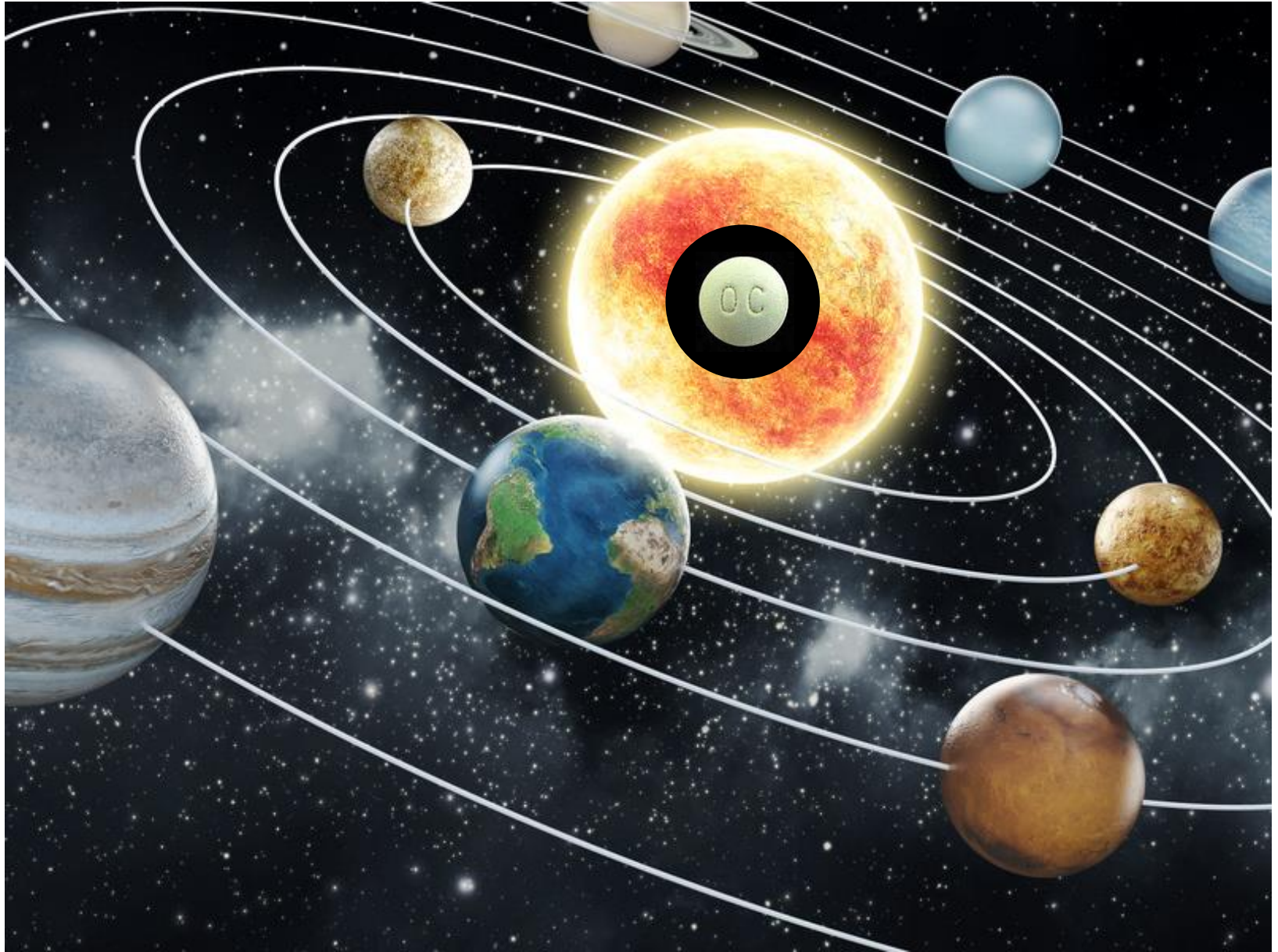


# Improving community-based care for chronic pain: antidote to the opioid epidemic

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University of Minnesota







**2003**

**VA/DoD CLINICAL PRACTICE GUIDELINE FOR  
THE MANAGEMENT OF OPIOID THERAPY FOR CHRONIC PAIN**

Version 1.0

<b>Recommendations</b>	<b>QE</b>	<b>Overall Quality</b>	<b>R</b>
Opioid therapy is indicated for moderate to severe pain that has failed other therapeutic interventions	III	Poor	I
Consider the ethical imperative to relieve pain	III III	Poor	I

