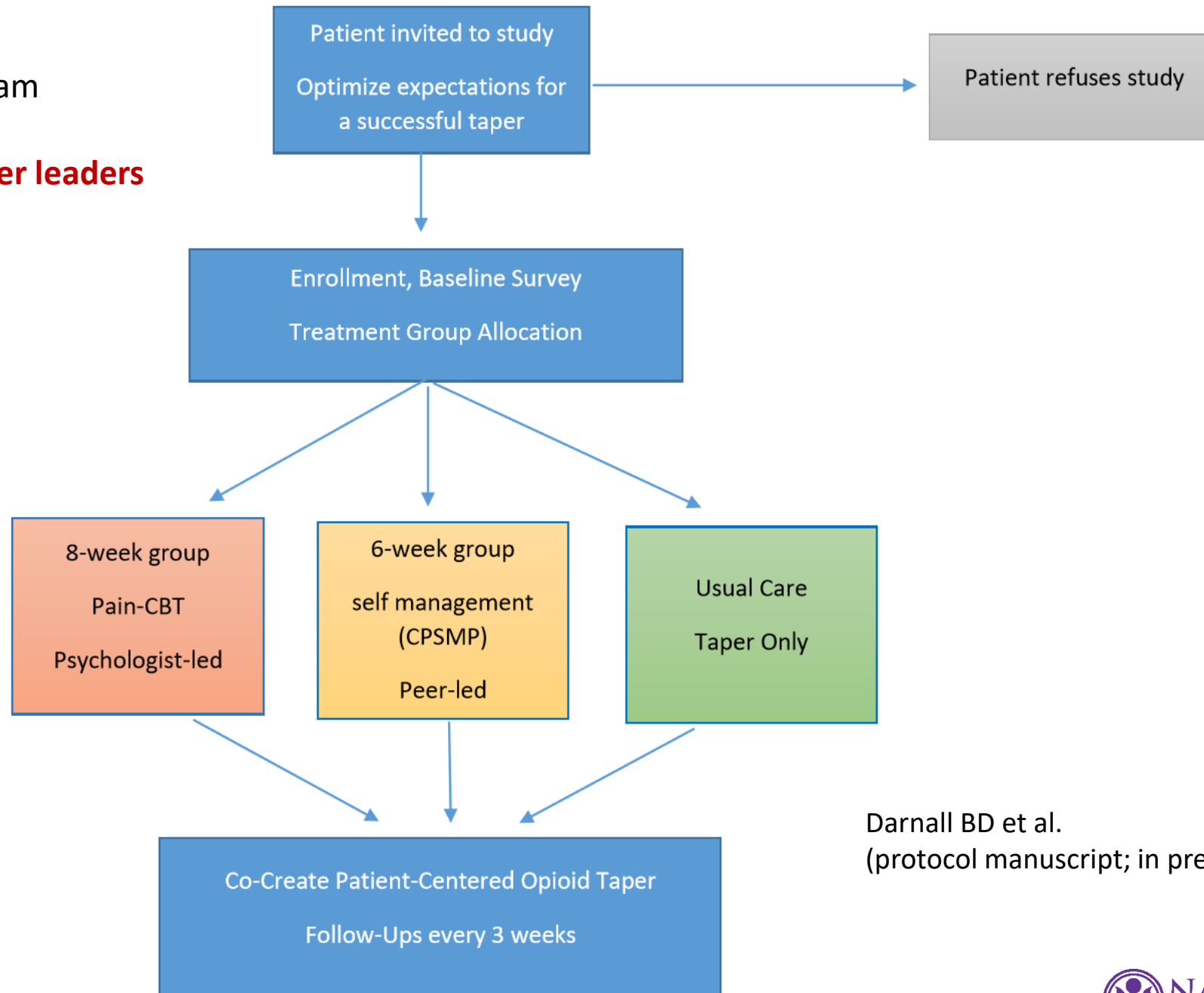
Two certified trained **peer leaders**

Darnall BD et al.

(protocol manuscript; in press, *Pain Med*)

Chronic Pain
Self-Management Program

Two certified trained **peer leaders**



Darnall BD et al.
(protocol manuscript; in press, *Pain Med*)

1365 Patients Taking Long-Term Opioids for Chronic Pain

- Stanford Pain Management Center (CA)
- Stanford Primary Care (CA)
- Intermountain Health (Salt Lake City)
- Veterans Affairs (Phoenix)
- MedNOW Clinics (Denver, CO)



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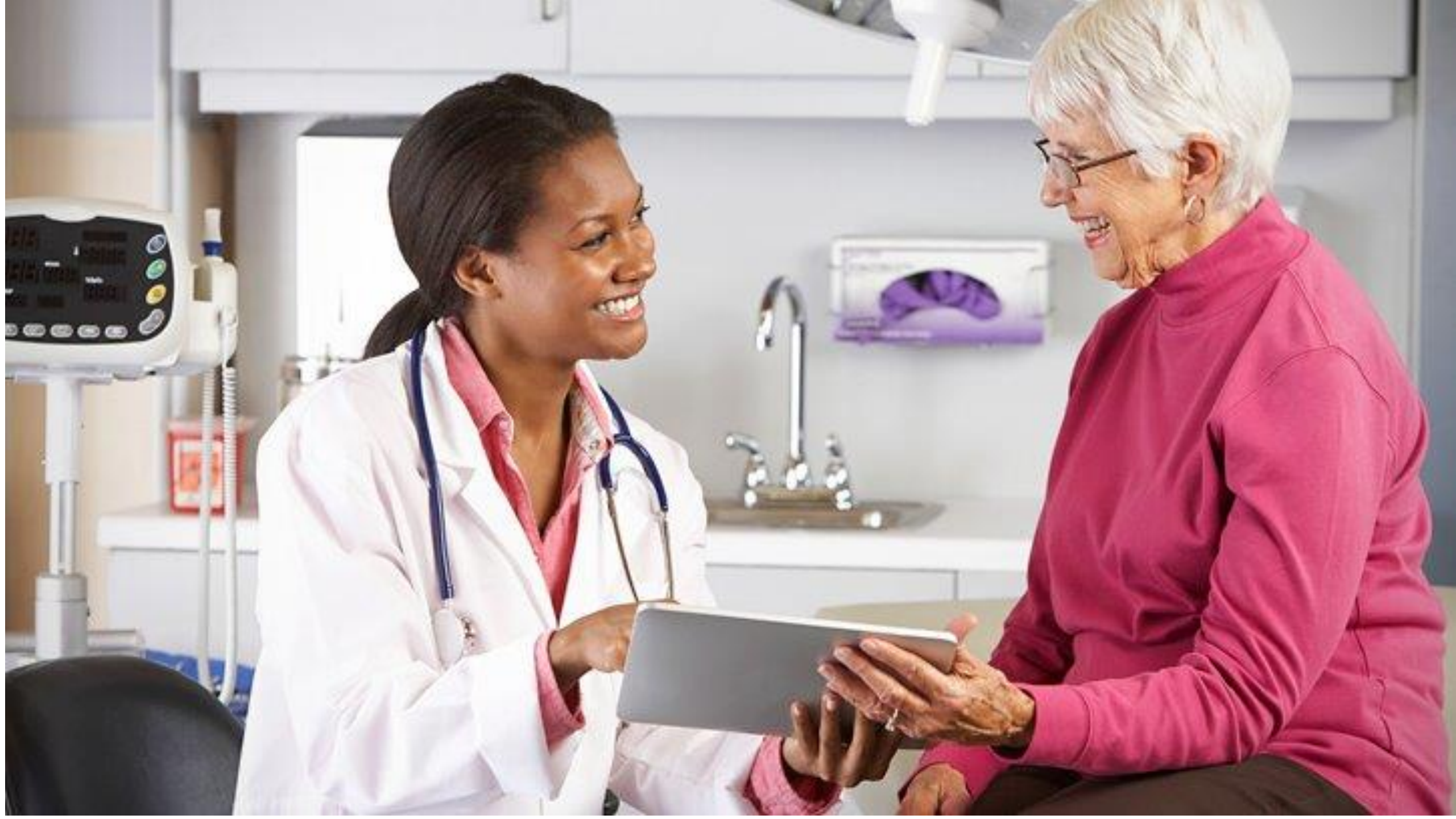


