A Novel Organizational Framework to Guide Pain Management in Patients with Concurrent Opioid Use Disorder and Serious Illness

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Presented at ASAM 2022

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Disclosure Information

An Organizational Framework to Guide Pain Management in OUD and Serious Illness

ASAM 2022 Annual Meeting

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- No disclosures

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- No disclosures

Learning Objectives

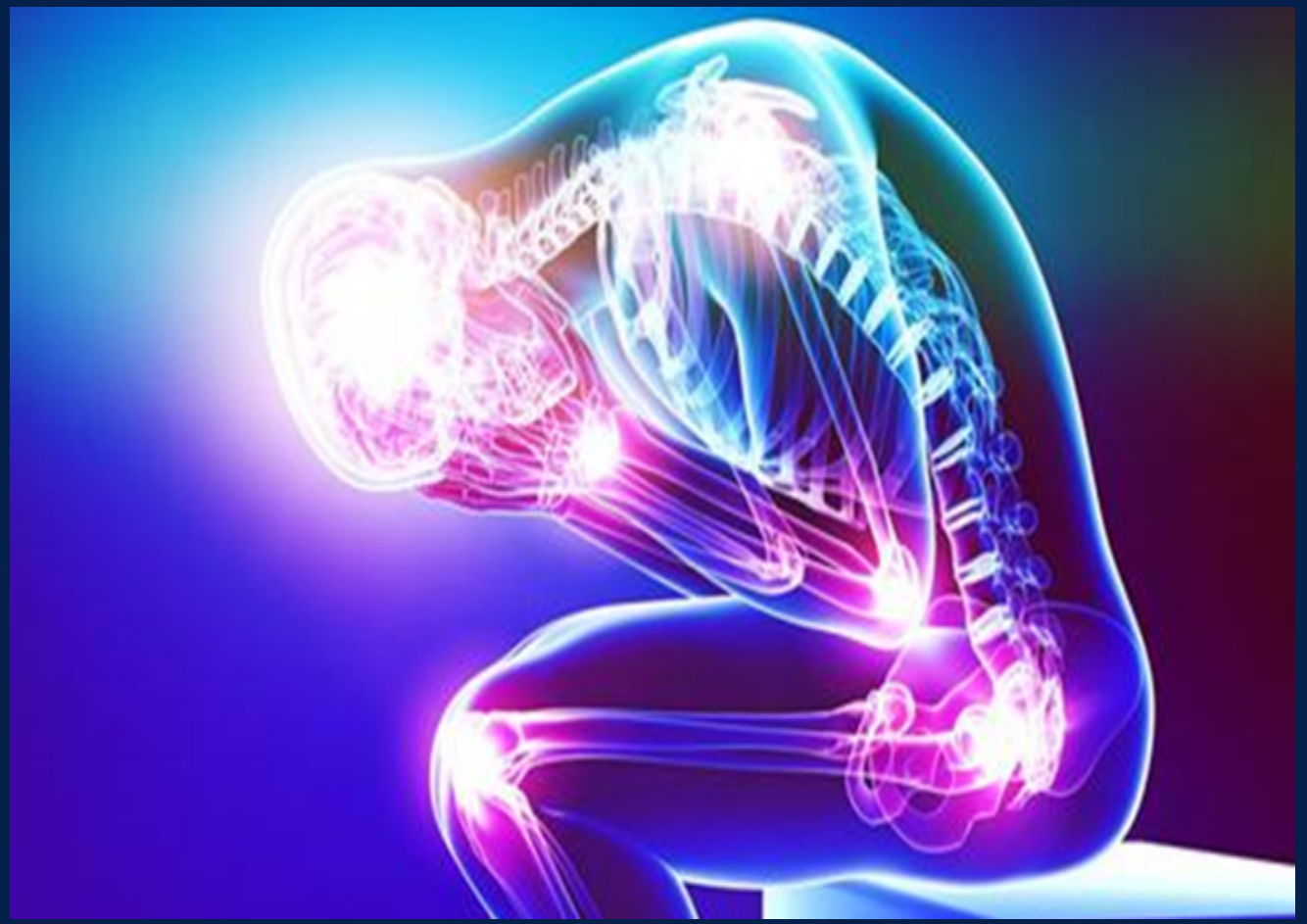
- Organize considerations for risks and benefits of opioid treatment using the 7P framework
- Evaluate medication management options for patients with complex pain, OUD, and serious illness
- Identify opportunities for Addiction specialists to partner with and advance primary addiction medicine skills in palliative care clinicians

Addiction consult for treatment recommendations

- 52yo woman with bladder CA and pain
- Admitted for curative resection of bladder and uterus, now with post-op pain
- Near complete response to neoadjuvant chemo
- H/o OUD, last heroin IV use 6 mo ago
- 2 months ago, self-tapered off 80mg daily at OTP despite recommendations not to
- Currently treated for pain and withdrawals with MSER by Palliative CAre
- Lives with a boyfriend w/ untreated OUD

Comorbid OUD and pain is common

- Pain is common for patients with OUD
  - 29-60% of people w OUD have chronic non-CA pain
  - 32% patients w chronic non-CA pain may have opioid misuse



Pain is also common in serious illness

- Pain is common for patients referred to Palliative Care (PC)
  - 80% of patients with CA report moderate to severe pain
    - Most will receive opioids
  - 20% of US adults report pre-existing chronic pain every or most days
  - 40% of chronic cancer pain is related to disease or treatments

Comorbid opioid misuse/ OUD are increasingly recognized in painful serious illness