Opinion of respected authorities, case reports, and expert committees

2017

## VA/DoD CLINICAL PRACTICE GUIDELINE FOR OPIOID THERAPY FOR CHRONIC PAIN

#	Recommendation	Strength*	Category†
<b>Initiation and Continuation of Opioids</b>			
1.	a) We recommend against initiation of long-term opioid therapy for chronic pain. b) We recommend alternatives to opioid therapy such as self-management strategies and other non-pharmacological treatments. c) When pharmacologic therapies are used, we recommend non-opioids over opioids.	a) Strong against b) Strong for c) Strong for	Reviewed, New-replaced

- “Rapidly growing understanding of the significant harms of LOT”
- “...no studies evaluating the effectiveness of LOT for outcomes lasting longer than 16 weeks.”



## The Effectiveness and Risks of Long-Term Opioid Therapy for Chronic Pain: A Systematic Review for a National Institutes of Health Pathways to Prevention Workshop

Roger Chou, MD; Judith A. Turner, PhD; Emily B. Devine, PharmD, PhD, MBA; Ryan N. Hansen, PharmD, PhD; Sean D. Sullivan, PhD; Ian Blazina, MPH; Tracy Dana, MLS; Christina Bougatsos, MPH; and Richard A. Deyo, MD, MPH

- “No study of opioid therapy versus placebo, no opioid therapy, or nonopioid therapy evaluated long-term (>1 year) outcomes related to pain, function, or quality of life.”

