Opioid Safety Project Webinar Series
Psychologically-Integrated Approaches to Pain Management

Wednesday, November 14, 2018
Presenter:
Dr. Elie Aoun, American Psychiatric Association

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TOTAL NUMBER OF PERSONS ENROLLED IN MEDICARE = 3,509,904
AS OF JULY 2016

COLORADO
814,529 enrolled in Medicare
Original Medicare: 510,904
Medicare Advantage & Other Health Plans: 303,625
37.3% covered under Medicare Advantage

IOWA
585,047 enrolled in Medicare
Original Medicare: 480,654
Medicare Advantage or Other Health Plans: 104,393
17.8% covered under Medicare Advantage

ILLINOIS
2,110,328 enrolled in Medicare
Original Medicare: 1,609,092
Medicare Advantage & Other Health Plans: 501,236
23.8% covered under Medicare Advantage

Our vision: AMA is working to enhance the delivery of care and enable physicians and health teams to partner with patients to achieve better health.

What we do: The AMA is leading meaningful innovation to enable a better health care system for patients, physicians and the country.

Our TCPI work: Share, Listen, Speak, Learn: series spreading practice improvement strategies and other important topics for physicians and their practices to the wider AMA audience via a variety of channels both inside and outside of TCPI.
Psychologically-Integrated Approaches to Pain Management

Opioid Safety Project Webinar Series
A Telligen QIN-QIO and the American Medical Association Collaboration

November 14, 2018

Elie G. Aoun, M.D.
Forensic Psychiatry Research Fellow - Columbia University
Council on Addiction Psychiatry Vice-Chair - American Psychiatric Association
• I have no financial relationships with an ACCME defined commercial interest or conflict of interests
Objectives

• Discussing constructs of pain disorders with a focus on the contribution of psychological phenomena on the subjective experience of pain

• Reviewing evidence based non-pharmacological including psychological interventions for the management of pain disorders

• Appraising functional status focused patient measures for the assessment of pain

• Examining different models of psychologically integrated interventions utilized in healthcare systems across the country
Why are we talking about this?
Why are we talking about this?
The scope of the problem

• The US:
  5% of the world’s population
  80% of the global supply of prescribed opioids
  99% of the world’s supply of hydrocodone
  We are an outlier!

• We need to reduce the amount of opioids that are being prescribed
  Lack evidence for efficacy for high dose therapy
Opioids limited to serious and severe pain

- Pain with a clear pathologic/physiologic/anatomic basis
- Underlying cause is disabling
- Cannot be improved by primary disease treatment or lifestyle changes
- Goal of pain treatment is comfort
- All other treatments (best efforts) have failed

➤ Lack evidence for efficacy for high dose therapy
➤ 90% of pain complaints do not meet these criteria

So... What is pain and how do we formulate it?

• “An unpleasant sensory and emotional experience associated with actual or potential tissue damage” (The International Association for the Study of Pain)

• Pain is:
  An integral aspect of life
  A natural defense to signal a threat
  A source of personal distress
  High social and economic cost (>200 billion/y)
  Biological, emotional, cultural and social factors
## Acute Vs. Chronic pain

<table>
<thead>
<tr>
<th></th>
<th>Acute</th>
<th>Chronic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duration</td>
<td>Hours to weeks</td>
<td>Months to years</td>
</tr>
<tr>
<td>Associated Sx</td>
<td>HTN, tachycardia, diaphoresis, hyperventilation, distress</td>
<td>May be absent, but may be seen during periods of acute exacerbation</td>
</tr>
<tr>
<td>Type of pain</td>
<td>Nociceptive (may have neuropathic pain elements)</td>
<td>Nociceptive or neuropathic</td>
</tr>
<tr>
<td>Etiology</td>
<td>Surgery, trauma, medical procedures</td>
<td>Arthritis, back pain, headache, MS</td>
</tr>
<tr>
<td>Prognosis</td>
<td>Generally self-limited</td>
<td>Unpredictable</td>
</tr>
<tr>
<td>Complications</td>
<td>Uncommon</td>
<td>Depression, anxiety, insomnia, SUD, functional impairments</td>
</tr>
<tr>
<td>Treatment</td>
<td>Analgesics</td>
<td>Multi-modal</td>
</tr>
</tbody>
</table>
Clinical assessment of pain