Eligibility

- ≥ 10 MEDD daily for 3 months
- Pain for 6 months

Exclusions:

- Active suicidality
- Unable to participate in behavioral groups
- Moderate to severe Opioid Use Disorder is exclusionary
- Screening: 3 items from the TAPS + DSM-V OUD



EMPOWER Guiding Principles



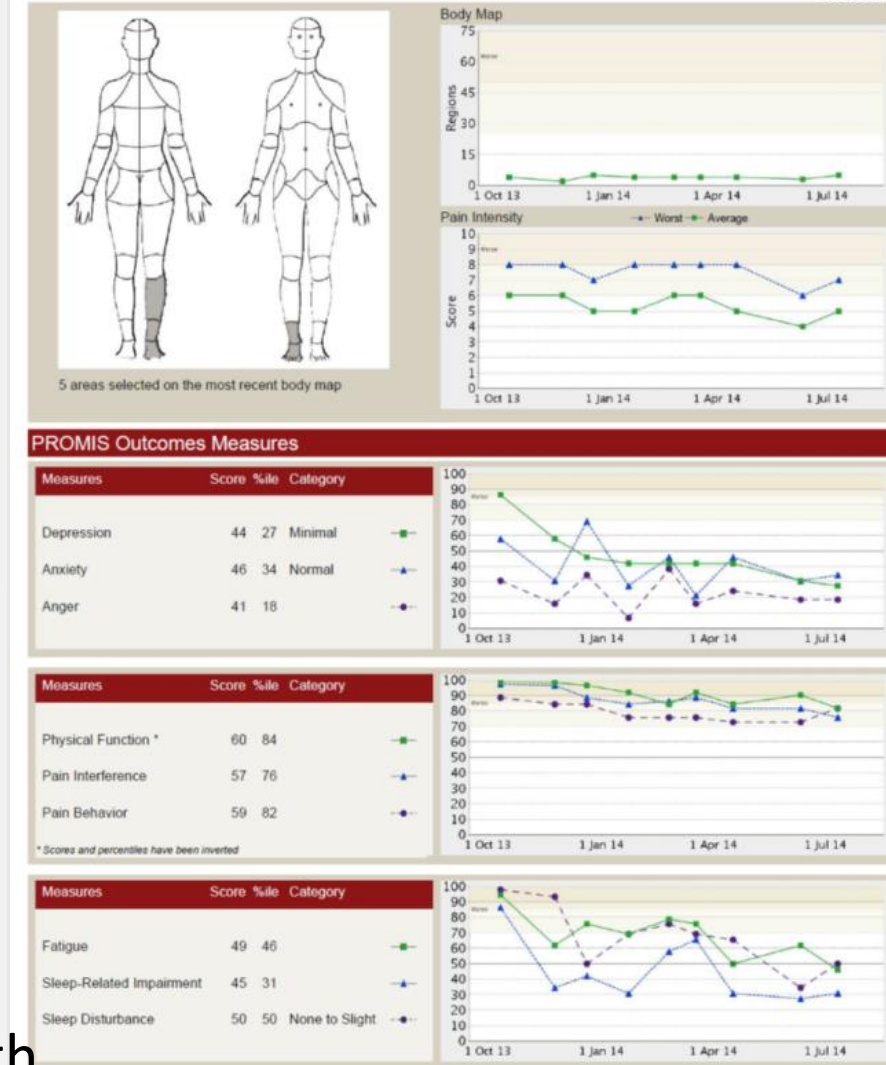
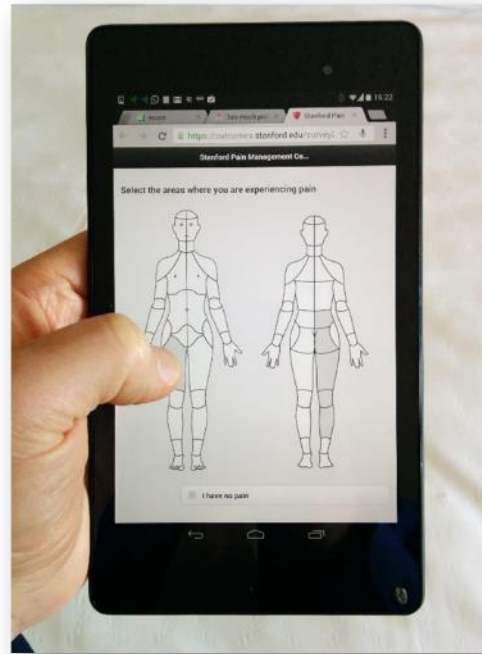
We must create a caring and safe system that makes patients want to join and remain in EMPOWER

EMPOWER Guiding Principles



We must create a caring and safe system that makes patients want to join and remain in EMPOWER

- Easy data entry
- Point of care reporting
- Over 30,000 patients and 100,000 longitudinal data assessments
- NIH PROMIS CAT for comparative metrics and computer adaptive testing to reduce patient burden
- Insights from real-world patients
- Open-source (free) licensing with minimal restrictions
- Comprehensive assessment of:
 - Physical, psychological and social functioning and health