- OUD and misuse are increasingly recognized in PC
  - 20-40% of patients with cancer found to have opioid misuse
  - 30-50% of urine screens showed unexpected results

van den Beuken, et al. J Pain Symptom Manage. 2016; Yennu S, et al.*J Clin Oncol* 2017; Yennurajalingam S, et al. *Cancer.* 2018; Yong, R, et al. *Pain,* 2021; Speed, T, et al. *International Review of Psychiatry* 2018; Rauenzahn S, et al. *Support Care Cancer 2017;* Carmichael, *Substance Abuse and Rehabilitation.* 2016

Most PC clinicians feel unprepared to care for patients with OUD

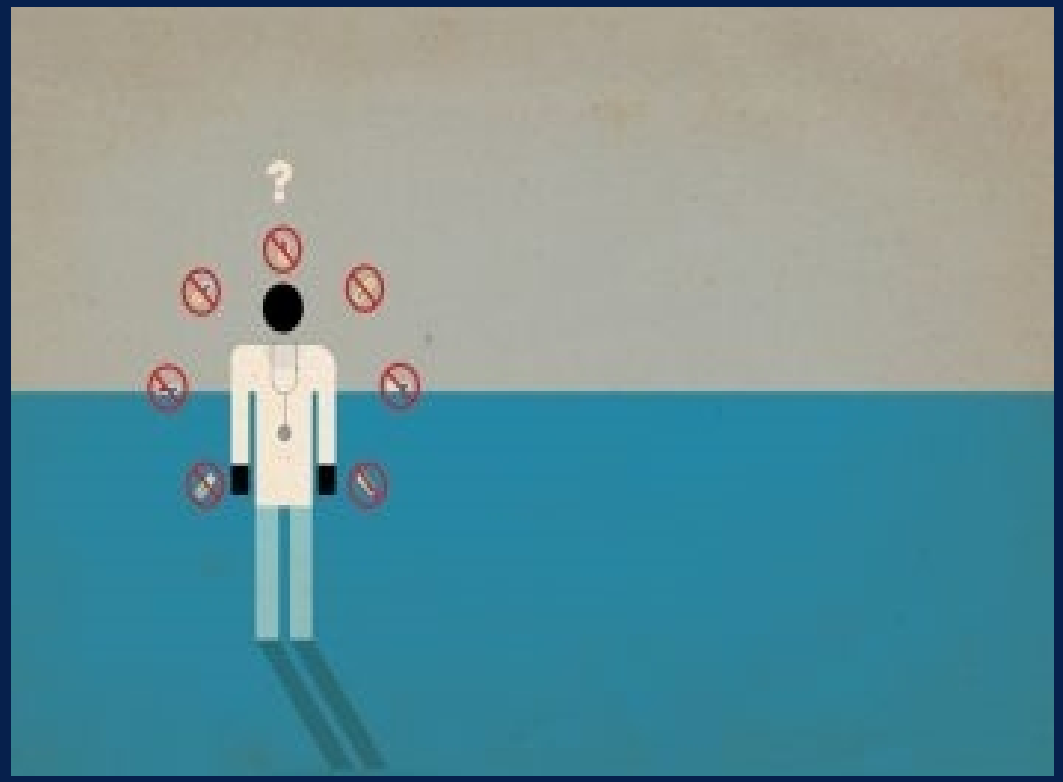
- PC and hospice providers have limited training in primary addiction medicine skills
  - Only 13% PC clinicians have X-waiver
  - Only 50% of PC clinicians w waiver actively prescribe MOUD

Patient or provider?

- Most studies on pain exclude patients with cancer and patients with SUD → lack of clinical guidelines on pain in OUD and serious illness

Merlin JS et al, J Pain Symptom Manage, 2018;
Childers, J, et al. *J Pain Symptom Manage* 2012

Addiction specialists may be asked to guide pain and OUD management



- However, most addiction specialists do not have extensive training in pain management
- ….. And most pain and palliative care specialists have little to no training in addiction medicine

What experiences have you had working with hospice or palliative care clinicians?

- Challenges?
- Successes?
- Models of integration or collaboration?

- A note about hospice vs. palliative care

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7Ps	Full agonist	Bupe/Nal	Methadone	Patient situation
Pain				
Pattern of OUD				
Prognosis				
Performance status				
Psychosocial				
Partnering w providers				
Patient-centered				

52yo woman with bladder CA and pain

- Admitted for curative resection of bladder and uterus, now also with post-op pain
- Near complete response to neoadjuvant chemo
- H/o OUD, not currently on MOUD

Social Hx:

- Lives with a boyfriend w/ untreated OUD
- Felt stigmatized being on methadone
- Hopes/Goals: To get rid of the CA.
  - To stop using drugs. Wants to come off MOUD ‘when this is all over’
  - Return to work. Motivated by her 4 estranged kids, “I would do anything for them; they don’t know it, but I would”

OUD History

- H/o remission x6yr on bupe/nal 8mg BID →self-tapered off when insurance changed → returned to use
- H/o remission x5yr on methadone 100mg/d → divorce and loss of job → left OTP and returned to use
- 6 mo ago – Last heroin IV use because of pelvic pain
- 6mo ago - Stabilized on 80mg methadone in OTP. Started CA treatment. PC started gabapentin and MSER for additional pain
- 2mo ago – started self-taper off Methadone by 1mg/week
- 1mo ago – stopped going to OTP despite concerns from PC; PC clinician increased MSER increased to ward off withdrawals

The team calls for recommendations about a discharge pain regimen. You recommend:

- Resume methadone and connect her to OTP
- Resume methadone TID, prescribed by PC or PCP
- Transition her to buprenorphine with no other opioid agonists
- Transition her to buprenorphine with other opioid agonists
- Continue treating with MSER, prescribed by PC or PCP

