Prescription Opioids for Pain:
Where are we in 2022?

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Disclosures & Affiliations

Disclosures:

- Joanna L. Starrels, MD, MS has disclosed she is a site PI for an NIH, FDA-mandated, multi-site observational study of the risks of prescription opioids, through a sub-contract with the Clinical Directors' Network and the Opioid Post-marketing Requirement Consortium.

- All relevant financial relationships have been mitigated.

- No commercial funding has been accepted for this activity.

Affiliations:

- Consulting fees from Venebio Group LLC and public health departments (NYC, DC)
- Royalties from UpToDate.com
- Presenter fees from SCOPE of Pain
- Contributed to guidelines including CDC Guideline on Opioid Prescribing (2016), NYC guidance on opioid prescribing

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Outline

Epidemiology of chronic pain and opioid prescribing

Best practices for prescribing and deprescribing opioids

Take-home points

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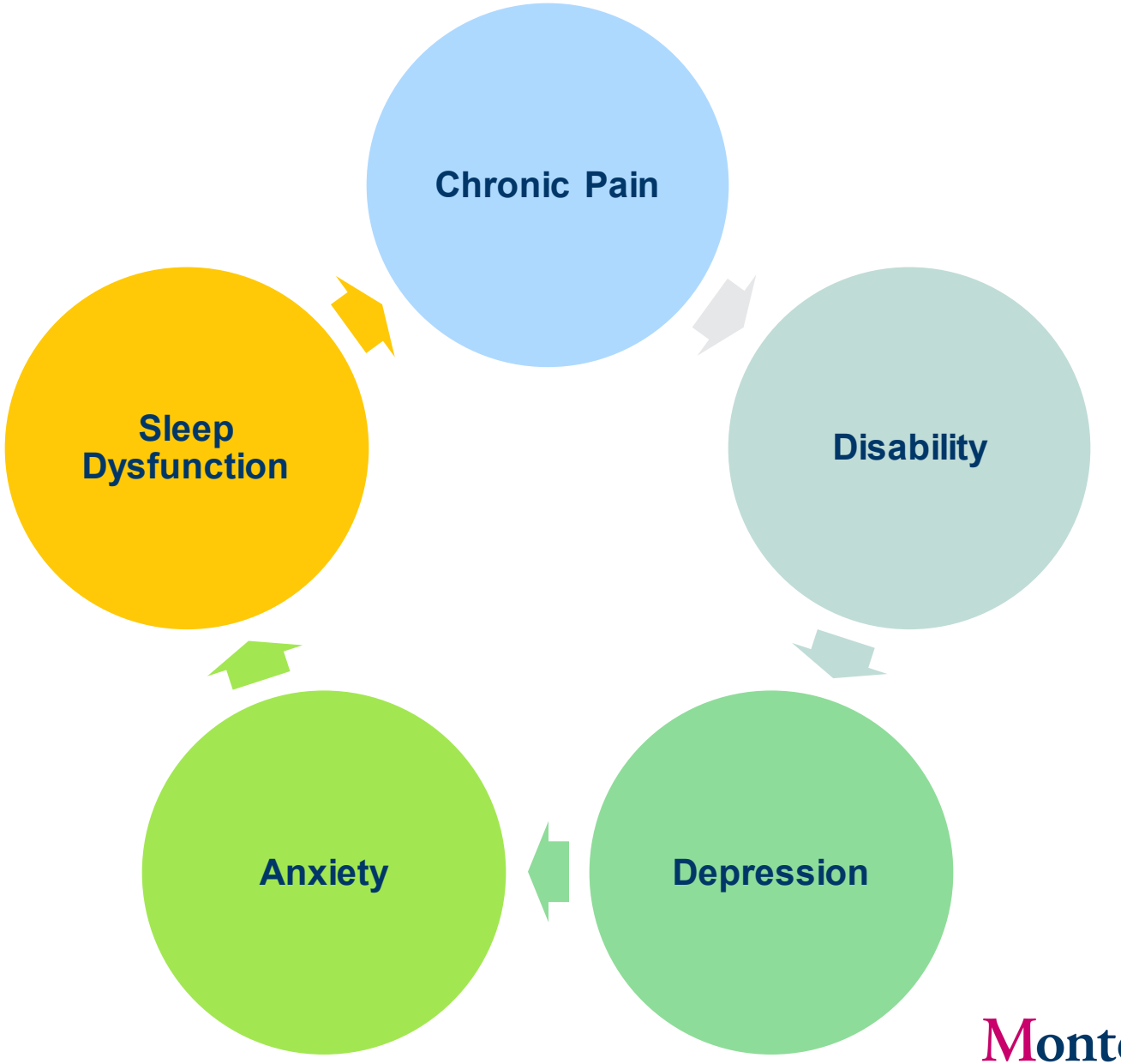
Chronic Pain