<http://choir.stanford.edu>

Assessments & Monitoring

Baseline, 6- and 12-month: comprehensive battery

Psychosocial factors (PROMIS)

Opioids

Substance use

Degree of choice

Readiness to taper

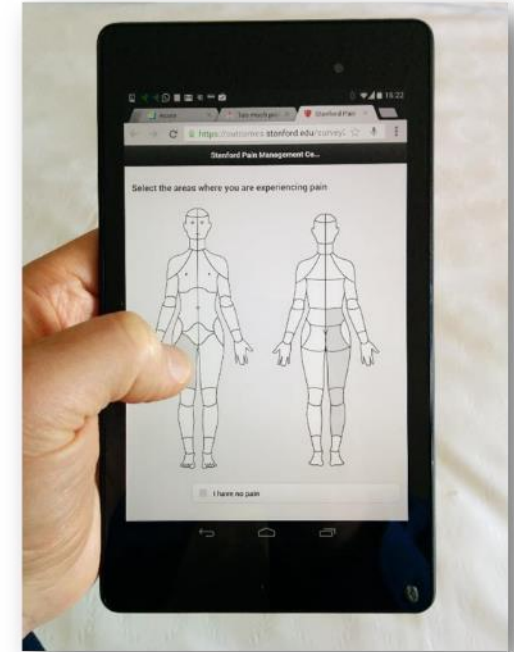
Taper beliefs

Satisfaction with clinician relationship

Comments

WEEKLY surveys for withdrawal symptoms, mood, comments

MONTHLY surveys for mood, suicidality, opioid dose, satisfaction, comments



Close Monitoring of Patient Response to Opioid Reduction

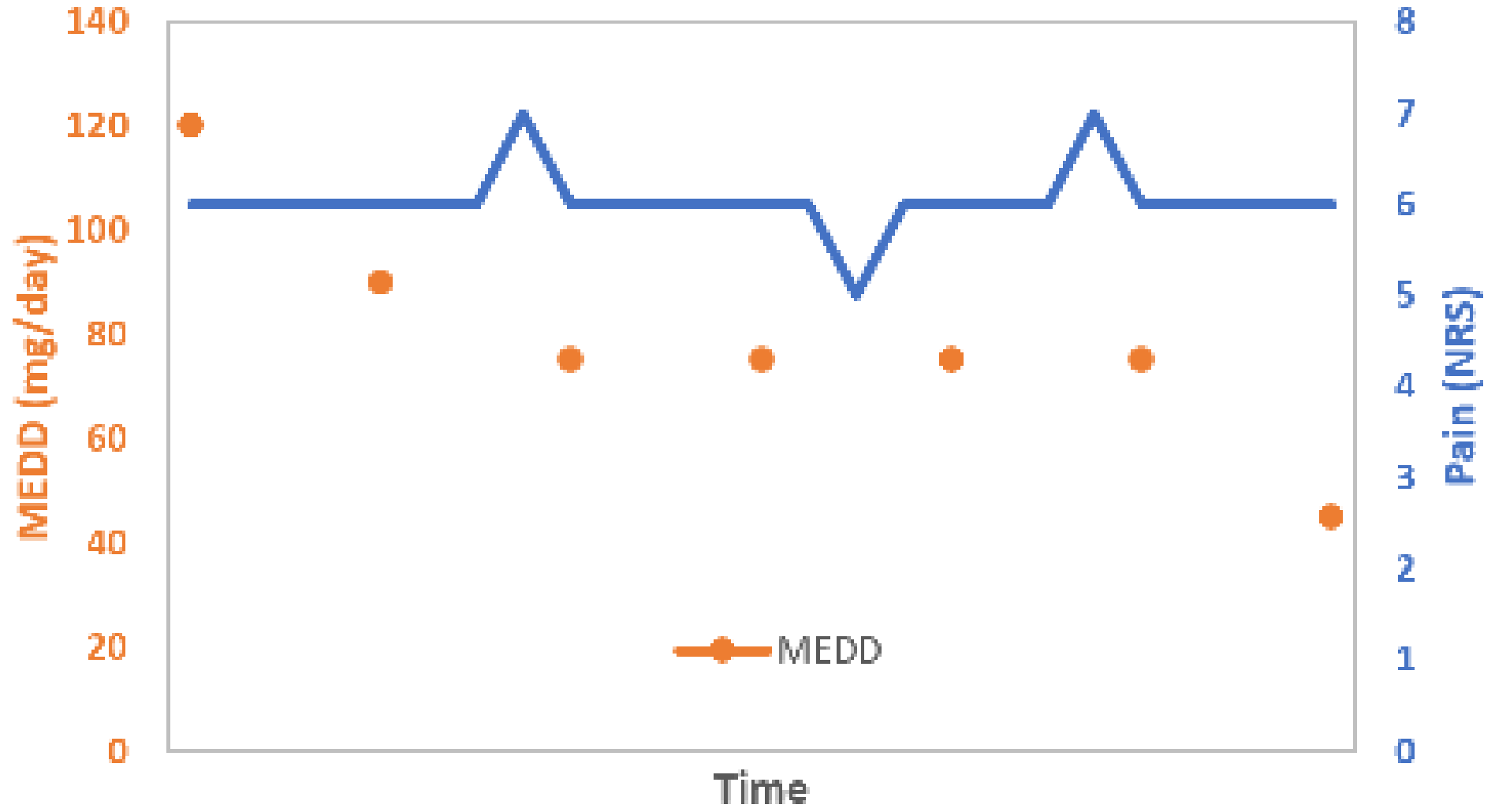
WEEKLY surveys for withdrawal symptoms, mood, comments