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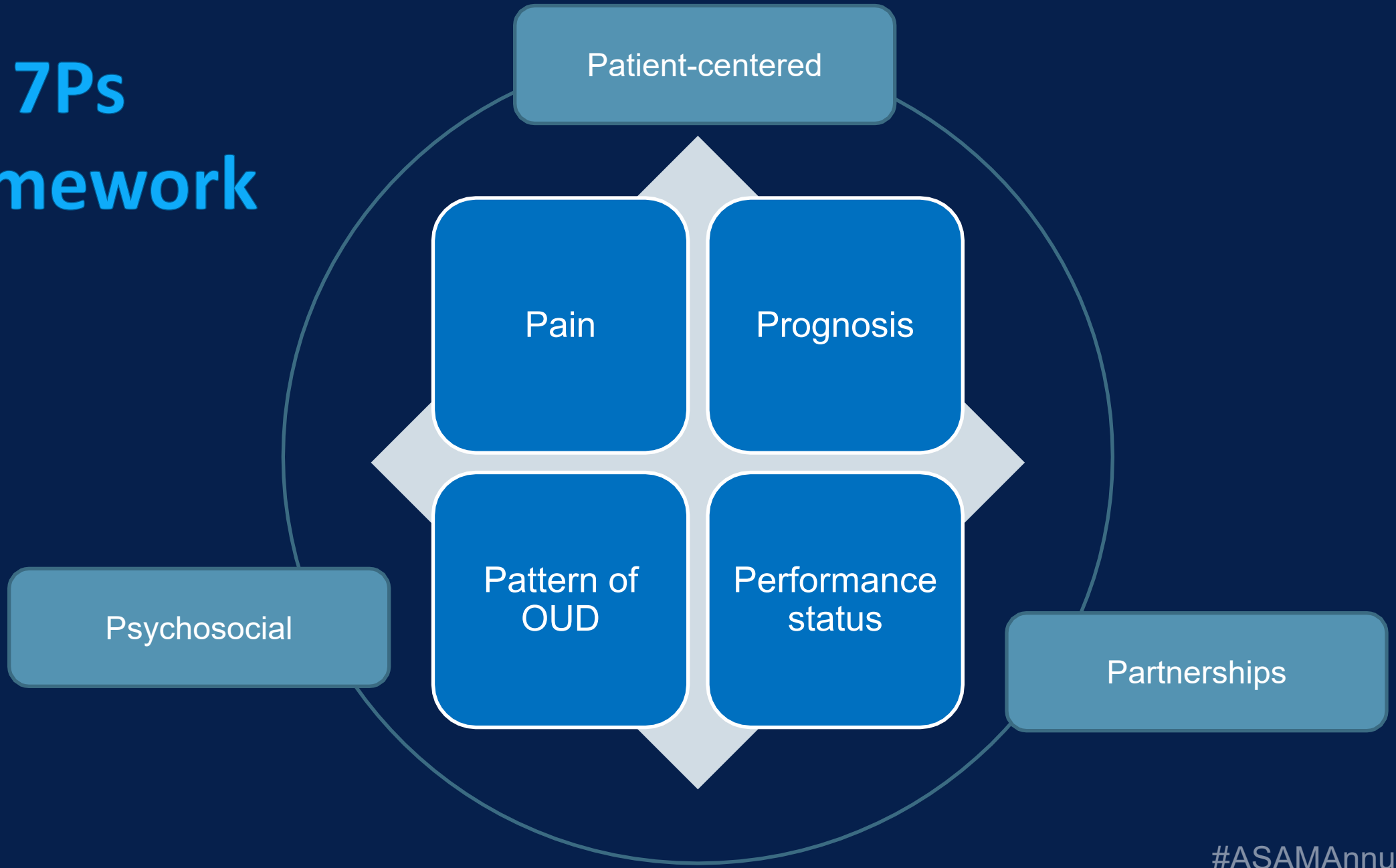
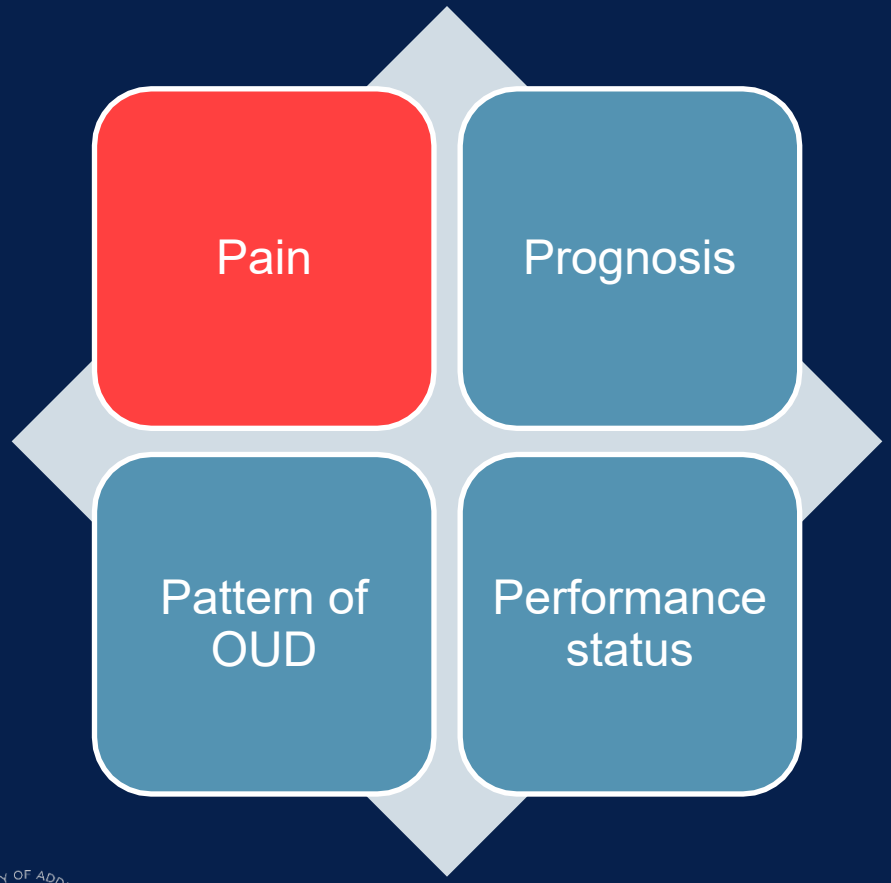
How can we put together risks/ benefits of opioids?