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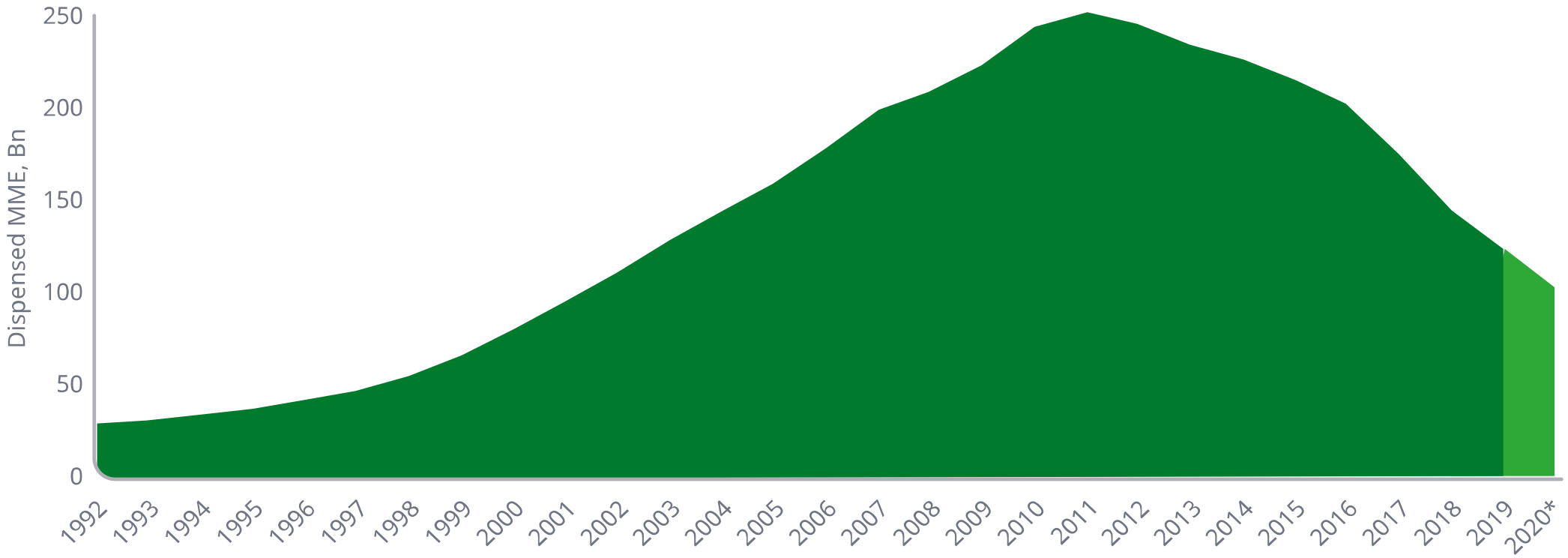
Epidemiology of chronic pain

- 50 million Americans (20.5%) report pain on most or all days
  - 19.6 million (8%) have high-impact chronic pain

- Higher prevalence among:
  - Older adults
  - Women
  - Rural residents
  - Adults with low wealth and/or having public insurance
  - More high-impact chronic pain in Black/African American adults
    - Due to social and structural determinants of health

Yong RJ, Pain 2022; Dahlhamer J et al. MMWR 2018; Janevic MR et al. J Pain 2017; 18(12).

Epidemiology of opioid prescribing



Source: IQVA Xponent, Mar 2020; IQVIA National Prescription Audi; IQVIA Institute, Nov 2020).