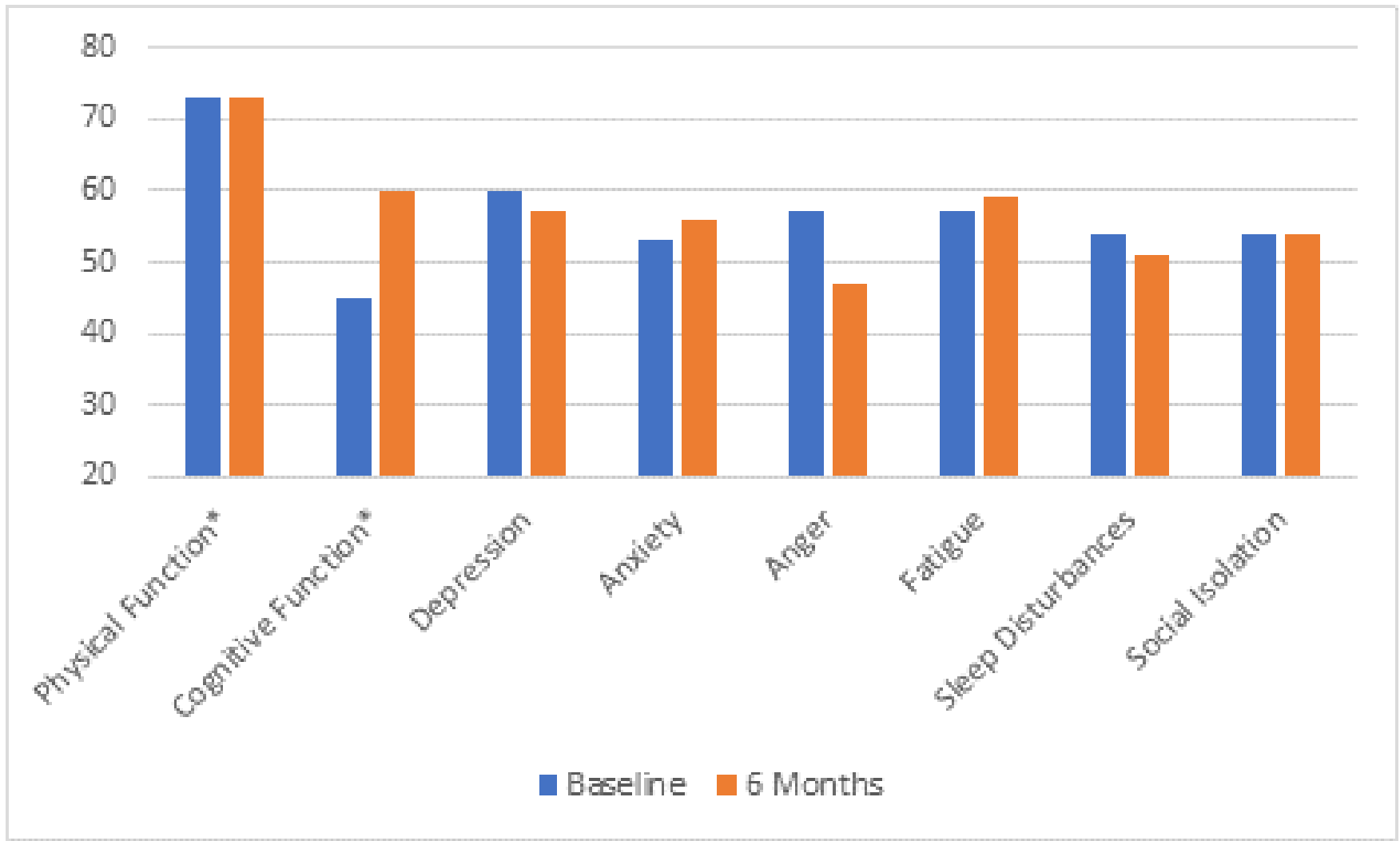
MONTHLY surveys for mood, suicidality, opioid dose, satisfaction, comments

- Alerts are sent to prescribers in real time
- Patients receive tailored messages



We track patients over 12 months







EMPOWER Study

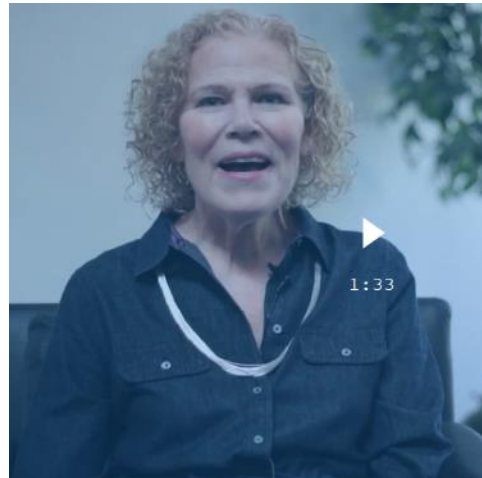
Effective Management of Pain and Opioid-Free Ways to Enhance Relief

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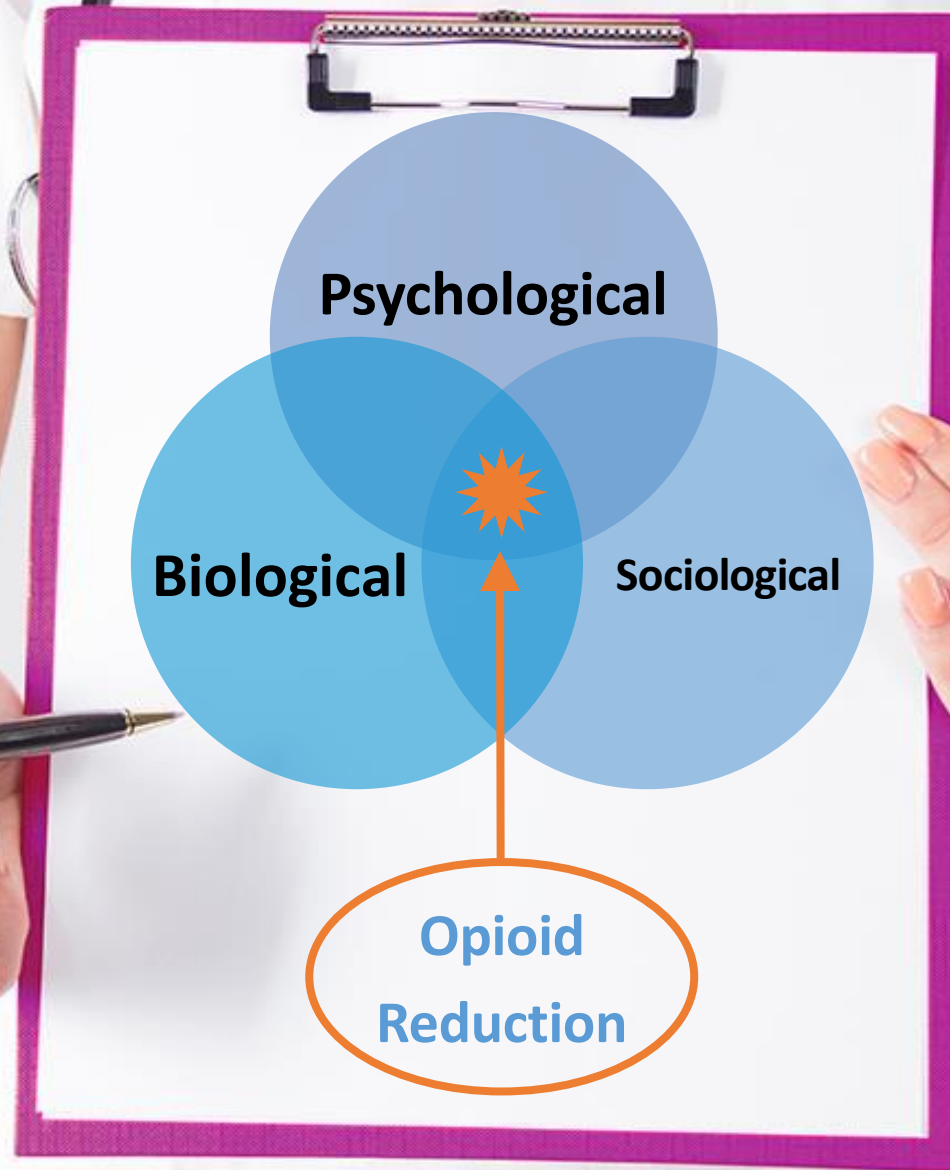
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Patient Stories



