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103 MAINE AVENUE, BANGOR, MAINE

Managing Legacy Patients on Controlled Substances:

Compassionate, Evidence-Based Responses

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…A collaboration between:

PCHC

St. Joseph Healthcare
St. Joseph Hospital
A Member of Covenant Health

Disclosures

- I do not accept any money from pharmaceutical companies/ commercial interests
- Speakers and planners have no significant or relevant financial relationships to disclose

Goals for Our Time Today

1. Introduce strategies for inheriting patients with chronic pain
2. Introduce compassionate tapering guidelines
3. Introduce the Schmidt Institute's Controlled Substance Stewardship Program

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Controlled Substance Stewardship:

An Overview

Four Principles of Opioid Stewardship

1. There is no evidence for benefit from opioids in the treatment of chronic pain for a population of people and for some of the most common conditions for which opioids are prescribed (back pain, headaches, fibromyalgia, neuropathic pain and chronic regional pain syndrome) there is evidence of no benefit.

2. For people on daily opioids for chronic pain the lifetime prevalence of opioid use disorder (using DSM V criteria) may be as high as 35%, so in the instance of a challenging tapering experience this must be part of the differential diagnosis.

3. Emotional trauma and significant mental illness are much more likely to be present in people with chronic pain and should always be assessed and addressed.

4. The best approach to the treatment of chronic pain is almost always multi-faceted and pharmacologic interventions are not the most important of those approaches.

CDC Guidelines

2016	2022
Start with lowest effective dose. Extra precautions > 50 MME, avoid > 90 MME	Start with lowest effective dose. Avoid increasing dosage above levels “likely to yield diminishing returns” (clearly identified as >50 MME in main body).
3-7 days usually sufficient for acute pain.	Only consider for acute pain if benefit exceeds risk. No greater quantity than needed for the expected duration of pain severe enough to require opioid.
Reevaluate every 3 months. Taper if benefits do not exceed risks.	Reevaluate every 3 months. For those already receiving high doses, consider tapering, but do not discontinue abruptly.

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OUD vs. CPOD

OUD	CPOD
Use related to social, occupational and behavioral issues	Poor pain control and function, psychiatric instability, aberrant behavior.
Illicit or iatrogenic initiation	Iatrogenic initiation
Patient goal of intoxication or euphoria	Rare goal of intoxication/ euphoria
Classic withdrawal symptoms	Worsening pain and declining function are predominant withdrawal symptoms

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Reference: Manhapra A, Sullivan MD, Ballantyne JC, MacLean RR, Becker WC. Complex Persistent Opioid Dependence with Long-term Opioids: a Gray Area That Needs Definition, Better Understanding, Treatment Guidance, and Policy Changes. J Gen Intern Med. 2020 Dec;35(Suppl 3):964-971. doi: 10.1007/s11606-020-06251-w. Epub 2020 Nov 6. PMID: 33159241; PMCID: PMC7728942.

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Controlled Substance Stewardship:

Strategies for New Patients with Chronic Pain

Learning Objectives

- Understand that safety and compassion underly the work of de-prescribing opioids and benzodiazepines.
- Understand that use disorders and physiologic dependence are not categorical and that we must regularly assess for addiction in people on long term controlled substances.
- Learn practical approaches to tapering opioids and benzodiazepines in newly established patients.

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Responsibilities of the Providers & Care Team

- Ensure consistent, aligned messaging to the patient
- Reassure patients that this will be done well and that you will be there to support them through the process
- Repeat #1 and #2

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Case question #1

Patricia is new to your practice. She is a 67 year old woman with chronic pain, depression, anxiety, insomnia, osteoarthritis, GERD, CAD, COPD, sleep apnea, stress incontinence, and obesity (BMI 42). She is currently taking oxycodone 10 mg four times a day, morphine ER 30 mg twice a day, lorazepam, 1 mg three times a day, zolpidem 12.5 mg at bedtime, cyclobenzaprine 10 mg three times day "as needed", oxybutynin 10 mg twice a day, metoprolol 50 mg twice a day, atorvastatin 40 mg a day and omeprazole 20 mg twice a day. She smokes 1 ppd. She drinks alcohol "socially".