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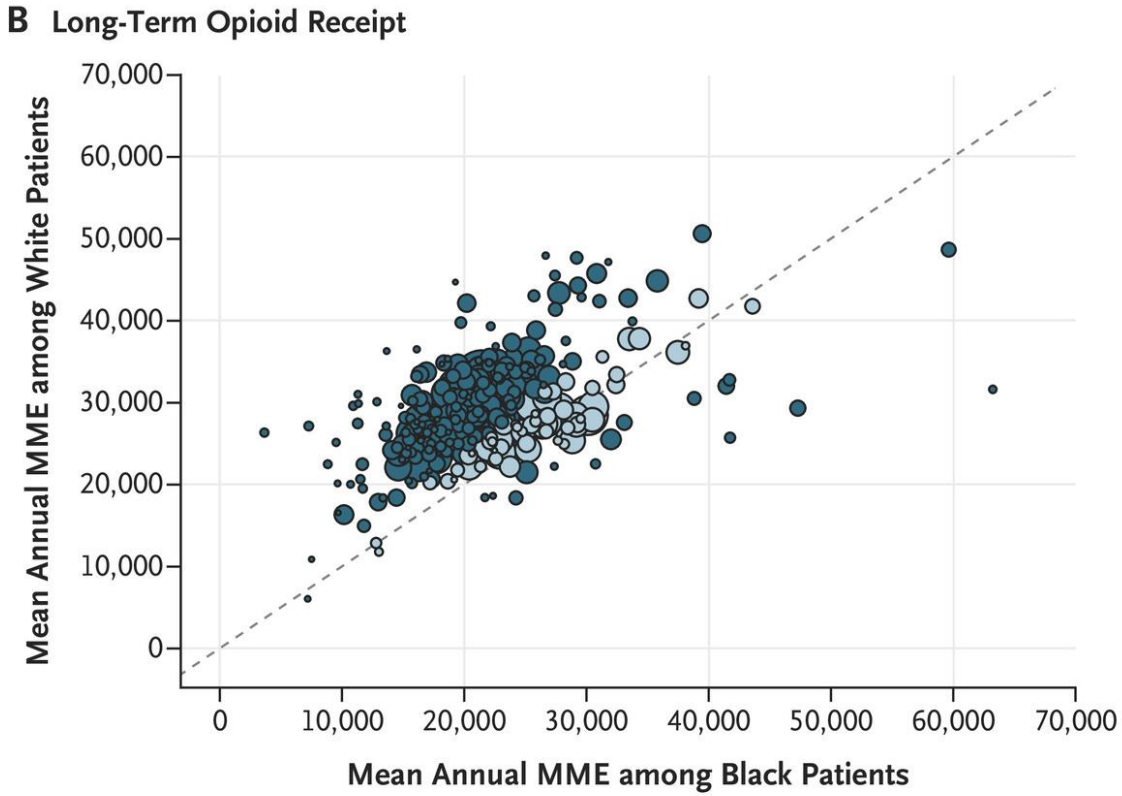
Opioid prescribing by race in the U.S.

- Within-system differences among 310 health systems (2016-2017 Medicare data)



Morden NE et al. N Engl J Med 2021;385:342-351.

The NEW ENGLAND JOURNAL of MEDICINE

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Why are Black patients less likely to be prescribed opioids, despite more high-impact chronic pain?

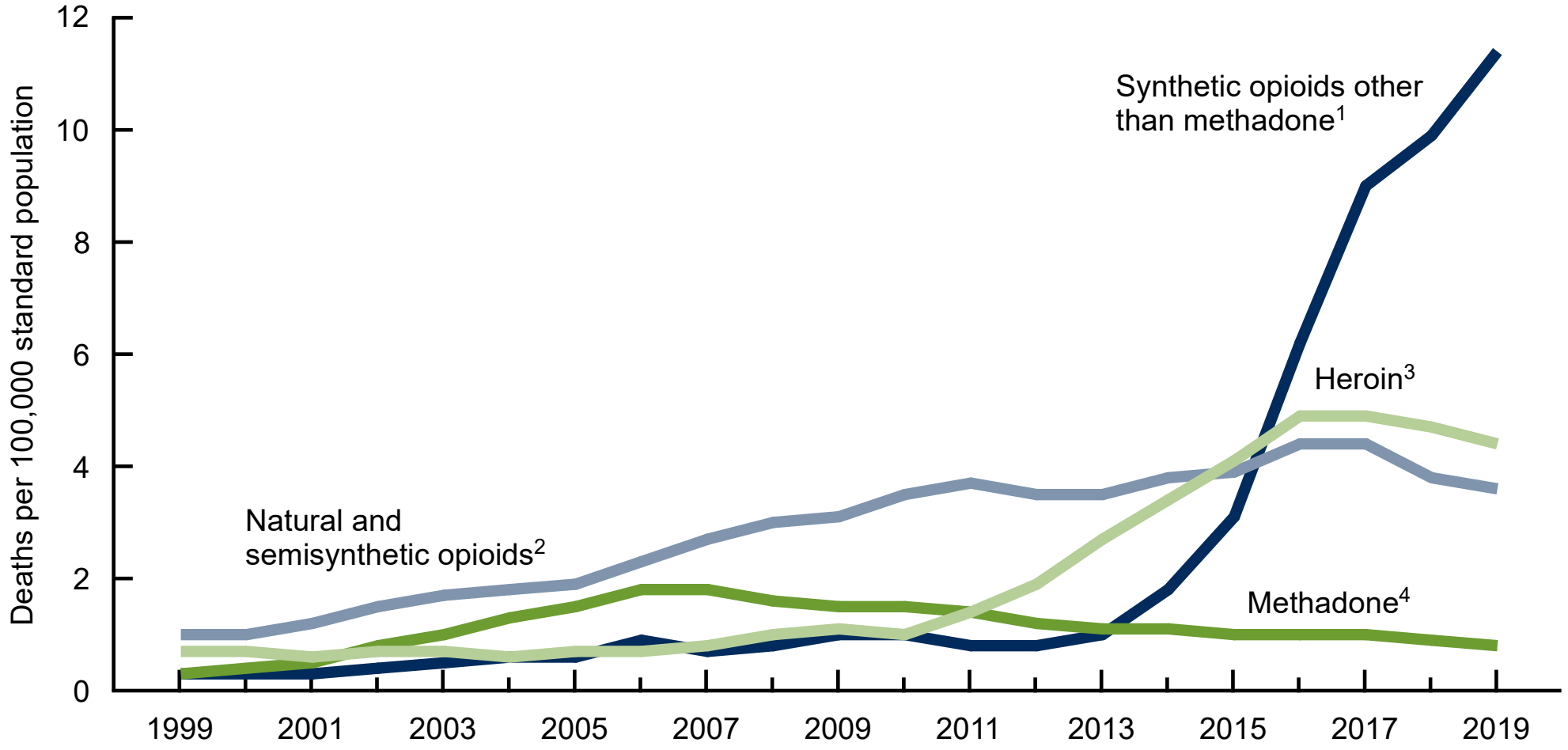
- Historic misconceptions about biological differences persist
  - Myths about Black tolerance for pain used to defend slavery and maltreatment in research and care
    - Black people as “insensitive to pain” (Dr. Samuel Cartwright, 1851)