Nuts and Bolts of Patient-Centered Pain Care and Opioid Tapering

The biopsychosocial model of **tapering**



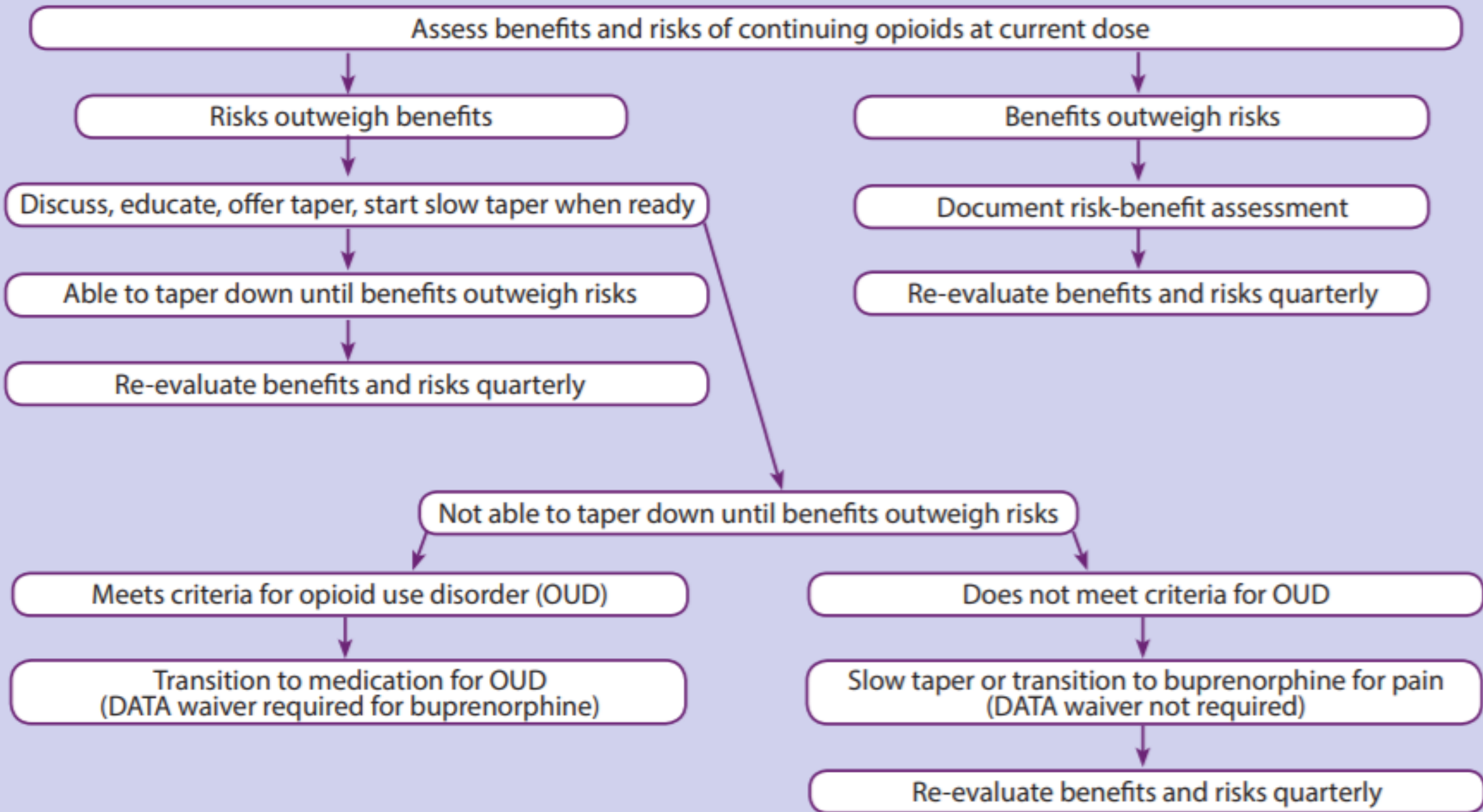
HHS Guide for Clinicians on the Appropriate Dosage Reduction or Discontinuation of Long-Term Opioid Analgesics

This HHS Guide for Clinicians on the Appropriate Dosage Reduction or Discontinuation of Long-Term Opioid Analgesics provides advice to clinicians who are contemplating or initiating a reduction in opioid dosage or discontinuation of long-term opioid therapy for chronic pain. In each case the clinician should review the risks and benefits of the current therapy with the patient, and decide if tapering is appropriate based on individual circumstances.

- Cautions with Opioid Tapering
- Collaborative Approach to Tapering
- Importance of Treatment Support (MH and OUD treatments)

October 2019

Opioid Tapering Flowchart



Cautions

- Patients on **long term opioid therapy** AND those who are **tapering** appear to be **vulnerable populations**
 - Increase *and* decrease in opioid dose increases risk of overdose
 - Conflicting evidence about opioid discontinuation

Consider Tapering to a Reduced Opioid Dosage, or Tapering and Discontinuing Opioid Therapy, when

- Pain improves
- The **patient requests** dosage reduction or discontinuation
- **Pain and function are not meaningfully improved**
- Patient is receiving higher opioid doses without evidence of benefit from the higher dose
- Patient has current evidence of opioid **misuse**
- Patient experiences **side effects** that diminish quality of life or impair function
- Patient experiences an **overdose or other serious event** (e.g., hospitalization, injury) or has warning signs for an impending event such as confusion, sedation, or slurred speech
- Patient is receiving medications (e.g., **benzodiazepines**) or has **medical conditions** (e.g., lung disease, sleep apnea, liver disease, kidney disease, fall risk, advanced age) that increase risk for adverse outcomes
- Patient has been treated with opioids for a prolonged period (e.g., years), and **current benefit-harm balance is unclear**