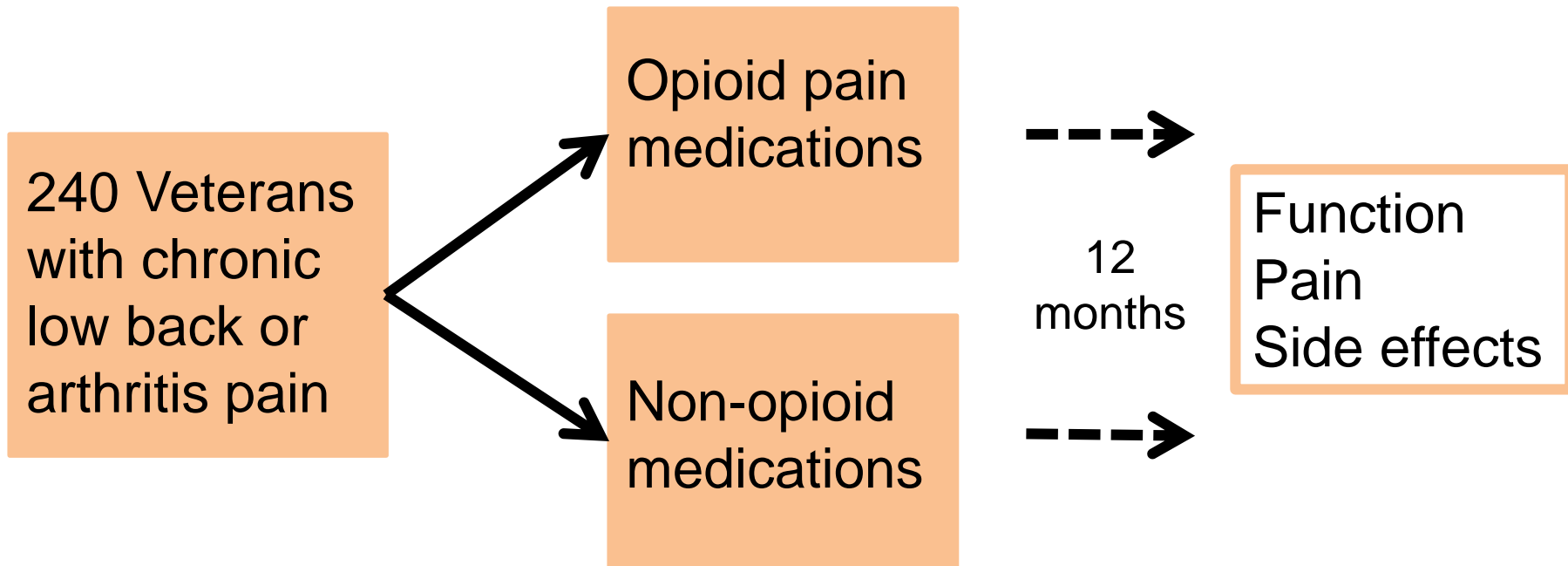
# Strategies for Prescribing Analgesics

## Comparative Effectiveness Trial

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Objective: To compare benefits and harms of opioid therapy versus non-opioid medication therapy over 12 months among patients with chronic back or osteoarthritis (OA) pain

- H1: Opioids will improve pain-related function & pain intensity more than non-opioids
- H2: Opioids will cause more adverse medication-related symptoms and events than non-opioids





# Eligibility

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- Inclusion criteria: Moderate-severe chronic back pain or hip/knee OA pain despite analgesic use
- Major exclusion criteria
  - Absolute contraindications to opioid therapy
  - Cognitive impairment or psychosis
  - Current long-term opioid therapy

# Interventions

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- Patients randomized to opioid or non-opioid arm
- All patients received individualized medication management within assigned arm
  - Follow-up visits monthly, then Q1-3 months
  - Treatment to target pain & individual functional goals
  - Telecare collaborative pain management

Original Investigation

# Telecare Collaborative Management of Chronic Pain in Primary Care

## A Randomized Clinical Trial

Kurt Kroenke, MD; Erin E. Krebs, MD; Jingwei Wu, MS; Zhangsheng Yu, PhD; Neale R. Chumbler, PhD;  
Matthew J. Bair, MD

- TCM intervention components
  - Symptom monitoring: PEG, PHQ-2, GAD-2
  - Medication optimization
- Pain improvement: 52% intervention vs. 27% usual care (NNT 4.1)

# Medication arms

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- All medications in both arms on VA formulary
- Each arm included 3 medication steps
- Opioid daily dose limited to 100 ME mg/day
  - (Initial plan was 200 ME mg/day)