Samuel Cartwright, from Wikipedia

  - In 2015, half of white medical students and residents endorsed beliefs about biological differences by race
    - Examples: Blacks have thicker skin, less sensitive nerve endings than whites
    - Beliefs about biological differences were associated with less accurate pain treatment recommendations (Hoffman 2016)

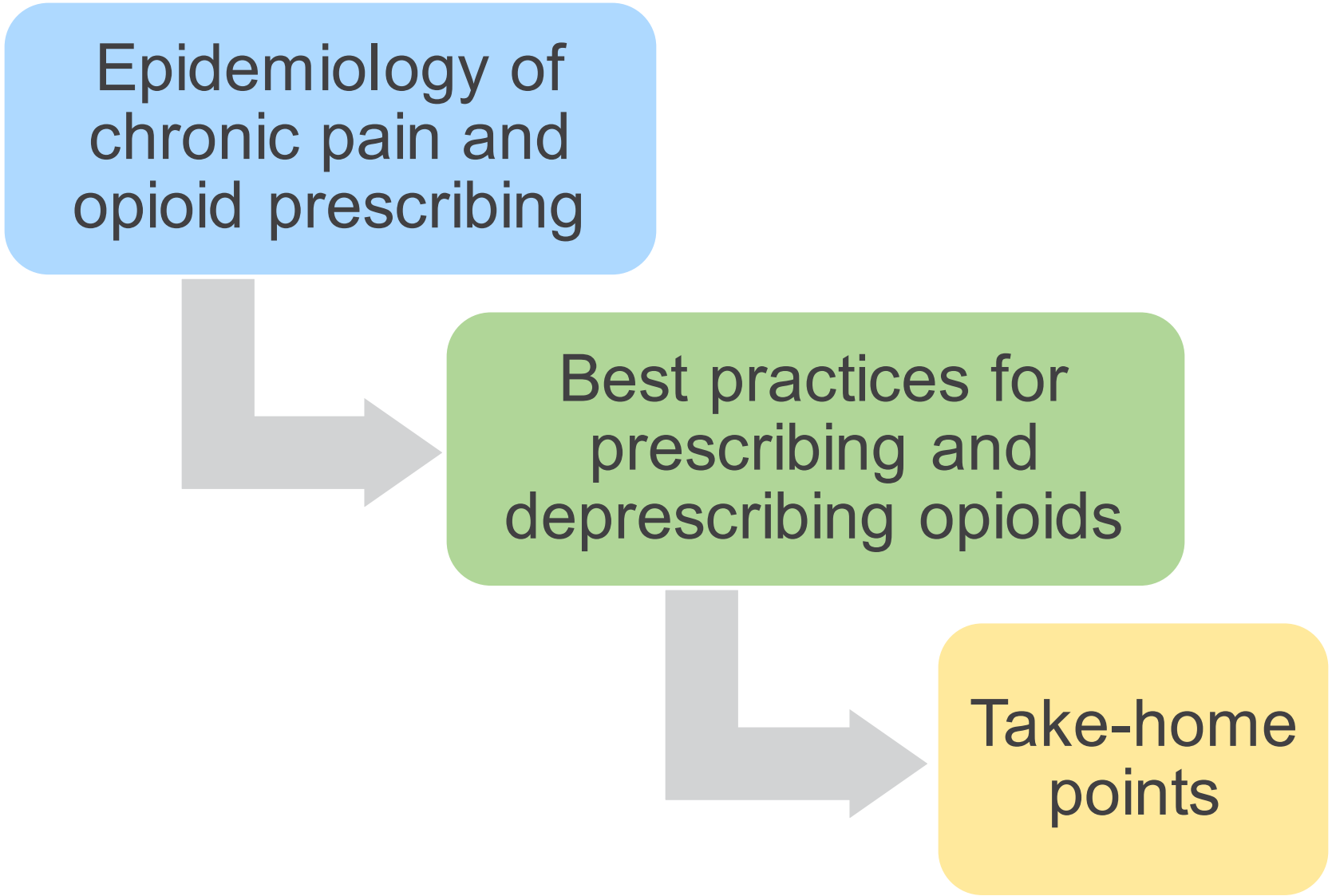
Hoffman KM et al. Racial bias in pain assessment and treatment recommendations, and false beliefs about biological differences between blacks and whites. PNAS 2016.