7Ps Framework



Pain – Are opioids indicated?



- Duration
  - Acute
  - Chronic (>=3mo)
- Etiology
  - Neuropathic
  - Nociceptive
  - Inflammatory
  - Myofascial
- Non-opioid responsive pain/ Total pain

Pain is more than a sensory experience

- **Pain**: unpleasant sensory, emotional, and behavioral experience associated with actual or potential tissue damage (not always corroborated by objective findings/ imaging)

- Chronic overstimulation of nociceptive neurons leads to CNS remodeling, glial death
- Pain relief (analgesia or euphoria) also changes the brain, reward pathways, motivation, and behaviors to obtain more relief

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(Pain 2020 Sep 1;161(9):1976-82)

Pain treatment considerations

Etiology

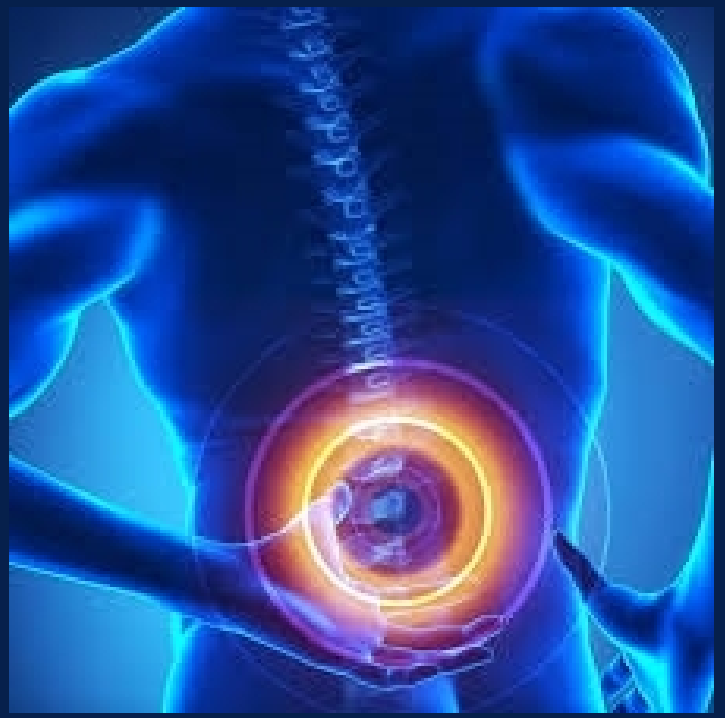
- Nociceptive
- Neuropathic
- Inflammatory

Chronicity

- Acute
- Chronic
- Maladaptive

Chronic pain/ Maladaptive Pain

- Pain as a disease
  - Examples: Fibromyalgia, most chronic low back pain, functional abdominal pain, Irritable bowel syndrome, chronic pelvic pain, chronic headaches
- Tissue injury not necessarily present
- Sensitization (hyper-excitability) and persistent signaling despite treatment of underlying cause



- Associated with:
  - Allodynia: normally non-noxious stimulation becomes painful (e.g. bed sheet)
  - Hyperalgesia: abnormally intense response to normally noxious stimulus

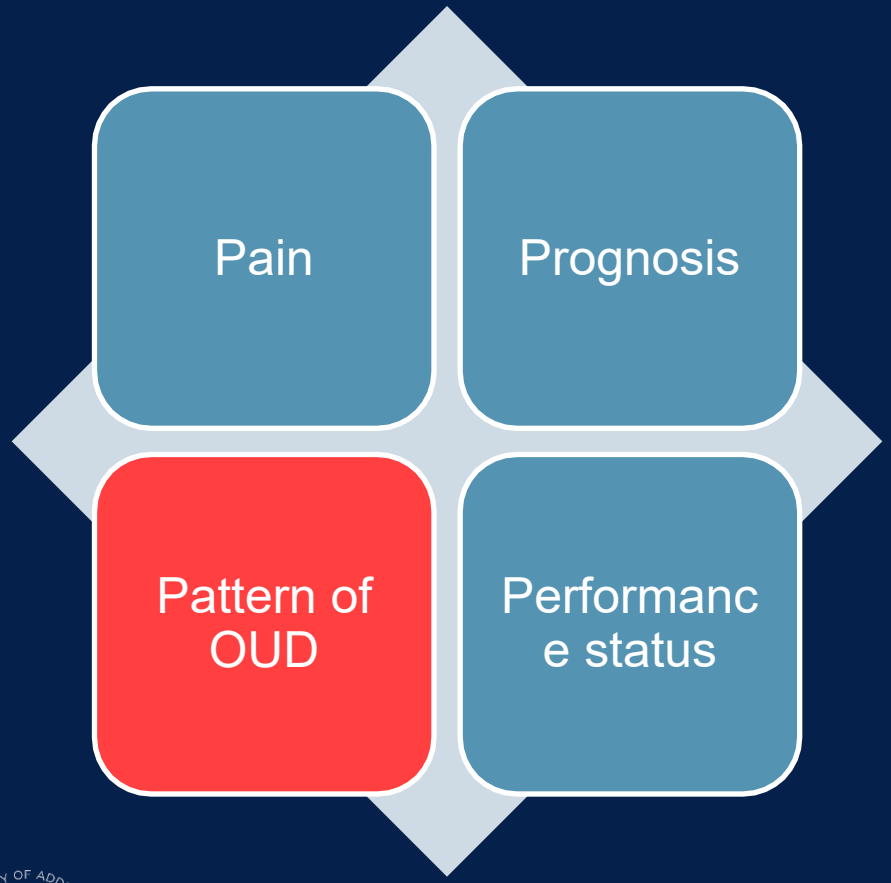
Multimodal Treatment in Maladaptive Pain