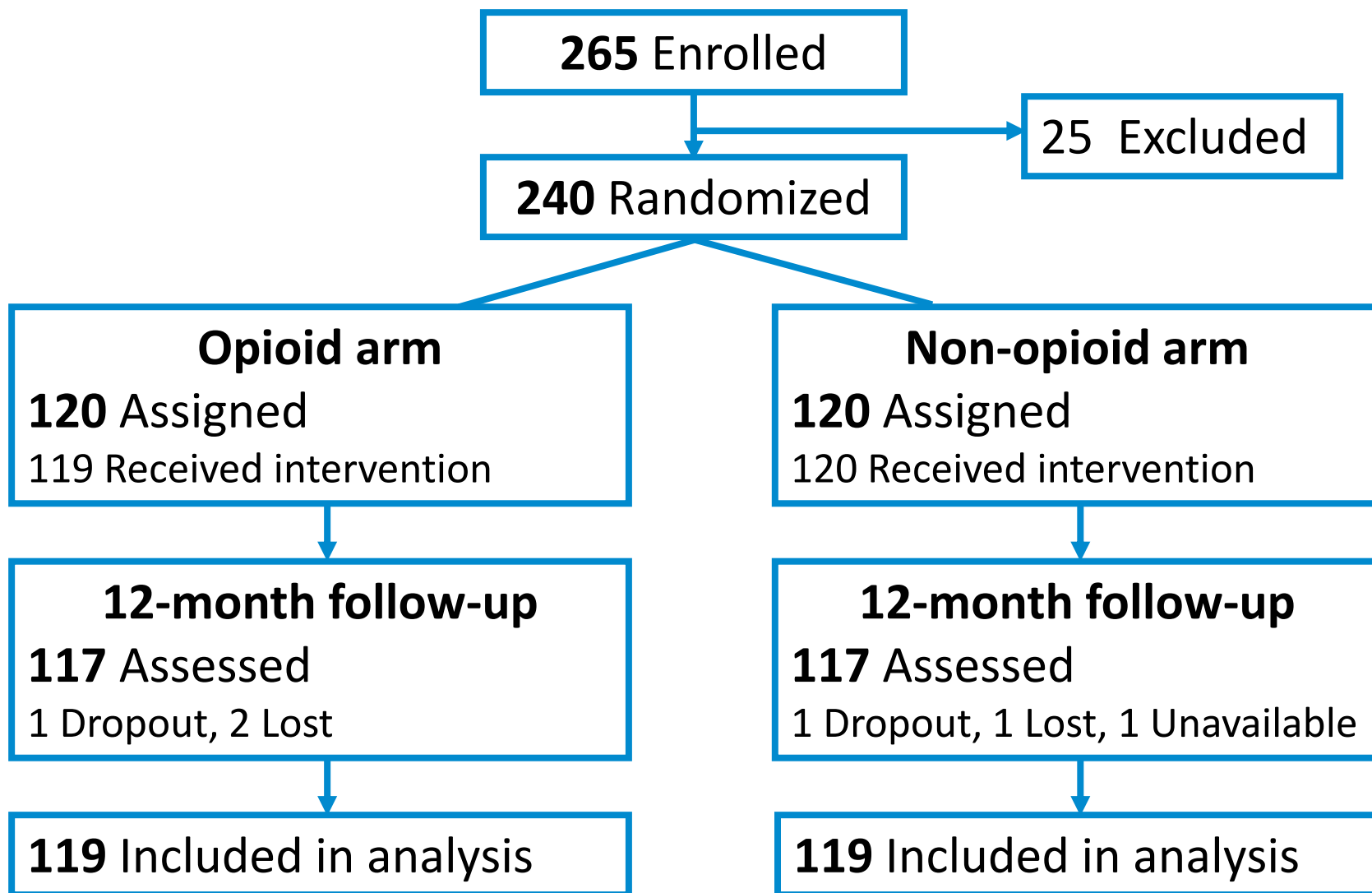
# Medication arms

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**Table: Medications within arms**

	<b>Opioid arm</b>	<b>Non-opioid arm</b>
<b>Step 1</b>	Morphine IR* Oxycodone IR Hydrocodone/APAP	Acetaminophen* Oral NSAIDs Diclofenac topical
<b>Step 2</b>	Morphine SR Oxycodone SA	Nortriptyline, amitriptyline Gabapentin Lidocaine topical
<b>Step 3</b>	Fentanyl transdermal (Methadone)	Pregabalin Duloxetine Tramadol

\* Preferred initial medication selection





# Response at 12 months: pain-related function and pain intensity

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Number (%) with clinically significant improvement

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	<b>Opioid (n=117)</b>	<b>Non-opioid (n=117)</b>	<b>P-value</b>
<b>BPI interference</b>	69 (59.0%)	71 (60.7%)	0.722
<b>BPI severity</b>	48 (41.0%)	63 (53.9%)	0.007

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# Intervention contacts

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	<b>Opioid (n=120)</b>	<b>Non-opioid (n=120)</b>
<b>Clinic visits, number</b>	2.8 ± 2.0	2.8 ± 2.1
<b>Phone visits, number</b>	6.1 ± 2.9	6.2 ± 2.6
<b>Visit duration, minutes</b>	230 ± 95.5	216 ± 82.5