Prescription opioid overdose death



Source: National Center for Health Statistics, National Vital Statistics System, Mortality

Outline



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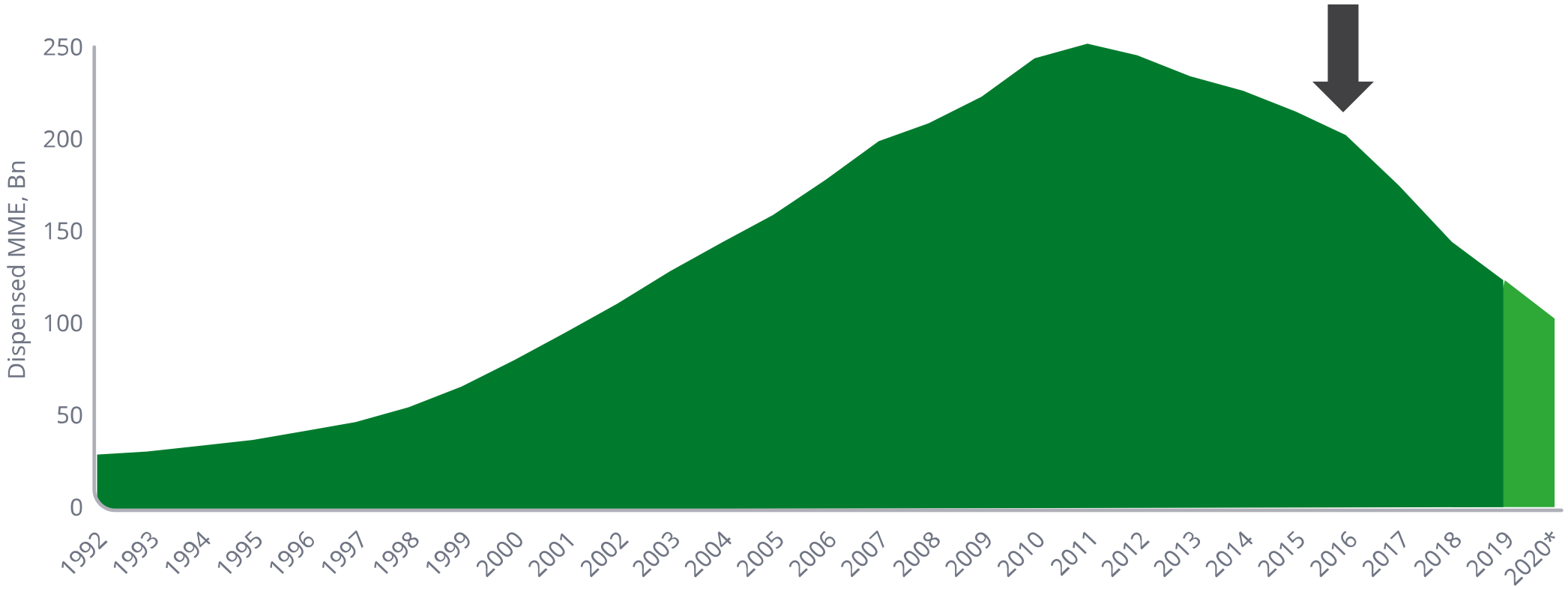
Clinical guidelines for opioid prescribing (2016)

- **When to prescribe opioids for chronic pain**
  - Non-pharmacologic and non-opioid therapies are preferred
  - Establish functional treatment goals
  - Discuss risks/benefits of opioids, and patient/provider responsibilities
- **How to prescribe opioids for chronic pain**
  - Start with immediate release (not long-acting) formulations
  - Prescribe lowest effective opioid dose (avoid and justify >90 MME)
  - For acute pain, not more than 3 to 7 days' supply
  - Regularly reassess; taper if pain and functional benefits do not outweigh risks
- **Assessing and mitigating risks and harms**
  - Use the prescription drug monitoring program, urine drug testing, give naloxone
  - Avoid concurrent benzodiazepine use when possible
  - If OUD, provide or refer for OUD treatment

What happened?