- Pain description
- Pain intensity
- Pain location
- Duration
- Aggravating/Alleviating factors

But most importantly ➔ impact on functional status/pain related impairments/Pain Interference
The relationship between pain and psychiatry

- DSM.5; National Comorbidity Survey replication
- Psychiatric disorders in chronic pain
- Depression and anxiety disorders/symptomatology
- Pain and PTSD: possible common neurophysiologic substrate

- Somatic Symptom Disorder. (F45.1)
- Illness Anxiety Disorder. (F45.21)
- Conversion Disorder (Functional Neurological Symptom Disorder. (F44.4-7)
- Psychological Factors Affecting Other Medical Conditions. (F54)
- Factitious Disorder (includes Factitious Disorder Imposed on Self, Factitious Disorder Imposed on Another). (F68.10)
- Other Specified Somatic Symptom and Related Disorder. (F45.8)
- Unspecified Somatic Symptom and Related Disorder. (F45.9)
The link in the pain-psychiatric pathology co-morbidity

• A causal link?
• Is pain antecedent to psychiatric pathology or vice versa
• A bidirectional relationship
• Chronic pain is a risk factor for new depression
• But also, depression is a risk factor for chronic pain
• Psychiatric symptoms affecting the perception of pre-existing pain
• A complex subjective experience modulated by sensory, affective, and cognitive components.
• Expression of pain affected significantly by social and economic factors.

The link in the pain-psychiatric pathology co-morbidity

- Diathesis-stress model
- Antidepressants helpful for pain
- Sex differences? Pubertal development effects?
- BDNF dual role in pain and depression
- “Illness behavior:” behaviors an individual shows to the world in response to a disease state.
- Physicians disproportionately interact with individuals who amplify illness behavior

→ abnormal illness-affirming behavior (Conscious Vs. unconscious)

The impact of pain–mental disorder comorbidity

- Patients with chronic pain conditions and comorbid psychiatric disorders have poorer treatment outcomes and greater levels of disability.

- Their rehabilitation may also be compromised if the psychiatric disorders are not recognized. Recognizing psychiatric comorbidity compromises rehabilitation.

- Vs. Treating comorbid mental disorders improves perception of pain (as well as the functional status).


A psychologically-informed assessment of pain

• The expression of pain is affected by personality, emotional, and motivational factors
• The brain as a passive recipient of pain Vs dynamically involved in pain processing (Neural matrix model)
• A comprehensive evaluation of co-occurring psychiatric comorbidity
• An assessment factors influencing the presentation of pain (psychosocial history, motivations)
• An assessment of functional status and functional goals
• Formal psychiatric diagnoses?
• Patient’s resistance to psychiatric referrals

Pain assessment instruments

• Subjective report ➔ quantitatively trackable semi-objective report
• Interventions that can be delivered by PCPs to address the psychosocial problems complicating the clinical picture
• The Brief Pain Inventory (Cleeland & Ryan, 1994): pain’s impact on functional status
• The Pain Disability Index (Tait, Pollard, & Margolis, 1987): pain’s interference with family/home, recreation, social activities, occupation, sexual behavior, self-care, and life support activities
• The Modified Somatic Perception Questionnaire (Main, 1983): to assess “bodily awareness” of pain and co-occurring psychological symptoms
1. Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain other than these everyday kinds of pain today?
   - Yes
   - No

2. On the diagram, shade in the areas where you feel pain. Put an X on the area that hurts the most.

3. Please rate your pain by circling the one number that best describes your pain at its worst in the last 24 hours.
   - No pain
   - Pain imaginable
   - Pain imaginable

4. Please rate your pain by circling the one number that best describes your pain at its least in the last 24 hours.
   - No pain
   - Pain imaginable
   - Pain imaginable

5. Please rate your pain by circling the one number that best describes your pain on the average.
   - No pain
   - Pain imaginable
   - Pain imaginable

6. Please rate your pain by circling the one number that tells how much pain you have right now.
   - No pain
   - Pain imaginable
   - Pain imaginable