- Associated with risk of SUD/misuse, anxiety/ PTSD/depression, stress, sleep disturbances

- TX: multi-modal (psych, PT, etc), maximize analgesia adjuvants
  - Must treat concurrent SUD, psychosocial factors
  - Opioids: limited e/o long-term benefit or effect on function, especially with high doses
  - Goals focus on titrating meds to function

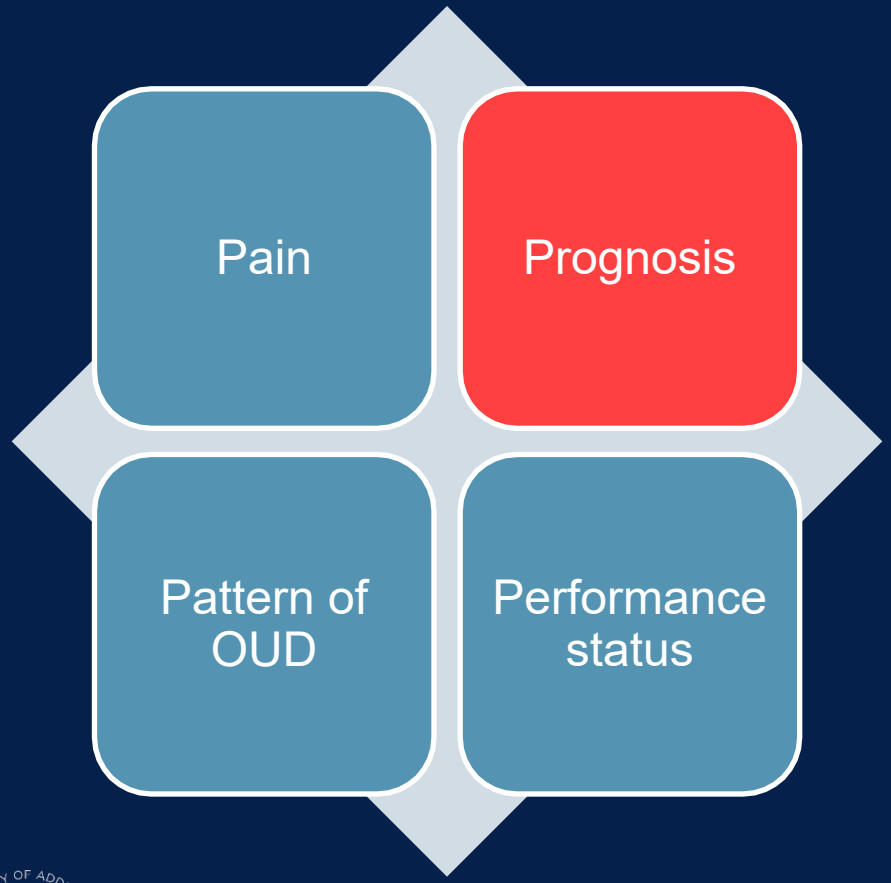
HHS Publication (SMA) 12-4671; (International Review of Psychiatry.2018 Sep 3;30(5):136-46); (BMC health services research, 6(1), p.46)

Pattern of OUD



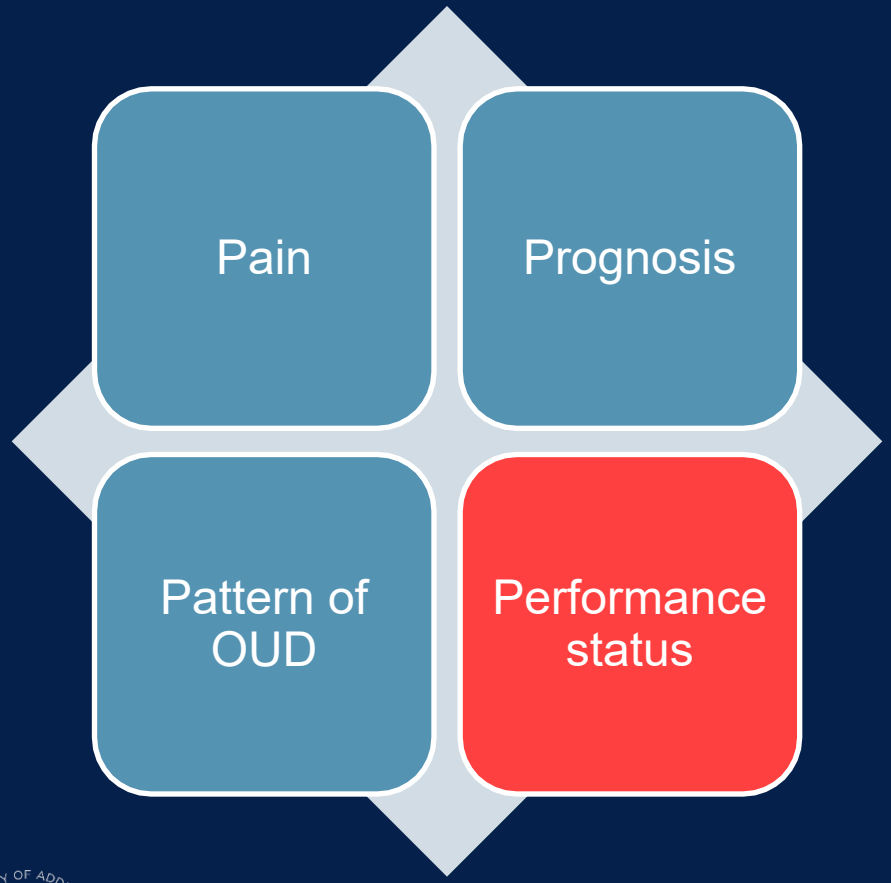
- Substance use vs. SUD diagnosis
- Severity of SUD
- Activity of SUD
- Other substances used
- Current or prior h/o treatment
- Patient motivations/ triggers