# Summary

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- Opioid therapy was not superior to non-opioid medication therapy over 12 months
  - Pain-related function: no difference
  - Pain intensity: small significant difference favoring non-opioids
- Opioid therapy caused significantly more medication-related adverse symptoms

# Implications of study findings

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- Results support CDC guideline recommendation that non-opioid medications are preferred for chronic pain
- Relatively high response rates in both arms, consistent with prior trial of similar TCM intervention

# What next?

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**De-implement  
inappropriate  
opioid therapy**

**Implement  
effective pain  
therapies**





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*STATE OF THE ART CONFERENCE*

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**Non-pharmacological Approaches  
to Chronic Musculoskeletal  
Pain Management**

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**VA HSR&D**

- Prompted by White House summit on prescription opioid crisis
- Focus on alternatives to opioid therapy



# Objectives



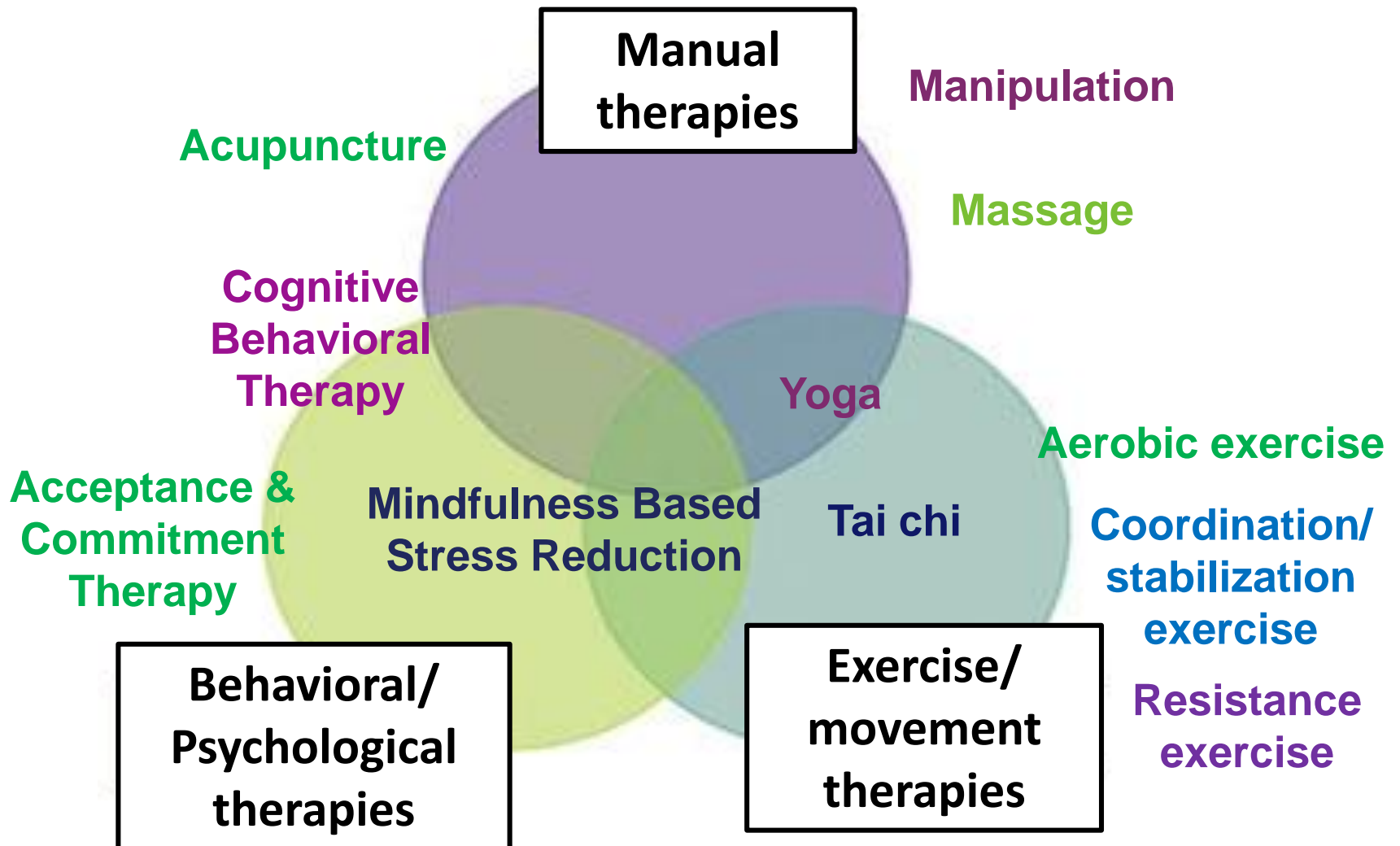
STATE OF THE ART CONFERENCE

**Non-pharmacological Approaches  
to Chronic Musculoskeletal  
Pain Management**

**VA HSR&D**

- To synthesize existing evidence and gaps related to non-pharmacological approaches for chronic musculoskeletal pain management
  - Psychological/behavioral therapies
  - Exercise/movement therapies
  - Manual therapies
  - Models for care delivery
- To identify approaches ready for implementation
- To identify a research agenda

# Approaches ready for implementation (sufficient evidence)



# Research agenda (evidence gaps)



*STATE OF THE ART CONFERENCE*

**Non-pharmacological Approaches  
to Chronic Musculoskeletal  
Pain Management**

**VA HSR&D**

- For most therapies, need further study of...
  - Delivery approaches
  - Dose (e.g., frequency, intensity, duration)
  - Strategies for improving adherence
  - Strategies for maintaining benefits
  - Effects of combining and sequencing therapies

# Models for pain care delivery



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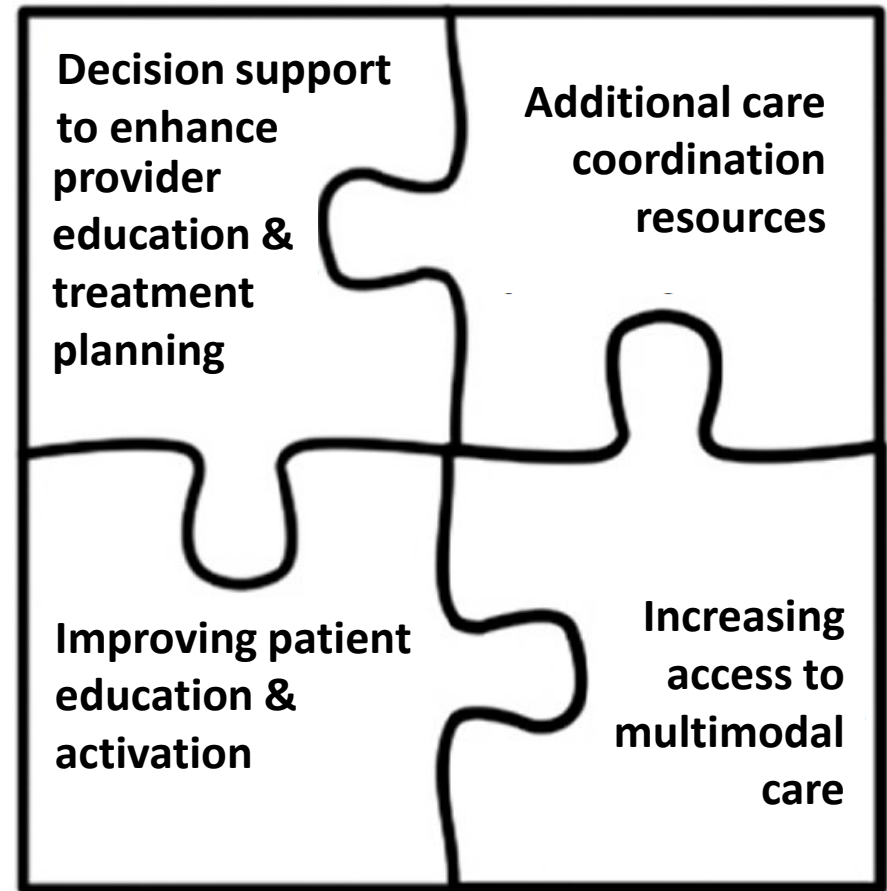
Non-pharmacological Approaches  
to Chronic Musculoskeletal  
Pain Management