7. What treatments or medications are you receiving for your pain?

8. In the last 24 hours, how much relief have your pain treatments or medications provided? Please circle the one percentage that shows how much relief you have received.
   - No relief
   - 0% 10% 25% 30% 35% 40% 45% 50% 55% 60% 65% 70% 75% 80% 85% 90% 95% 100%

9. Circle the one number that best describes how, during the past 24 hours, pain has interfered with your:
   - General activity
   - Mood
   - Walking ability
   - Normal work (includes both work outside the home and housework)
   - Relations with other people
   - Sleep
   - Enjoyment of life

   - Does not interfere
   - Completely interferes
Pain Disability Index

**Family/home responsibilities:** This category refers to activities of the home or family. It includes chores or duties performed around the house (e.g., yard work) and errands or favors for other family members (e.g., driving the children to school).

<table>
<thead>
<tr>
<th>No disability</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>Worst disability</th>
</tr>
</thead>
</table>

**Recreation:** This category includes hobbies, sports, and other similar leisure time activities.

<table>
<thead>
<tr>
<th>No disability</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>Worst disability</th>
</tr>
</thead>
</table>

**Social activity:** This category refers to activities that involve participation with friends and acquaintances other than family members. It includes parties, theater, concerts, dining out, and other social functions.

<table>
<thead>
<tr>
<th>No disability</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>Worst disability</th>
</tr>
</thead>
</table>

**Occupation:** This category refers to activities that are a part of or directly related to one’s job. This includes nonpaying jobs as well, such as that of a housewife or volunteer worker.

<table>
<thead>
<tr>
<th>No disability</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>Worst disability</th>
</tr>
</thead>
</table>

**Sexual behavior:** This category refers to the frequency and quality of one’s sex life.

<table>
<thead>
<tr>
<th>No disability</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>Worst disability</th>
</tr>
</thead>
</table>

**Life-support activity:** This category refers to basic life-supporting behaviors such as eating, sleeping, and breathing.

<table>
<thead>
<tr>
<th>No disability</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>Worst disability</th>
</tr>
</thead>
</table>
# Modified Somatic Perception Questionnaire

<table>
<thead>
<tr>
<th>SYMPTOM</th>
<th>NOT AT ALL</th>
<th>A LITTLE, SLIGHTLY</th>
<th>A GREAT DEAL, QUITE A BIT</th>
<th>EXTREMELY, COULD NOT HAVE BEEN WORSE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Heart rate increase</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Feeling hot all over</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>3. Sweating all over</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>4. Sweating in a particular part of the body</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Pulse in neck</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Pounding in head</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>7. Dizziness</td>
<td></td>
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<tr>
<td>8. Blurred vision</td>
<td></td>
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<tr>
<td>9. Feeling faint</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Everything appearing unreal</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Nausea</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Butterflies in stomach</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Pain or ache in stomach</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. Stomach churning</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. Desire to pass water</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. Mouth becoming dry</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17. Difficulty swallowing</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18. Muscles in neck aching</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19. Legs feeling weak</td>
<td></td>
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</tr>
<tr>
<td>20. Muscles twitching or jumping</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>21. Tense feeling across forehead</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>22. Tense feeling in jaw muscles</td>
<td></td>
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</tbody>
</table>
The Pain Catastrophizing Scale

- Measuring the tendency to magnify the threat of pain, psychological burden of pain, and helplessness.

<table>
<thead>
<tr>
<th>When I'm in pain ...</th>
<th>0 - not at all</th>
<th>1 - to a slight degree</th>
<th>2 - to a moderate degree</th>
<th>3 - to a great degree</th>
<th>4 - all the time</th>
</tr>
</thead>
<tbody>
<tr>
<td>I worry all the time about whether the pain will end.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I feel I can't go on.</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>It's terrible and I think it's never going to get any better.</td>
<td></td>
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</tr>
<tr>
<td>It's awful and I feel that it overwhelms me.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I feel I can't stand it anymore.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I become afraid that the pain will get worse.</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>I keep thinking of other painful events.</td>
<td></td>
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</tr>
<tr>
<td>I anxiously want the pain to go away.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I can't seem to keep it out of my mind.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I keep thinking about how much it hurts.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I keep thinking about how badly I want the pain to stop.</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>There's nothing I can do to reduce the intensity of the pain.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I wonder whether something serious may happen.</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