Risk vs.
Benefit

Current
Level of
Function

Risk vs.
Risk

Factors that increase risk of adverse outcomes with opioid therapy

Mental health and medical comorbidities

Substance use disorder comorbidities

Recent opioid overdose

Concomitant benzodiazepine or other sedative use

Nonadherence with opioid safety monitoring

High prescribed opioid dose

Non-participation in whole-person pain care plan



Original Investigation | Substance Use and Addiction

Association Between Opioid Dose Variability and Opioid Overdose Among Adults Prescribed Long-term Opioid Therapy

Jason M. Glanz, PhD; Ingrid A. Binswanger, MD; Susan M. Shetterly, MS; Komal J. Narwaney, PhD; Stan Xu, PhD

- **Overdose risk increased** with independently associated with both **dose variability** and **high opioid dose**
 - Highest category of dose variability in the preceding 3 months (SD >27.2 mg of morphine equivalents) compared to the lowest category of dose variability had a matched OR of 3.32 (95% CI, 1.63-6.77)
 - Highest category of dose (>100mg of morphine equivalents) in the 3 months before the index date vs lowest dose category (0-20mg of morphine equivalents) had a matched OR of 2.37 (95% CI, 1.41-3.98)
- **Overdose risk decreased** for individuals with **sustained opioid therapy discontinuation** (defined as 3 continuous months with 0mg of morphine equivalents before the index date) were 51% less likely to have experienced an overdose than individuals who had not discontinued opioid therapy (mOR, 0.49; 95% CI, 0.26-0.93)

Other Factors that Likely Increase Risk of Tapering

Rapid Tapering

Lack of Communication with patient

One Size Fits All approach

Not addressing mental health conditions

Not addressing OUD/SUD

Approach to Patients Who Are Not Doing Well on Taper or Resistant to Taper

- This group needs careful consideration
- Consider DDX
 - More severe neurobiological adaptations to LTOT
 - OUD
 - “gray zone” (i.e. do not meet criteria for OUD, but manifest persistent withdrawal symptoms)
 - Chemical Coping
 - Untreated mental health condition
 - Diversion

Approach to Patients who are Not Doing Well on Taper or Resistant to Taper

- Treatment
 - Pause and carefully consider treatment options
 - Screen for mood, SI for all patients on LTOT
 - Intensification of support for most
 - Optimize treatment of comorbidities and whole person treatment of pain for most
 - MAT for OUD
 - Evidence-based treatment for mental health conditions
 - Transition to buprenorphine and then gradually taper buprenorphine for “gray zone”

Opioid Exposed ≠ Opioid Naïve

**Long-term opioid therapy
changes the brain and requires
a careful and individualized approach
to reduce opioid-related risks.**

“The Gray Zone”



Simple
Dependence



Opioid
Use
Disorder

What is Opioid Use Disorder?

Opioid Use Disorder is defined in *DSM-5* as a **problematic pattern** of opioid use leading to **clinically significant impairment or distress** manifested by at least two symptoms in a 12- month period.

Withdrawal \neq Opioid use disorder

Worried about taper \neq Opioid use disorder

Just having a high prescribed dose \neq Opioid use disorder

Loss of Control

- Using **larger amounts** or over a **longer period** than intended
- Persistent desire or **inability to cut down** on or control opioid use
- Spending a lot of **time** to obtain, use, or recover from opioids

Craving

- Craving or strong desire or urge to use opioids

Use despite Consequences

- **Failure to fulfill obligations** at work, school, or home
- Continued use despite **social or interpersonal problems**
- **Activities are given up/reduced**
- Recurrent use in **physically hazardous** situations
- Continued use despite **physical or psychological problems**

*tolerance and withdrawal are not counted if patient taking medications as prescribed

Physiological Criteria

- Tolerance*
- Withdrawal*

2-3 = mild OUD

4-5 = moderate OUD

≥ 6 = severe OUD

Patients with Opioid Use Disorder – Strong Evidence to Guide Treatment



- Be non-stigmatizing of OUD and meds for OUD
- Reassure that effective treatments are available
- Offer and encourage medications for OUD
- Employ a whole person approach
- Apply higher intensity risk mitigation



Cochrane
Library

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

Screening * Brief Intervention * Referral to Treatment

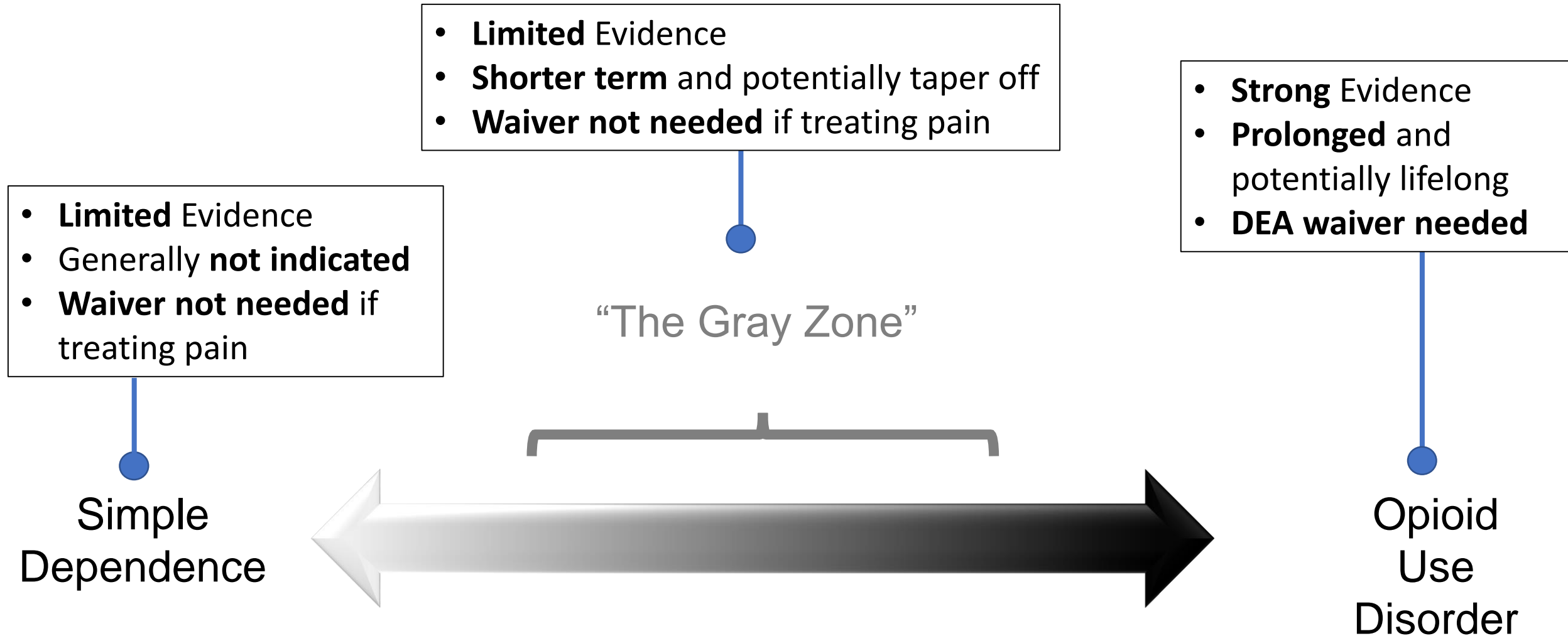
- Screening can help create a framework to **identify people at high risk** for substance misuse.
- Screening can provide **early intervention** with individuals at risk for developing a substance use disorder
- Goals of **Brief Intervention**:
 - raise awareness of substance use and consequences and motivate towards positive behavioral change
 - educate people about use and health risks
 - encourage to think differently about use make changes to improve their health