Source: IQVA Xponent, Mar 2020; IQVIA National Prescription Audi; IQVIA Institute, Nov 2020).

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Providers turning patients away

- 43% of PCP clinics surveyed unwilling to prescribe to a new patient on long-term opioids

- Why?
  - Stigma of chronic pain or opioid use
  - Fear of liability
  - Payor and pharmacy barriers

Lagisetty P et al. Assessing reasons for decreased primary care access. Pain (2021),

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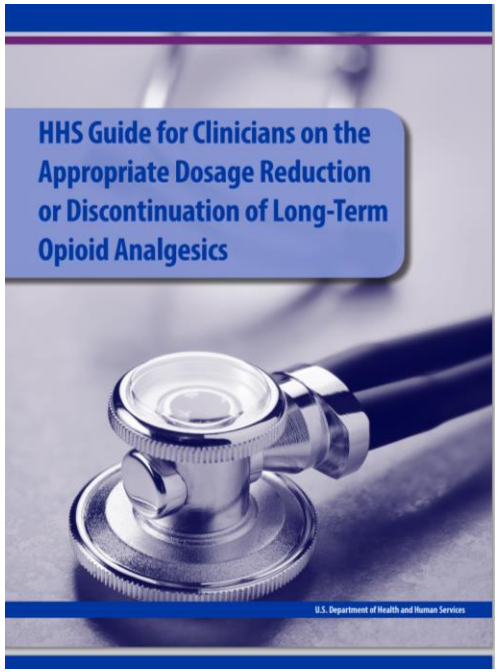
Overzealous opioid de-prescribing

- Risks of rapid taper or discontinuation
  - Opioid withdrawal
  - Exacerbation of pain
  - Psychological distress, suicidality, and death[1]
  - Termination of chronic medical care[2]
  - Illicit opioid use[3]
  - Opioid-related hospitalization and ED visits[4]
  - Overdose and overdose death[5]



U.S. Department of Health and Human Services Guideline (2019)

- Opioids should not be tapered rapidly or discontinued suddenly
  - Except if there is a life-threatening issue, such as impending overdose

[1]Demidenko MI et al., Genl Hosp Psych (2017), Oliva EM et al., BMJ (2020); [2] Perez HE et al., JGIM (2019); [3] Binswanger IA et al., DAD (2020), Coffin PO et al., Plos One (2020); [4]Mark TL et al., JSAT (2019); [5]James JR et al., JGIM (2019), Glanz JM et al., JAMA Network Open (2019)

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Inequities in judicious opioid prescribing

- Compared with white patients, Black patients are:
  - Less likely to be prescribed opioids, and prescribed fewer or lower dose[3]
  - More likely to have prescription opioids tapered[1]
  - More closely monitored, including more urine drug testing[2]
- Similar and less pronounced trends for Latinx vs. white non-Hispanic
- Compared with men, women are:
  - Less likely to be prescribed opioids, and prescribed lower dose[6]
  - More likely to have prescription opioids tapered[5]
- Notably, Black and female patients have *lower* risk for prescription opioid death than white and male patients

[1]Buonora M et al., Pain Medicine (2019); [2]Becker WC et al., Ann Family Med (2011), Hausmann LR et al. Pain (2013); [3]Pletcher MJ et al., JAMA (2008), Joynt M et al, JGIM (2013), Todd KH Ann Emerg Med (2000), Wisniewski AM et al., J Addict Med (2008), Morasco BJ et al., Pain (2010); [4] Hoffman KM et al., PNAS (2016); [5]Buonora M et al., Pain Medicine (2019); [6]Kaplovitch E, et al. PLoS One (2015), Wisniewski AM et al, J Addict Med (2008)

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2022 CDC Guideline

"Misapplication [of the 2016 guideline] including inflexible application of recommended dosage and duration thresholds, **contributed to patient harms…**

These experiences underlined the need for an updated guideline reinforcing the importance of **flexible**, **individualized**, **patient-centered** care."

My summary of key changes:

- More room for individualized care rather than algorithmic
- Less paternalistic, more collaborative
- Emphasized provider responsibility to provide care
- New guidance about pain treatments, how to taper, sub-acute pain, need for taper if > a few days
- Clarified that the guideline is not for payors or regulators to set standards

Dowell D et al. NEJM (2022), CDC website

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Operationalizing tapering "if benefits do not outweigh risks"

High risk

- Adverse effects
- Overdose
- Risky use or misuse
- High dose opioids or concurrent sedatives (e.g., benzodiazepines)
- OUD -> switch to OUD treatment

Low benefit

- Persistent or worsening pain
- Poor function

Consider:

- Risks/benefits of tapering too
- Patient and provider perspectives

New CDC Guideline: "In situations where benefits and risks of continuing opioids are considering to be close or unclear, shared decision-making with patients is particularly important."