Total
General treatment approaches

• Practice should reflect the principles of physiatry (Physical medicine and rehabilitation):

1. Focusing on optimizing function
2. Treatment using a combination of medications, physical interventions, psychological interventions and patient education and training.
3. A multidisciplinary approach increases the odds of success (MD, RN, psychologists, physical therapists, occupational therapists, and interventionalists)
A quick note on acupuncture

• 5200 yo technique: 365 points mapped along Meridians (aka “channels of energy flow”)
• Auricular acupuncture (based on a reflex somatotopic system)
• Osteopuncture (periosteal electroacupuncture)
• Transcutaneous electrical acupoint stimulation (TEAS)
• Suggested mechanism of action: endorphin release creating analgesia (central and descending via the hypothalamus, PAG, and raphe nuclei)
• NIH Consensus Panel: evidence only for dental pain and nausea
• Possible efficacy for other indications but more research needed

Psychological interventions to help manage pain

• Interventions for those with pain but not necessarily a psychiatric disorder.

• Psychodynamic therapy? Not necessarily (but some evidence for IBS)

• BUT FIRST... PATIENT EDUCATION!!!!

• Key for engagement in the treatment plan (patient buy-in)

• Very important for managing this waxing and waning course of disease

• Includes a discussion on sleep hygiene, exercising, dietary modification, pharmacologic therapy, and non-pharmacologic therapy

Psychological interventions to help manage pain

- Scope of possible interventions: CBT, meditation, mindfulness, relaxation, hypnosis, coping skills training and biofeedback
- Can be delivered face-to-face, online, over the phone or using computer/tablet programs
- Evidence for chronic headache, recurrent GI distress pain, fibromyalgia, sickle cell disease...
- Evidence for adults and for children... lots and lots of studies, reviews, cochrane...
Cognitive behavioral therapy

- Pts with chronic pain patients: high level of pain catastrophizing exacerbating underlying pain
- Enabling patients to understand, recognize, and modify counterproductive psychological and behavioral patterns.
- Developing sustainable skills using methods such as distraction, relaxation, visual imagery, and home written exercises
- Catastrophizing → increased baseline activity in the 1\textsuperscript{ary} somatosensory cortex/insula

- Study of pts with FM: CBT Vs. Patient education only
- CBT less pain catastrophizing on fMRI and pain scales (BPI, Pain Interference scales and Pain Catastrophizing scales) at at 1 and 6 months

CBT changes the brain's processing of pain

- CBT ➞ larger improvement of fibromyalgia Sx
- fMRI: CBT ➞ increased activations in the ventrolateral prefrontal/lateral orbitofrontal cortex; regions associated with executive cognitive control
- Correlation between catastrophizing and neuronal changes in somatosensory cortex processing of pain

Mindfulness Meditation

- Developing non-judgmental awareness to noxious stimuli and improving coping mechanisms
- Restructure and reduce worrisome thoughts via breathing exercises, sitting meditation, and simple yoga positions
- 2nd generation techniques also incorporate more complex meditative concepts such as non-self and non-attachment
- Structured guided sessions and daily home programs
- In pts with chronic pain: improved sleep, symptom severity, and perceived stress.

- RCT: Mindfulness-based stress reduction (MBSR) Vs CBT
- MBSR ➞ greater improvements in pain perception, mental distress, and sleep quality

A note on using psychological approaches to treat pain in children

• 2012 Cochrane
• 2884 children and adolescents with headache, stomach pain
• Interventions aim to control pain, modify situational, emotional, familial, behavioral factors playing a role in the onset and maintenance of pain
• Cognitive strategies: hypnosis, stress management, guided imagery, and cognitive coping skills
• Behavioral strategies: relaxation training, biofeedback, and behavioral management programs
• Reduction in pain frequency, pain intensity and anxiety
• Also reduced disability
• Benefits for up to 12 months after the intervention
Pain management programs

• OP, community based, or intensive residential programs
• Grounded in CBT (with rehabilitation interventions to improve function)
• Focus: improve self-management and independence (not the pain itself)
• Integrated Tx: meds, injections, physical rehab, psychological interventions
• Cultural specificities may impact the effects
• Cochrane (2012): effective model, cost-effective, less medication use, and healthcare utilization
• Also, improved sleep, return to work and reduction in stress and disability.
• Highest effect on the impact of pain (ie. physical and psychological functioning) but direct effect on pain itself not as strong

Pain management programs

Multidisciplinary groups:
- MD
- Psychologists
- PT
- OT
- Specialist pain consultant
- Specialist Nursing
- Pharmacist.