VA HSR&D

- Unable to identify published systematic reviews
- Requested an evidence brief from the VA Evidence-Synthesis Program to include studies of...
  - Models using system-based mechanisms to increase uptake and organization of multimodal pain care
  - Adults with chronic musculoskeletal pain
  - Interventions integrated with primary care, excluding those conducted entirely within specialty settings

# Models for pain care delivery

- 11 articles (10 studies) included
- Most RCTs of fair-good quality (3 poor)
- Most had 12 month follow-up (range 6-18)
- Most used usual care control
- Baseline mean pain on 11-point scale: 5.1-7.7
- 9 diverse models

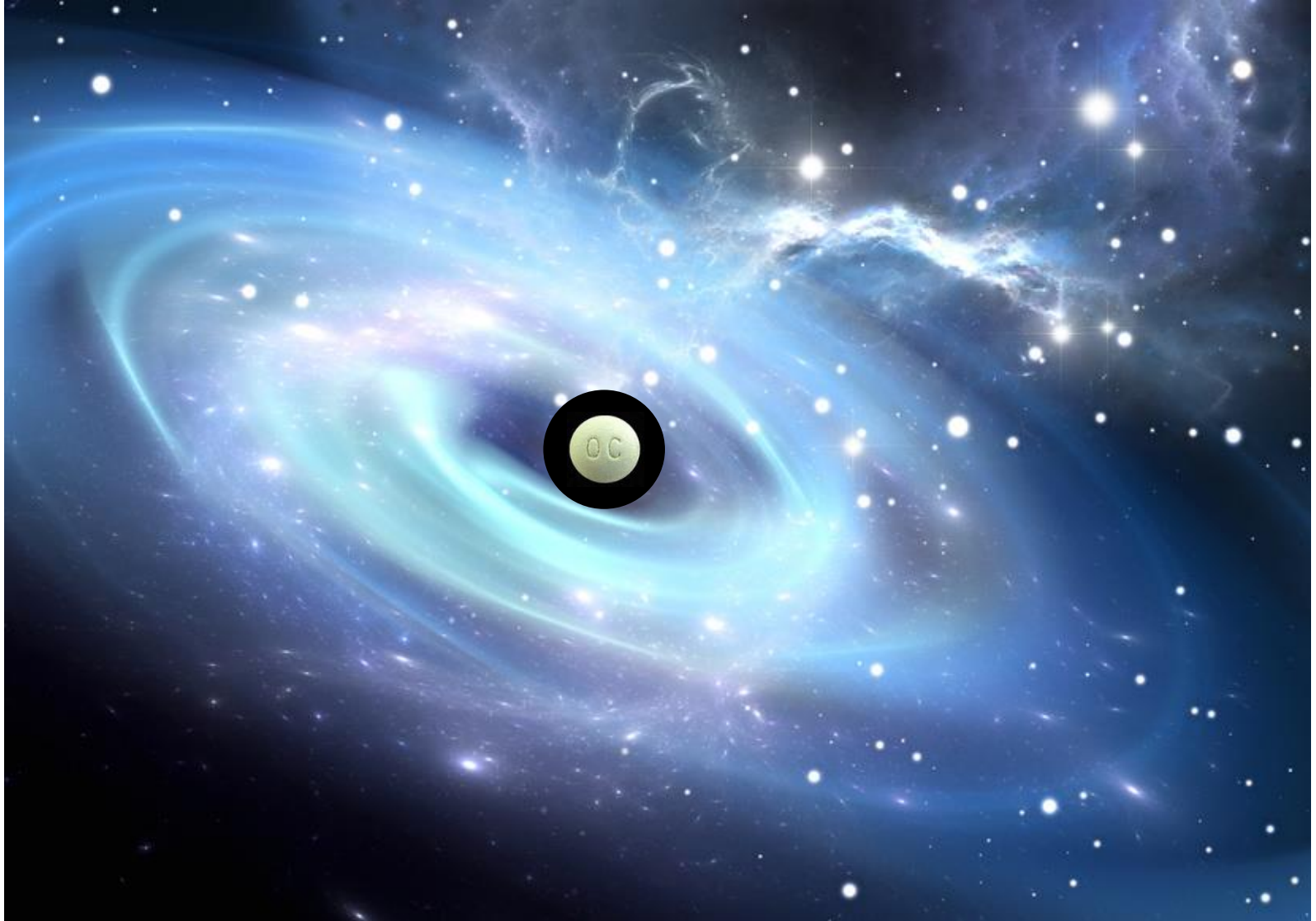