APPLY IT

- **Screening tool: NIDA QUICK SCREEN**

- **Screening tool: TAPS**

Use of buprenorphine across the spectrum of opioid exposure



Buprenorphine Prescribing

- Prescribing buprenorphine for pain
 - Any prescriber who is able to prescribe CIII medications
- Prescribing buprenorphine for OUD
 - Requires DEA Waiver
 - MD/DO – require 8 hour CME and obtaining X-waiver from DEA
 - PA/NP – require 24 hour CME and obtaining X-waiver from DEA
- [Free online DEA waiver training](#) for MD/DOs, PAs, NPs is available through PCSSNOW.org

After appropriate screening, how do we apply best methods to opioid reduction?

Practical Tips

1. Assess for OUD
2. Assess patient interest in opioid reduction
3. Assess patient concerns for opioid reduction
4. Validate fears, provide education
5. Support team-based opioid reduction plans that minimize NOCEBO and optimize positive expectation and patient engagement
6. Zero is not the goal
7. Closely monitor patient response to opioid tapering, especially mood and suicidality
8. Offer adjuvants
9. Recognize that opioid tapering is not right for everyone
10. Provide patients with treatment and resources (virtual teams)
11. Consider rapid access to a brief skills-based pain management class

Barry



5 year Hx of opioid use for shoulder pain

History of rotator cuff surgical repair

Unemployed carpenter, laid off in August

History of alcohol abuse

Endorses cannabis use which is legal in your state

Remote history of lost prescriptions and ED visits for opioids

EMPOWER OUD Screen

- In the PAST 3 MONTHS, did you use a prescription opiate pain reliever (for example, Percocet, Vicodin) **not** as prescribed or that was **not** prescribed for you?
- In the PAST 3 MONTHS, have you tried and failed to control, cut down or stop using an opiate pain reliever?
- In the PAST 3 MONTHS, has anyone expressed concern about your use of an opiate pain reliever?

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- Apply higher intensity risk mitigation



Beverly

Church volunteer

Watches her grandchildren after school

Taking opioids 8 years for widespread pain and rheumatoid arthritis

Taper greatly increases her pain and her function tanks.

Collaborative Opioid Taper

- If no immediate safety concerns: **gradual, flexible taper pace**
 - Slower tapers (e.g. 5-20% per month) generally better tolerated
 - May need to go slower (e.g. 2-10% every 1-2 months) and add in frequent pauses in some patients
- Assess and treat mental health and SUD comorbidities
 - Maintain vigilance DURING taper

Medications for Opioid Withdrawal

Indication	Treatment Options
Autonomic symptoms (sweating, tachycardia, myoclonus)	First line: Clonidine; Alternatives: Baclofen, Gabapentin, Tizanidine
Anxiety, dysphoria, lacrimation, rhinorrhea	Hydroxyzine, Diphenhydramine
Myalgias	NSAIDs, Acetaminophen, Topical medications like menthol/methyl salicylate cream, lidocaine cream/ointment
Sleep disturbance	Trazodone
Nausea	Prochlorperazine, Promethazine, Ondansetron
Abdominal cramping	Dicyclomine
Diarrhea	Loperamide, Bismuth subsalicylate



Gerald

Taking opioids for 17 years

Pain comorbidities

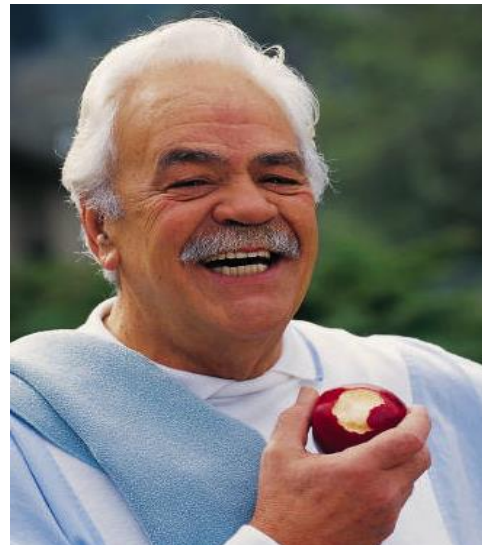
Ongoing severe depression

Disinterested in tapering

Taper implemented due to pressures from healthcare system

Gerald's pain intensifies, he has withdrawal symptoms, and he becomes actively suicidal

Clinical Vignettes



Monitor, Monitor, Monitor closely and adjust according to the patient's response to the taper



Monitor & Protect Your Patients

- Mood
- Distress or decompensation
- Suicidality
- Increased pain



If patients are doing poorly on a taper, **pause and protect.**

- Assess
- Connect to resources
- Strong cautions against tapering without highly structured support and relevant services in place

treat *the patient* not the pill

recognize that less is not always better. Tapering confers health risks, and not everyone should be tapered.

provide behavioral resources, even if just print and online

consider group support if you have a large enough patient pool

Comprehensive Care in Low-Resource Settings

Creating virtual teams

Barriers to Patient-Centered Care

Your own discomfort with opioid tapering and difficult conversations



Identify Your Discomfort in Patient Interactions

Patient anger or emotions can lead to:

- Confrontation
- Escalation
- Avoidance
- Negative associations that carry forward to next visits and with other similar patients



Two Diffusion Techniques for Patient Anger/Frustration

- Label the possible emotional experience and voice it: “It seems as if you may be angry or upset with ...”
- **VALIDATE** their experience with compassion: “I understand why you would be fearful or angry.”