Prognosis



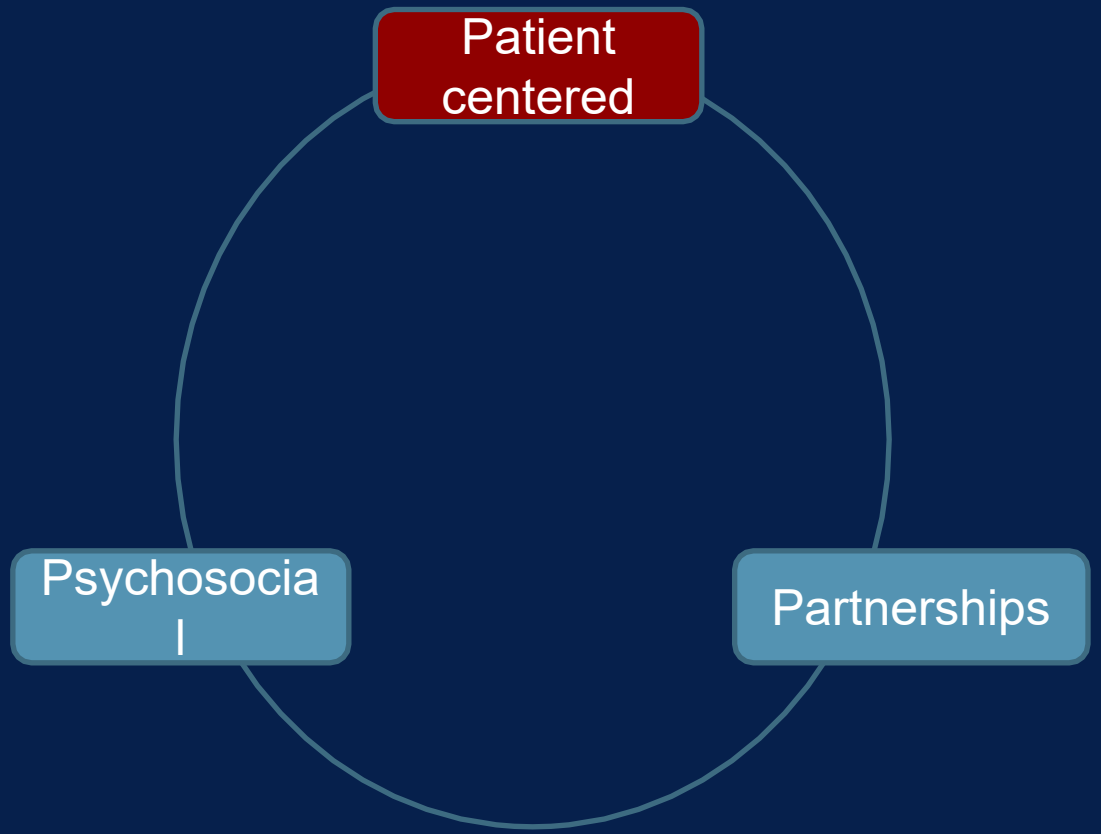
- Patients are living longer with serious illness
- Expected prognosis?
- Further disease directed treatment options?
- Weeks, months, years?