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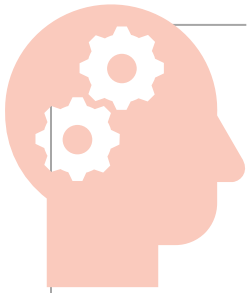
Applying harm reduction principles to opioid prescribing and de-prescribing

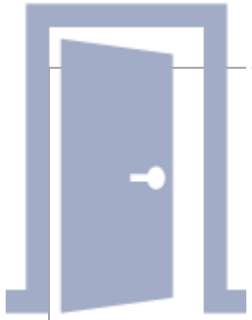


Respecting the rights of people prescribed opioids

- Individualized care
- No forced withdrawal

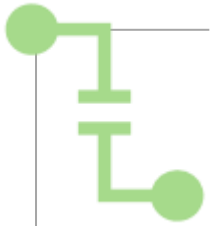
Acknowledging a spectrum of use and problems

- Sometimes benefits exceed risks
- People may not be able to taper off



Providing non-judgmental, low-threshold services

- Do not refuse care



Meeting people where they are

- Shared decision-making
- Slow taper

Patients have told us this is what they need.

Matthias M et al., J of Pain (2017); Ritchie CS et al., The Gerentologist (2020); Goesling J et al., Pain (2019); Dassieu L et al., Canadian J of Pain (2021); Perez HE et al., AMERSA abstract (2019); Henry S et al., J of Pain (2019).

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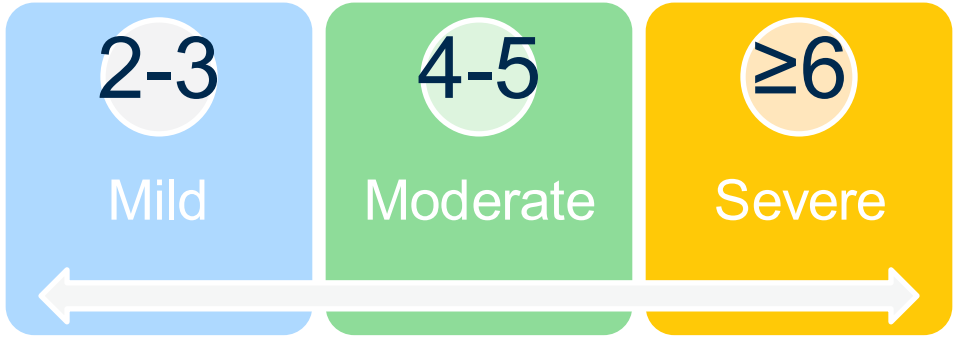
Diagnosing OUD when opioids are prescribed

DSM-5 diagnostic criteria

- ❑1. Taking more or for longer than intended
- ❑2. Unsuccessful efforts to stop or cut down
- ❑3. Spending a great deal of time obtaining/using/recovering
- ❑4. Craving
- ❑5. Failure to fulfill major role obligations due to use
- ❑6. Continued use despite resulting social or interpersonal problems
- ❑7. Important activities reduced because of use
- ❑8. Recurrent use in hazardous situations
- ❑9. Continued use despite resulting physical or psychological problems
- ❑10. Tolerance*
- ❑11. Withdrawal symptoms*



*Tolerance and withdrawal don't contribute if taken under medical supervision

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If your patient meets criteria for OUD

- If moderate or severe OUD
  - Connect them with evidence-based treatment wi
    buprenorphine
- If mild OUD
  - Offer transition to buprenorphine or referral to opioid treatment program
  - Less evidence to guide treatment; may be reasonable to attempt taper
- It is not always clear
  - Ongoing assessment, additional criteria may emerge
  - Even if no OUD but risks>benefits and unable to taper, may benefit from buprenorphine per CDC

"All clinicians, and particularly clinicians prescribing opioids in communities without sufficient treatment capacity for opioid use disorder, **should obtain a waiver** to prescribe buprenorphine for opioid use disorder." – 2022 CDC Guideline

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Treating acute pain in people with OUD

- Evaluate and treat acute pain
- Continue to treat OUD and/or opioid withdrawal also
- If opioids are needed, consider tolerance and increase dose if needed
- As for everyone, plan a taper off within a few days in most cases

- Avoid these common mistakes:

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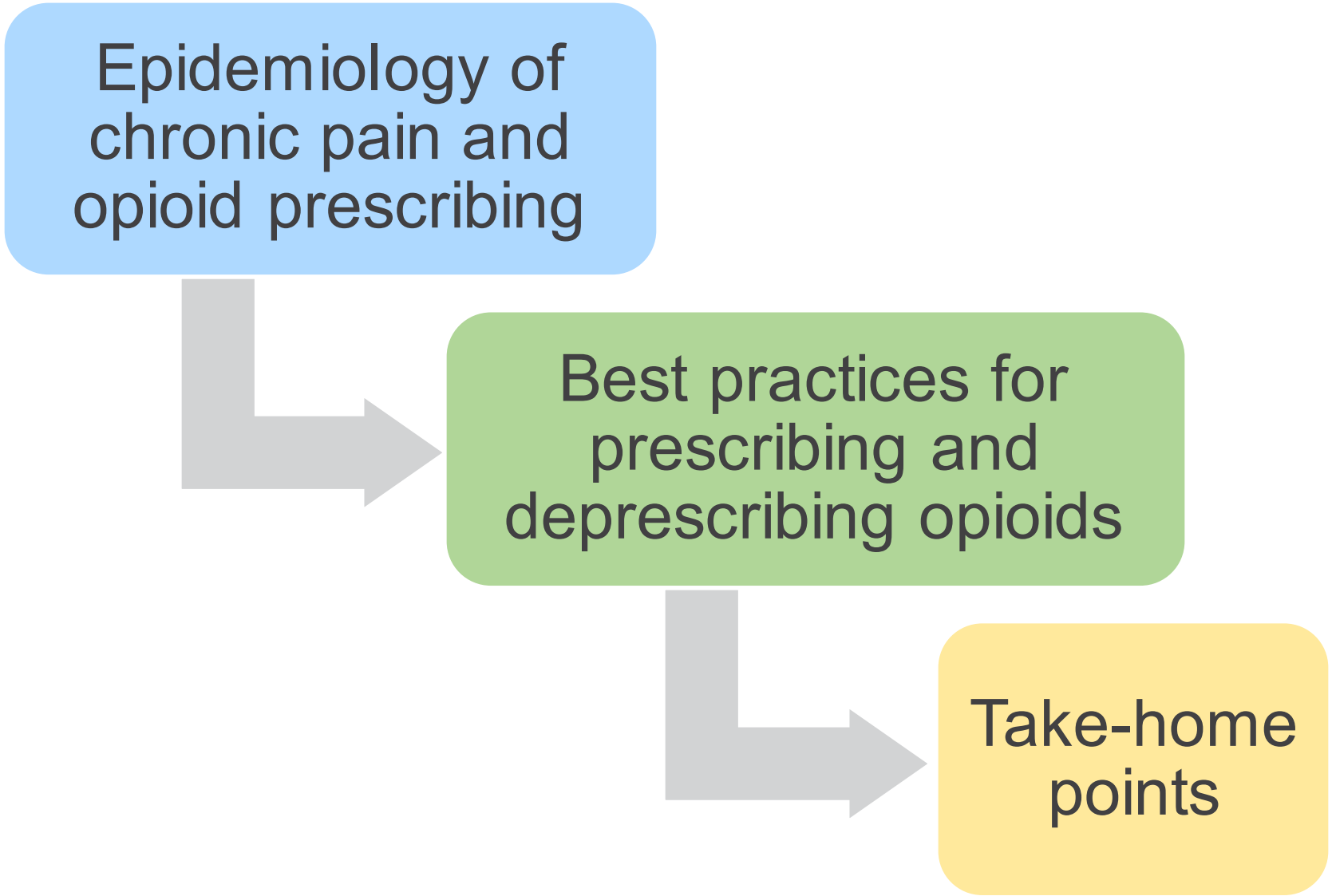
Outline



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Take-home points

- The prescription opioid landscape continues to evolve
- Limit unnecessary opioids and take precautions to reduce risks, and consider each individual
- Be mindful of biases and equity
- For patients already prescribed long-term opioids for chronic pain
  - Accept them as patients and work with them
  - Assess for and treat OUD
  - If tapering, taper slowly in collaboration with patient
- Treat acute pain in people with OUD
- Understand and treat the whole person


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What do we bring to the encounter?

Patients with chronic pain

- Bad experiences with physicians and the medical system
  - Pain discounted or ignored
  - Assumptions about their intent
  - Medical trauma 2/2 procedures
- Mental health struggles – depression, anxiety
- Trauma
- Stigmatized due to pain, disability, opioid use, mental health
- Experiences of racism

Providers

- Little training in chronic pain
- Bias towards chronic pain, opioid use
- Hidden curriculum
  - “Drug-seeking”, “legitimate pain, ”“abuse”
  - White supremacy, paternalism
- Fear of litigation
- Pressure for productivity
- Frustration with the system
- Burnout
- Empathy, curiosity, hardworking, goal to help

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