Key components include:
- Cognitive Therapy
- Graded Exposure
- Graded Activation
- Acceptance
- Mindfulness
- Skills Training and Activity Management
- Physical Exercise
- Education
A multidisciplinary approach!

- Cochrane, 2014: (41 studies/6858 participants)
- Psychological and social factors may play a role in the development and maintenance of pain and disability
- Multidisciplinary biopsychosocial rehabilitation reduces perception of pain, less disability, improved functional status, increased likelihood to return to work
- Pts with the greatest appreciable psychological impairment benefit the most

- A 2016 RCT: multidisciplinary rehabilitation superior to CBT in improving fatigue

The POST model SF-VAMC

- In response to findings from a 2013 govt survey ➔ concerns Re: opioid prescribing
- A multidisciplinary consultative service to address the needs of pts with chronic pain on chronic opioids Tx
- The team: an addiction psychiatrist, a pain psychologist, addiction psychologist, a pharmacist, an NP, a nurse and a teaching service with trainees from each service
- Unified plan with recs for pain management, addiction status/risk and comorbidities, comorbidities affecting safe opioid prescribing
The POST model SF-VAMC

• Involvement with the execution of the recommendation
• Short or long term follow up
• Development of opioid and BZD taper guide, alternative Rx for pain
• Alternative pain services
• Pharmacy E-consult
• Pain clinic for referral for procedure
• Integrated pain team within medical practice
• IPRP (intensive pain rehab program)
• Individual pain CBT sessions
# Opioid Dose Reductions

*Note: these are general guidelines. Individual cases may require adjustments in management.*

## Gradual Dose Reductions:

*Consider a gradual dose reduction for most patients. Reduce dose 10-25% every 1-4 weeks as tolerated.*

<table>
<thead>
<tr>
<th>9 week taper</th>
<th>11 week taper</th>
</tr>
</thead>
<tbody>
<tr>
<td>Week 1-2 ↓ to 30mg q12 hours</td>
<td>Week 1-2 ↓ to 30mg QAM &amp; 15mg QPM &amp; 30mg QHS</td>
</tr>
<tr>
<td>Week 3-4 ↓ to 15mg q8 hours</td>
<td>Week 3-4 ↓ to 30mg q12 hours</td>
</tr>
<tr>
<td>Week 5-6 ↓ to 15mg q12 hours</td>
<td>Week 5-6 ↓ to 15mg q8 hours</td>
</tr>
<tr>
<td>Week 7-8 ↓ to 15mg daily</td>
<td>Week 7-8 ↓ to 15mg q12 hours</td>
</tr>
<tr>
<td>Week 9 discontinued</td>
<td>Week 9-10 ↓ to 15mg daily</td>
</tr>
<tr>
<td></td>
<td>Week 11 discontinued</td>
</tr>
</tbody>
</table>

## Rapid Dose Reductions:

*Consider a rapid dose reduction for medically dangerous situations. Reduce dose every 1-7 days as tolerated.*

<table>
<thead>
<tr>
<th>Methadone</th>
<th>Morphine SA</th>
<th>Oxycodone SA</th>
</tr>
</thead>
<tbody>
<tr>
<td>↓ 20-50% per day to 30mg/day</td>
<td>↓ 20-50% per day to 45mg/day</td>
<td>↓ 20-50% per day to 30mg/day</td>
</tr>
<tr>
<td>↓ 5mg/day every 3-5 days to 10mg/day</td>
<td>↓ 15mg/day every 1-5 days</td>
<td>↓ 10mg/day every 1-5 days</td>
</tr>
<tr>
<td>↓ 2.5mg/day every 1-5 days</td>
<td>Discontinue</td>
<td>Discontinue</td>
</tr>
<tr>
<td>Discontinue</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The POST model SF-VAMC

Non-Opioid Alternatives:
Consider addition of non-opioid alternatives prior to initiating a taper and short-term use of medications to reduce potential withdrawal symptoms.