Performance Status



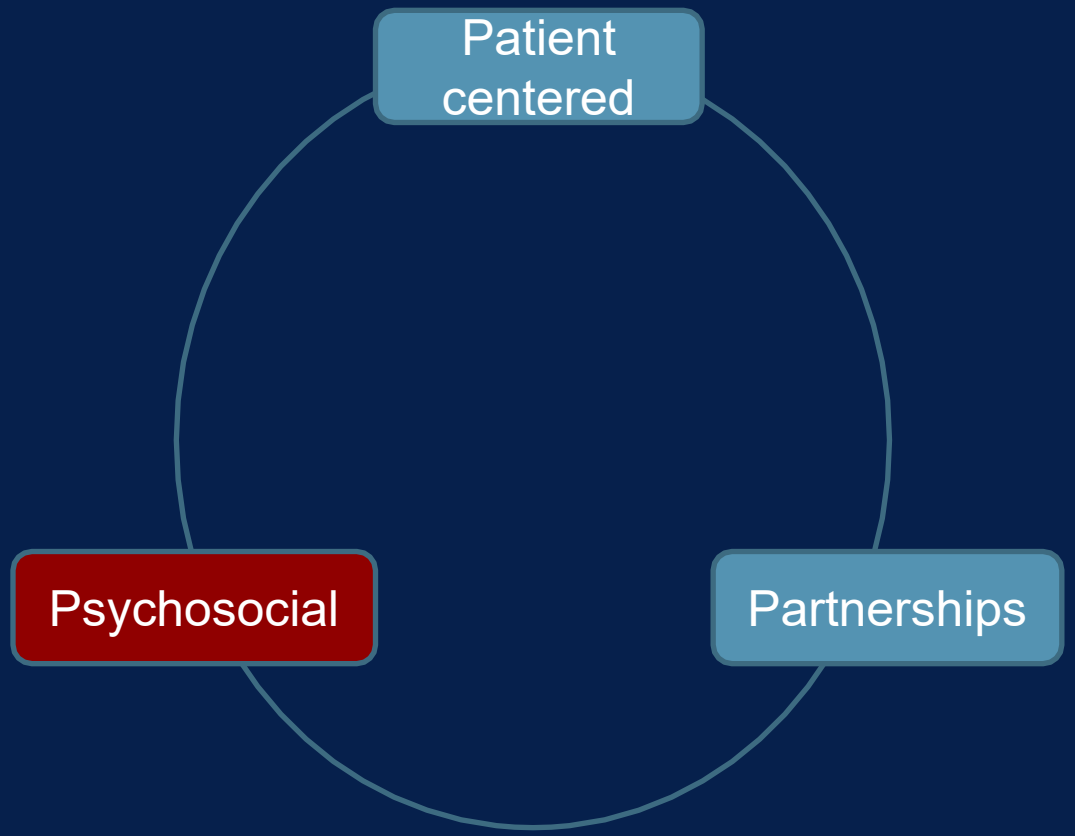
- Physical function
  - ADL/IADL
  - Oral intake
  - How most time is spent in bed
- Cognitive function
- Functional goals

Patient-centered/ Parity



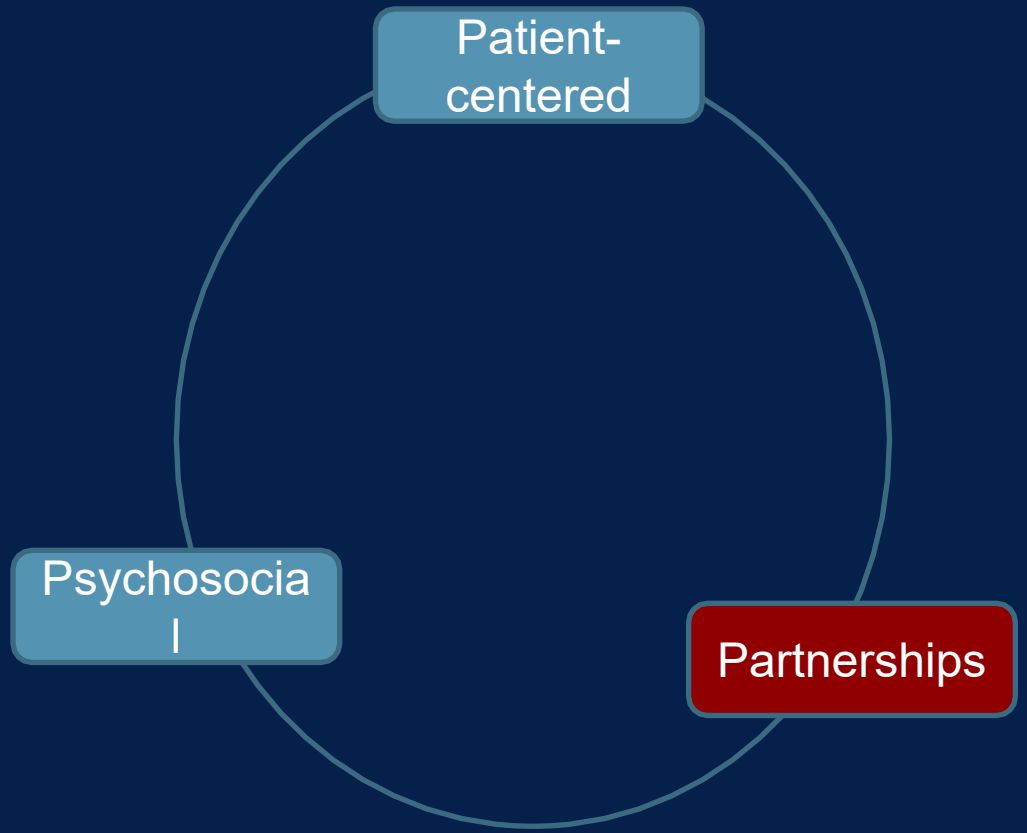
- Patient goals with OUD
- Patient goals with health
- Access to cancer treatment
- Access to pain management
- Access to OUD treatment
  - Race/ethnicity
  - Gender

Psychosocial factors



- Housing, transportation, food security
- Insurance coverage
- Social family supports
- Existential or spiritual distress

Partnerships with other providers



- Interventional pain
- Physical therapy, PMR
- Complementary therapies
- Psychiatry/ psychology/ pain psych
- Peer recovery/ patient navigators
- Social workers, chaplains
- OTP
- Primary care
- Addiction specialists
- … who will prescribe?