# Models for pain care delivery

- Best evidence for 5 models
  - 4 good-quality VA trials combined decision support with case management: ESCAPE, SEACAP, SCAMP, and SCOPE
  - 1 fair-quality British trial combined risk stratification with risk-matched treatment pathways: STarT Back
  - Clinically relevant improvement in pain intensity & pain-related function over 9-12 months (NNT range 4.1-12.70)
- Consider implementation of models across multiple VA facilities, with further evidence development



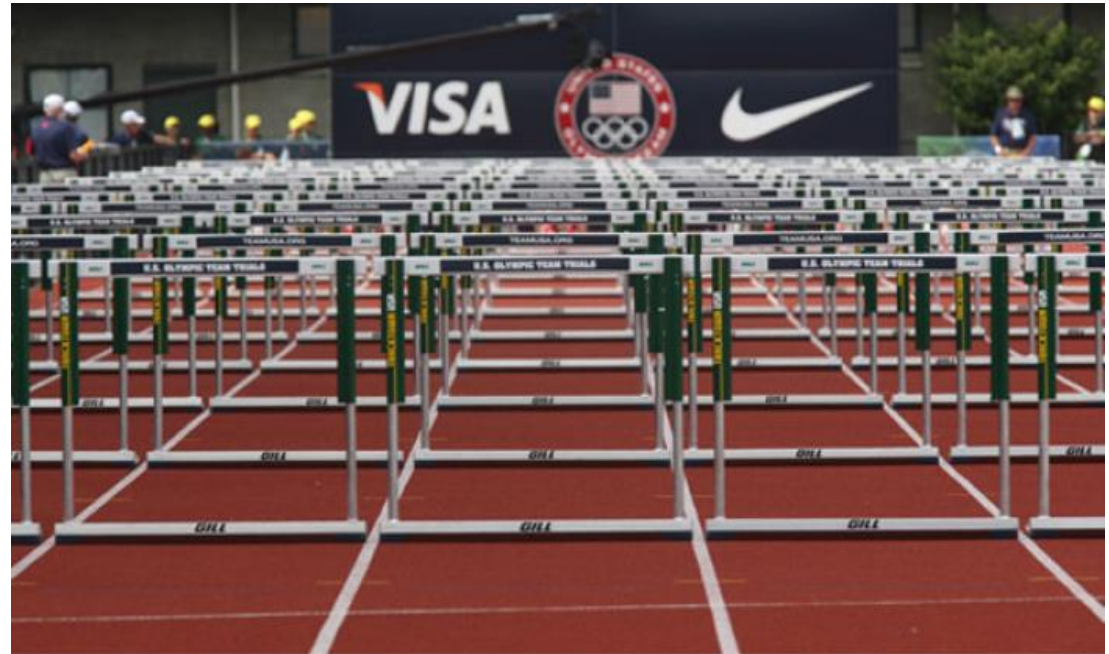
# Implementation challenges



# Implementation challenges



**Access to medications**



**Access to evidence-based non-pharmacological therapies**

Thank you!

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