<table>
<thead>
<tr>
<th>Non-Opioid Alternatives</th>
<th>Withdrawal Symptom</th>
<th>Management Strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pain psychology, pain classes,</td>
<td>Sweats/palpitations</td>
<td>Clonidine 0.1mg q6h prn (hold</td>
</tr>
<tr>
<td>pain clinic referral</td>
<td></td>
<td>if BP &lt;90/60mmHg)</td>
</tr>
<tr>
<td>Physical therapy, acupuncture,</td>
<td>Anxiety, dysphoria,</td>
<td>Hydroxyzine 25mg q8h prn</td>
</tr>
<tr>
<td>TENS unit, aqua therapy, yoga</td>
<td>lacrimation, rhinorrhea</td>
<td></td>
</tr>
<tr>
<td>Topical treatments (i.e., menthol</td>
<td>Diarrhea</td>
<td>Loperamide 4mg x1, then 2mg</td>
</tr>
<tr>
<td>/m-salicylate cream, capsacin</td>
<td></td>
<td>prn (max dose 16mg/day)</td>
</tr>
<tr>
<td>cream, lidocaine cream)</td>
<td>Muscle aches</td>
<td>Menthol/m-salicylate cream QID</td>
</tr>
<tr>
<td>NSAIDs (i.e., ibuprofen, naproxen,</td>
<td></td>
<td>prn</td>
</tr>
<tr>
<td>meloxicam, etodolac, diclofenac,</td>
<td>Muscle spasm</td>
<td>Methocarbamol 1000mg q6h</td>
</tr>
<tr>
<td>salsalate)</td>
<td></td>
<td>prn</td>
</tr>
<tr>
<td>Acetaminophen</td>
<td>Nausea/vomiting</td>
<td>Ondansetron 4-8mg q6h prn</td>
</tr>
<tr>
<td>Gaba-mediated (i.e., gabapentin,</td>
<td>Pain</td>
<td>Acetaminophen 325mg #2 tabs</td>
</tr>
<tr>
<td>pregabalin [NF])</td>
<td></td>
<td>TID prn</td>
</tr>
<tr>
<td>Tricyclic antidepressants (i.e.,</td>
<td>Sleep disturbance</td>
<td>Trazodone 50mg QHS prn</td>
</tr>
<tr>
<td>amitriptyline, nortriptyline)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SNRIs (i.e., venlafaxine, duloxetine)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Resources:
Opioid Dose Adjustments: Examples of Opioid Rotations and Dose Reduction Strategies
Opioid Tapering Fact Sheet

Adopted by the San Francisco VA Opioid Safety Initiative (OSI) Committee Nov 16th, 2015
THANK YOU

Discussion
Medication Management and Opioid (MMO) Initiative

- In alignment with national action towards improving medication management and opioid misuse, CMS is focused on patients and improving their health outcomes, reducing unnecessary utilization, and generating cost savings for public and private payers. Our intent is to generate commitments from clinicians, practices and improvement networks and organizations to be in action by signing the MMO Pledge. This pledge will be open to all clinicians and partners to complete.

Sign MMO Pledge

https://www.healthcarecommunities.org/Home/MMOPledge.aspx

- Note: For the last two questions on the pledge, please fill in as follows:
  - Which CMS Network are You or Your Organization Associated? Quality Innovation Network – Quality Improvement Organizations (QIN-QIOs)
  - Please select your QIN-QIO: Telligen
Your One-Stop Resource for Opioid Safety!

Events | Podcasts | Tools | Resources
Questions?

Please join us next month!
Dec. 12th @ 12:00 pm CST
Opioid Safety Series
“Patient and Family Perspectives”

Registration Link

Sandy Swallow, Program Specialist
Sandy.swallow@area-d.hcqis.org
515-223-2105

Telligen QIN-QIO website:
www.telligenqinqio.org

American Medical Association:
https://www.ama-assn.org/