What additional history is important in assessing her controlled substance prescriptions?

A. Level of current functioning
B. History of emotional trauma
C. PHQ 9 score
D. Pain history and description of current pain
E. All of the above

Language Examples for Navigating Conversations with Patients

"As **better information** has become available, we have learned that your dose of opioid has much higher risks than lower doses.

- Your risk of accidental overdose is increased 900%.
- Your risk of dying sooner than you otherwise would is increased 300%.
- You are at increased risk of injury.
- You are at risk for becoming the victim of a crime.

As many as 4 out of 10 people taking opioids will develop an addiction, and they may not even know it. **Taking opioids for even a short time causes dependence**. That means that you would have withdrawal symptoms if the meds were stopped suddenly. Higher doses of opioids have not been shown to help and **may actually increase your pain**. Also, there are **no studies that prove there is actual benefit** from taking opioids for a long time and for problems like headaches, back pain, fibromyalgia and neuropathy good studies show that opioids do NOT help. Additionally, **opioids increase the risk of heart disease, erectile dysfunction, severe constipation, depression, and suicidality**."

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Language Examples for Navigating Conversations with Patients

We are going to **gradually reduce your dose** of opioid over time. I know that this will be hard for you and that it is frightening. My team and I will work with you and **be here for you as we make this change**. We will offer a variety of resources and treatments to help with your pain and to help you cope with this change in your treatment plan. I am confident that **this is the right choice for you and that you will be safer and better when we complete this process**.

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Role of Other Members of the Care Team

- Behavioral health providers can play a vital, supportive role in helping have these difficult conversations with patients
- Verbal and non-verbal communication of other care team members can have a profound impact: “We care about you, and we realize that this is difficult. We are here for you.”

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The Mechanics

Address medication changes in person if possible.

- NO blame, assume responsibility appropriately

Take a gradual approach if possible.

- 5% to 10% reduction at a time

Frequent follow up

Reframing of the PURPOSE of medication.

- "You no longer take this medication for pain, it's only to keep you from being sick while we take you off."

Trauma informed care

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Case question #2

After a careful history and physical exam, and discussion with Patricia you recommend addressing her opioid prescriptions as a first step. You ae concerned about continuing plain oxycodone due to its significant risk for diversion and misuse. Your options include which of the following?

A. Stop the oxycodone and work on tapering the morphine.
B. Convert her total MME all to morphine ER and taper.
C. Convert her total MME to all oxycodone and taper.
D. Convert the oxycodone to oxycodone/APAP for the taper.
E. All of the above are options.

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Controlled Substance Stewardship:

Strategies for Compassionate Tapering

Schmidt's CSS Model: Compassionate Tapering

More Patient Centered Language

"I've been thinking a lot about your care. As new information becomes available it is more and more apparent that these medications are not the right ones for your problem, and I think we need to move to a safer and more effective treatment plan. I know this will be difficult for you and I know it is frightening to consider. I will work with you and be available for you and we will get there together."

OR

"I've been thinking a lot about your care. As new information becomes available it is more and more apparent that your dose is unsafe, offers no benefit and may be making your pain worse. I think we need to reduce your dose to a safer level. I know this will be difficult for you and I know it is frightening to consider. I will work with you and be available for you and we will get there together."

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Schmidt's CSS Model: Compassionate Tapering

Other Strategies Include:

- Put the plan in writing
- Normalize the common reactions (i.e. anxiety, insomnia, achiness)
- Monitor while you taper (pill counts, UDS, PMP)
- Rate of taper can be customized but should be inexorable
- **Talk to the patient about the nature of addiction, repeatedly**
- Never reverse
- Rarely plateau
- No early refills
- Constantly reassure
- Resist disparaging prior prescribers
- Maintain close contact, especially once taper is complete

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Schmidt's CSS Model: Compassionate Tapering

Risk Factors Driving Faster Tapering:

- COPD
- Sleep Apnea
- Heart disease
- On Benzodiazepines
- Suspicion of misuse or diversion
- Substance Use Disorder
- Trauma or PTSD
- Bipolar, depression, schizophrenia, other SPMI

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Schmidt's CSS Model: Compassionate Tapering

Expect Pushback

Patient Pushback	Provider Response/Outcome
Anger	Patience
Tears	Empathy
Insults	Require civility
Threats	Set firm limits
Misbehavior	Ditto (be understanding)
Complaints to boards	Support from board
Negotiating	Calm, compassionate persistence
Suicide Threats	Usual care- opioids don't prevent suicide

Be Prepared for the Risks

- Withdrawal Symptoms
- Increased Pain (rebound hyperalgesia)
- Resistance
  - ✓ Depression is a predictor
  - ✓ Think about OUD
  - ✓ Think about CPOD
  - ✓ MAINTAIN EQUANIMITY

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Case question #3

Patricia is very unhappy with your decision to convert her oxycodone to oxycodone/APAP, which she says upsets her stomach. In addition, she has seen her orthopedic surgeon who is planning a knee replacement if she can lose weight. You should now:

A. Hold the taper until she is post op.
B. Convert back to plain oxycodone since oxycodone/APAP upsets her stomach.
C. Continue with the tapering plan and help her with evidence based interventions for weight loss.
D. Assess/reassess for OUD.
E. C&D

Schmidt's CSS Model: Compassionate Tapering

Tapering: The Nitty Gritty

- No evidence to support one medication over another
- Can use the medication the patient has been taking
- Can switch medications
- CAVEAT: opioid conversions require a dose reduction
- When tapering long acting, may need to switch to short acting once lowest increment is reached
- **Outcomes improve with psychotherapy**
- **Use Caution with Methadone**
- **Remember naloxone**

A reminder:

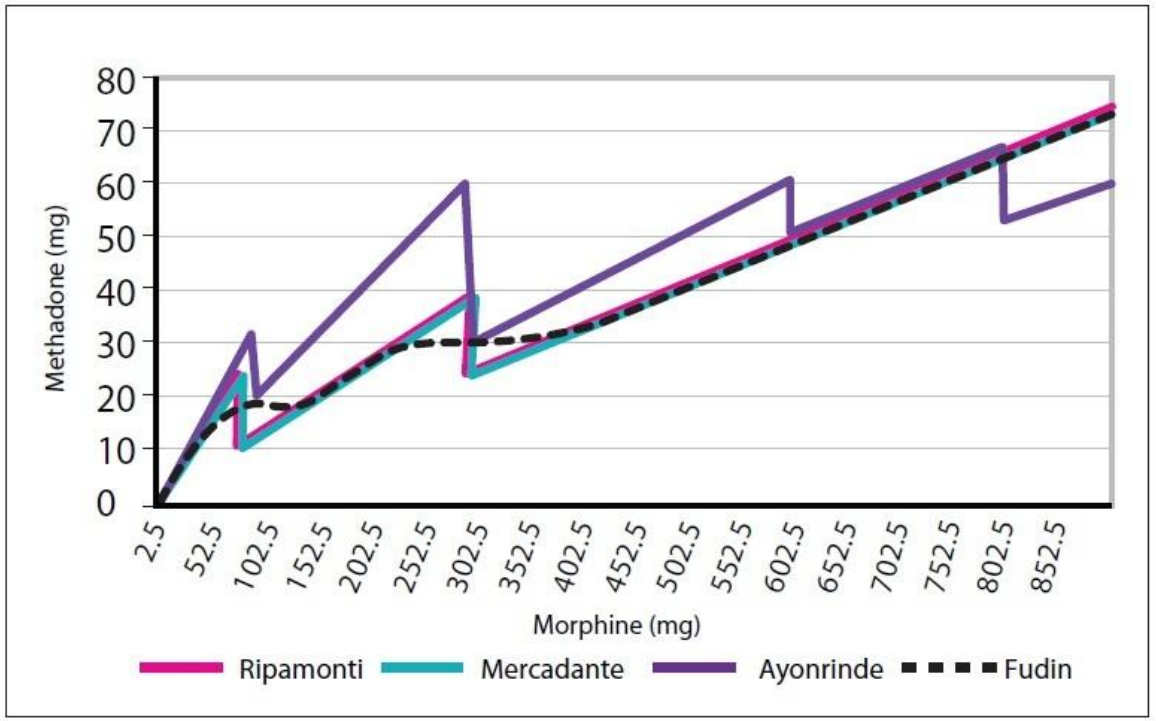

Figure 3. Morphine to methadone equianalgesic dosing ratios including Fudin equation.