Addiction consulted for treatment recommendations

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- Near complete response to neoadjuvant chemo
- H/o OUD, last heroin IV use 6 mo ago, then stabilized on MMT 80mg daily
- Felt stigmatized being on methadone so self-tapered 2mo ago despite recommendations not to
- Currently treated with MSER by PC
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The team calls for recommendations about a discharge pain regimen. You recommend:

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- Resume methadone TID, prescribed by PC or PCP
- Transition her to buprenorphine with no other opioid agonists
- Transition her to buprenorphine with other opioid agonists
- Continue treating with MSER, prescribed by PC or PCP

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“I just want to be ok”

- Started buprenorphine via SL buprenorphine low dose initiation during the admission
- Outpatient Palliative care provider Rx buprenorphine (mono) 8mg BID SL and short course of full agonist opioids for post-op pain
- CA status stable

Case 2

- Larry, 62 year old man with metastatic lung cancer
- Bone only mets, s/p biological treatment
- Now observation only
- OUD in methadone clinic for 15 years
- Two years ago palliative NP “took over” methadone prescribing for pain, added oxycodone
- Issue with taking more
- Routine UDS positive for fentanyl

Pain

- Pain – primarily low back and hip, hip pain localized to groin. No point tenderness
- He says it is severe, 10/10 most of the time even with methadone and oxycodone from the PC clinic
- Scans: "No aggressive osseous focus is seen. Degenerative endplate changes are noted along the lumbar spine" and "previously identified left iliac and acetabular metastases are inconspicuous"

Pattern of OUD

- Per patient, stable on methadone for number of years
- Use of fentanyl was a one-time "slip" due to pain
- "I don’t know why I'm being punished“ and “I’m dying, why does it matter?”
- Daughter with him, also denies noting any recent substance use

Prognosis/Performance Status

- Stable disease, no other mets
- Appears well, eating well
- Goal is to live as long as possible
- Per oncology, could live multiple years

POLL: What would you recommend?

A. Continue to prescribe methadone with additional PRN opioid agonists

B. Prescribe methadone only

C. Transition to buprenorphine with no other opioid agonists

D. Tradition to buprenorphine with the addition of opioid agonists

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What Happened Next

- Evaluated in joint specialty PC/addiction clinic
- Transitioned to bup/nx through very slow low dose induction
- Complained that pain was "much worse" with the transition
- We prescribed oxycodone prn – dose that got his pain to an "acceptable" level was 200 mg daily
- Two months and four urine drug screens later....
- Two urine screens positive for cocaine, one positive for fentanyl

Lots of Angry EPIC messages later….

- Larry continues to follow in the palliative REP clinic monthly
- Is prescribed bup/nx, gabapentin
- Walks his dog several times a day
- Traveled to the Bahamas
- Pain overall has improved
- Cancer continues to be stable on observation only (one year later)

Roles for Addiction Specialists

- Helping the team make a diagnosis of SUD
- Helping the team consider the 7Ps in crafting a pain regimen
- Partnering with the team to decide most appropriate treatment for SUD – medications, psychosocial interventions, and appropriate peer support groups and local resources
- Guiding the team on harm reduction goals
- Providing expert presence for lower confidence clinicians

What is one idea you plan to incorporate into your practice next week?

Final Takeaways/Summary

- Decisions to use opioids in treating pain require constant risk vs. benefit analysis and balancing risk mitigation with harm reduction
- The 7P framework can help organize important treatment considerations: Pain characteristics, Prognosis, Patterns of substance use, Performance status, Psychosocial context, Partnership with other providers, and patient-centered factors that Addiction specialists can help primary providers be aware of in considering analgesic regimens
- Opportunities abound for Addiction specialists to be leaders in collaborations with PC through education, consultation, mentorship, support for X-waivers, and contributing to research on treatment for pain, OUD

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Changing the Plan Visit

- Discussed the results openly: "Tell me about using the fentanyl"
- Normalized: “ A lot of people have difficulty with substances when they’re undergoing stressful things like cancer”
- Evocation from patient: “What are your thoughts about what’s going on with your use?”
- Set clear limit: we would taper off the oxycodone; continue buprenorphine
- Discussed other ways we could support him: addressing anxiety, involvement of our peer

Collaboration Models

Consultation

- Increasing involvement and effectiveness of specialty consultants
- ***Targets patients at highest risk*** of poor outcomes

Pros:

- High specialty level quality of care, no additional training necessary

Cons:

- Limited workforce
- Potential increased fragmentation of care

Integration

- Educating other clinicians
- Embedding specialty principles and interventions into daily practice
- ***For all patients***

Pros:

- Decreased workforce needs

Cons:

- Relies on sustained commitment of non-specialty clinicians

Nelson JE, Bassett R, Boss RD, et al.

Mixed Collaboration

- Team based interdisciplinary oncology approach proposal
- Cancer Survivorship and Opioid Tapering
- Embed Pal Care routine psychosocial and spiritual assessments in addition to standard pain assessments
- Systematic ongoing opioid risk assessment (SOAPP-R or ORT)
- Pal Care education/training on Behavioral Health pain-CBT
- Consultation with Addiction Med

- Team based interdisciplinary approach proposal
- New cancer diagnosis and SUD
- Embed substance use and SUD assessment in addition to standard pain, psychosocial, and spiritual assessments
- Provide guidance on specific harm reduction and SUD treatment goals
- Addiction Med education/training on goals of care conversations
- Consultation with Palliative Care

Goodlev ER, Discala S, Danall BD, et al

An example of Impactful Partnership

Intervention:

- Regular meetings of HPM, pain management, and addiction medicine clinicians to discuss challenging palliative care cases
- Two DATA waiver training live sessions for providers in central KY

Aims:

- Increase HPM provider awareness and comfort with opioid use disorder, chronic pain, and interventional pain treatment options
- Provide DATA waiver training on buprenorphine for opioid use disorder to HPM providers.