Professional Skype-Based Coaching for Healthcare Clinicians: Dr. Claire Ashton James
See Resource PDF that accompanies this webinar

Protecting the Health Care Team



Face to Face visits + Documentation



Treatment Agreement + Informed Consent



Prescription Drug Monitoring Program



Urine Drug Testing



Overdose education and Naloxone prescription

Checklist for prescribing opioids for chronic pain



U.S. Department of
Health and Human Services
Centers for Disease
Control and Prevention

If RENEWING without patient visit

- Check that return visit is scheduled ≤ 3 months from last visit.

When REASSESSING at return visit

Continue opioids only after confirming clinically meaningful improvements in pain and function without significant risks or harm.

- Assess pain and function (eg, PEG); compare results to baseline.
- Evaluate risk of harm or misuse:
 - Observe patient for signs of over-sedation or overdose risk.
 - If yes: Taper dose.
 - Check PDMP.
 - Check for opioid use disorder if indicated (eg, difficulty controlling use).
 - If yes: Refer for treatment.
- Check that non-opioid therapies optimized.
- Determine whether to continue, adjust, taper, or stop opioids.
- Calculate opioid dosage morphine milligram equivalent (MME).
 - If ≥ 50 MME/day total (≥ 50 mg hydrocodone; ≥ 33 mg oxycodone), increase frequency of follow-up; consider offering naloxone.
 - Avoid ≥ 90 MME/day total (≥ 90 mg hydrocodone; ≥ 60 mg oxycodone), or carefully justify; consider specialist referral.
- Schedule reassessment at regular intervals (≤ 3 months).

EVALUATING RISK OF HARM OR MISUSE

Known risk factors include:

- Illegal drug use; prescription drug use for nonmedical reasons.
- History of substance use disorder or overdose.
- Mental health conditions (eg, depression, anxiety).
- Sleep-disordered breathing.
- Concurrent benzodiazepine use.

Urine drug testing: Check to confirm presence of prescribed substances and for undisclosed prescription drug or illicit substance use.

Prescription drug monitoring program (PDMP): Check for opioids or benzodiazepines from other sources.

ASSESSING PAIN & FUNCTION USING PEG SCALE

PEG score = average 3 individual question scores (30% improvement from baseline is clinically meaningful)

- Q1:** *What number from 0–10 best describes your **pain** in the past week?*
0 = “no pain”, 10 = “worst you can imagine”
- Q2:** *What number from 0–10 describes how, during the past week, pain has interfered with your **enjoyment of life**?*
0 = “not at all”, 10 = “complete interference”
- Q3:** *What number from 0–10 describes how, during the past week, pain has interfered with your **general activity**?*
0 = “not at all”, 10 = “complete interference”

Discharging Patients from Practice

- Distinguish “stopping or changing a treatment” from “termination from practice”
- In general, when “stopping or changing a treatment” such as opioids, make every effort to continue to engage the patients in care
 - If opioids discontinued, attempt to maintain close follow-up for several months after discontinuation
 - Screen, assess, and offer or arrange for treatment of OUD/SUD

Discharging Patients from Practice

- Exceptions include significant disruptive, threatening, or otherwise dangerous behaviors that may compromise the safety of the health care team
- If a patient is terminated from practice, make sure to follow guidance for state medical board

Behavioral Pain Medicine in Low Resource Settings

The biopsychosocial model of **pain**





- Insurance coverage
- Time
- Co-pays
- Travel
- Work / family obligations
- Pain / health
- Proximity (rural settings)
- No psychologists nearby who are trained to treat pain

Darnall BD et al. *Pain Med* 2016



From Catastrophizing to Recovery: a pilot study of a single-session treatment for pain catastrophizing

This article was published in the following Dove Press journal:

Journal of Pain Research

25 April 2014

[Number of times this article has been viewed](#)

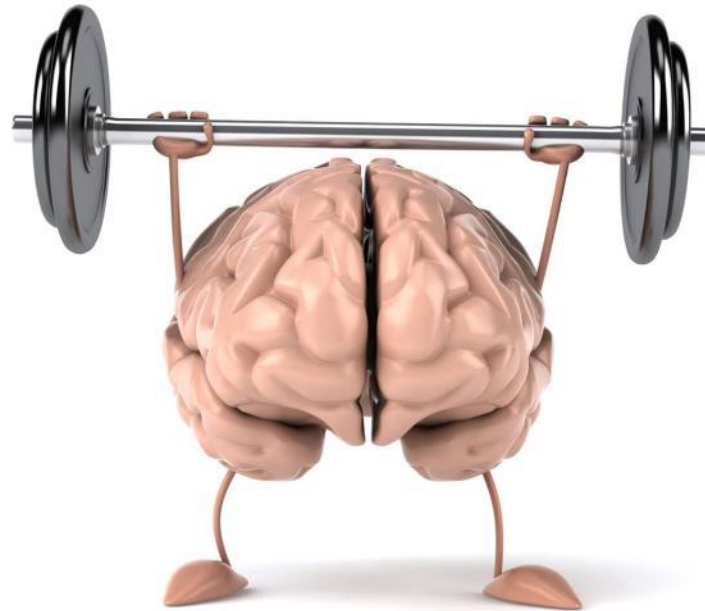
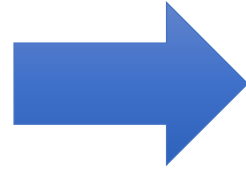
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and Pain Laboratory, Stanford
University School of Medicine,
Palo Alto, CA, USA

Background: Pain catastrophizing (PC) – a pattern of negative cognitive-emotional responses to real or anticipated pain – maintains chronic pain and undermines medical treatments. Standard PC treatment involves multiple sessions of cognitive behavioral therapy. To provide efficient treatment, we developed a single-session, 2-hour class that solely treats PC entitled “From Catastrophizing to Recovery” [FCR].

Objectives: To determine 1) feasibility of FCR; 2) participant ratings for acceptability, understandability, satisfaction, and likelihood to use the information learned; and 3) preliminary efficacy of FCR for reducing PC.

Design and methods: Uncontrolled prospective pilot trial with a retrospective chart and



From: Darnall BD. The Opioid-Free Pain Relief Kit © 2016. Bull Publishing

Certification Workshops for Healthcare Clinicians



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McGill
UNIVERSITY



MASSACHUSETTS
GENERAL HOSPITAL



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Healthcare



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RESOURCES

13-page PDF accompanies this webinar

Includes:

- Tipsheets, free online resources, and books for patients and clinicians
- HHS tapering guidance
- CDC prescribing checklist
- VA Taper Tool – includes medications for withdrawal
- VA OUD Provider Guide
- Professional coaching resource

Q&A