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Controlled Substance Stewardship:

The Schmidt Institute's Program

Case question #4

Your additional concerns for Patricia's medications and treatment plan include:

A. The combination of opioids and a benzodiazepine and a somnolent
B. Her anticholinergic burden
C. Long term use of a PPI
D. No apparent treatment for depression
E. Need for suicide risk assessment and safety plan, if needed.
F. Need for counseling/psychotherapy
G. Ongoing smoking
H. Need to assess alcohol use with a validated tool
I. Concerns about undiagnosed trauma
J. Misuse or diversion of oxycodone
K. Undiagnosed OUD
L. CPOD
M. Untreated COPD
N. Untreated sleep apnea
O. Exploitation of this patient
P. Post operative pain management
Q. Dose of zolpidem above max recommended
R. No higher line treatment for insomnia
S. ALL of the above!!

The Schmidt Institute CSS Model

- Began in 2013, with case reviews completed by Psychiatrist and Family Physicians.

- Now a **full interdisciplinary team of providers** reviews the cases, including:
  - Family Physician*
  - Psychiatrist*
  - Family Nurse Practitioner – Pain Specialist*
  - Clinical Pharmacists*
  - Licensed Clinical Professional Counselor
  - Peer Advocate

**Provide treatment for use disorder*

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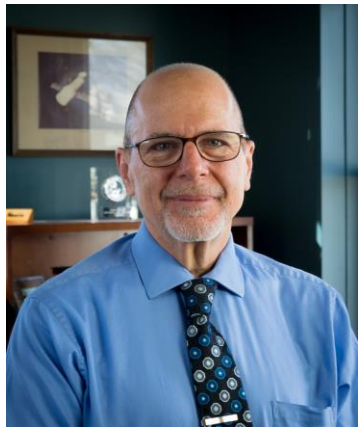
Controlled Substance Stewardship Team



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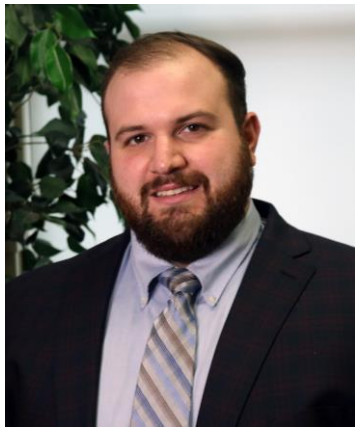

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Director of Pharmacy

Eva Quirion, FNP
FNP, Addiction and Pain Treatment Expertise

Amy Langley, FNP
Family Nurse Practitioner

Irene Madrigal, PharmD
Clinical Pharmacist

Trip Gardner, MD
Psychiatrist

Colleen Owens, LCPC
Director of Psychotherapy

Ernie Merritt
Patient Advocate

The Schmidt Institute's CSS Model

Case reviews prioritized based on provider referrals and reports run within EMRs, including:

- High dose (> 100 MME)
- Opioids and benzos
- Opioids in patients with use disorders
- Near miss overdoses
- Routine case reviews for outlier prescribers of opioids
- Premature deaths
- Suboxone and benzos
  >60 y.o. on benzo

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CSS Program Outcomes to Date

2,012

Total cases reviewed completed since September 2019

18,699

Total MME reduction realized since September 2019

15

Total organization clients engaged across Maine

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All CSS services are offered free of charge to organizations & providers statewide as part of a collaboration with the State of Maine Office of Behavioral Health.

For More Information:

On The Schmidt Institute or Controlled Substance Stewardship

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Thank you!

Questions?

…A collaboration between:

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