The Challenges of Narcotic Tapering in Chronic Pain Treatment

Speakers:

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Housekeeping

First a few housekeeping points....

- Slides will advance automatically
- Question & Answer period at end
- You may submit questions at any time
  - Q&A Panel is on the lower right side (If you don’t see it, click the “Q&A” button in the upper right)
  - Type a question into the lower section of the Q&A panel that appears
  - Ask “All Panelists” and be sure to click “Send”
  - If we cannot answer during the session, we will e-mail you
- Replay will be available – look for our e-mail
- When the webinar ends, a short survey will pop up
  - There will be a CCMC section which must be completed to receive continuing education credits
- If you experience computer broadcast audio problems, please use the dial in number posted in the Chat panel
Examples of Narcotics

Narcotics (opioids) are abundant and come in multiple forms.

- Codeine: Tylenol #3
- Hydromorphone: Dilaudid, Exalgo ER
- Oxymorphone: Opana
- Morphine: MSIR
- Morphine sustained release: MsContin, Avinza, Kadian, Oramorph SR
- Fentanyl: Duragesic patch, Actiq pops, Fentora, Onsolis
- Oxycodone: OxyIR, OxyContin,
- Propoxyphene: Darvon
- Meperidine: Demoral
- Methadone
- Tapentadol HCL: Nucynta
- Buprenorphine: Subutex, Suboxone
As we have mentioned in past webinars, we are all painfully aware of the issues associated with narcotics in the workers’ compensation industry.

NCCI Reports

- 20% of workers’ comp medical costs of fully developed claims are spent on prescription drugs
  - Narcotics account for 34% of this spend
  - Narcotic use early in the claim has increased
  - 80% of drug costs occur after Year Six

Source: NCCI Workers’ Compensation Prescription Drug Study, 2008 Update
A recent study by the California Workers’ Compensation Institute found an increased number of claims associated with opioid use...

Study Findings

TD Days by Morphine Equivalent Level
Medical Backs with No Spinal Cord Involvement

<table>
<thead>
<tr>
<th>Morphine Equivalent Level</th>
<th>Average TD Days Paid</th>
<th>Indemnity Claims</th>
<th>Percentage Payment Increases by Morphine Equivalent Level</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>All Claims</td>
<td>Indemnity Claims</td>
<td>All Claims</td>
</tr>
<tr>
<td>No Opiates</td>
<td>21.3</td>
<td>62.9</td>
<td></td>
</tr>
<tr>
<td>1 Prescription</td>
<td>21.3*</td>
<td>66.9</td>
<td>-0.1%</td>
</tr>
<tr>
<td>2 – 3 Prescriptions</td>
<td>38.8</td>
<td>84.2</td>
<td>82.2%</td>
</tr>
<tr>
<td>4 – 7 Prescriptions</td>
<td>60.6</td>
<td>102.3</td>
<td>184.5%</td>
</tr>
<tr>
<td>&gt; 7 Prescriptions</td>
<td>88.0</td>
<td>127.9</td>
<td>313.1%</td>
</tr>
</tbody>
</table>

* Not a statistically significant difference from the baseline.

Source: California Workers’ Compensation Institute June 2008 Pain Management and the Use of Opioids in the Treatment of Back Conditions in the California Workers’ Compensation System
Alex Swedlow, MHSA, Laura B. Gardner, MD, MPH, PhD, John Ireland, MHSA, and Elizabeth Genovese, MD, MBA, FACGEM, FAADEP
Industry Problem

... as well as increased benefit payouts associated with opioids.

Study Findings

Average Benefit Payments by Opiate Agonist Level
Medical Backs With No Spinal Cord Involvement Injuries

<table>
<thead>
<tr>
<th># of Opiate Agonist Prescriptions</th>
<th>Average Paid Benefits</th>
<th>Percentage Payment Increases by Level of Opiate Agonist Prescriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total Benefits</td>
<td>Medical</td>
</tr>
<tr>
<td>No Opiates</td>
<td>$6,598</td>
<td>$3,169</td>
</tr>
<tr>
<td>1 Prescription</td>
<td>$6,658*</td>
<td>$3,049*</td>
</tr>
<tr>
<td>2 – 3 Prescriptions</td>
<td>$9,932</td>
<td>$4,151</td>
</tr>
<tr>
<td>4 – 7 Prescriptions</td>
<td>$14,669</td>
<td>$5,960</td>
</tr>
<tr>
<td>&gt; 7 Prescriptions</td>
<td>$20,945</td>
<td>$9,132</td>
</tr>
</tbody>
</table>

*p > .05, not a statistically significant difference from the baseline.

Source: California Workers’ Compensation Institute June 2008 Pain Management and the Use of Opioids in the Treatment of Back Conditions in the California Workers’ Compensation System
Alex Swedlow, MHSA, Laura B. Gardner, MD, MPH, PhD, John Ireland, MHSA, and Elizabeth Genovese, MD, MBA, FACOEM, FAADEP
With us today is Fernando Branco M.D. F.A.A.P.M.R., Medical Director, Rosomoff Comprehensive Pain Center, Miami Jewish Health Systems.

**Fernando Branco M.D. F.A.A.P.M.R.**
Medical Director, Rosomoff Comprehensive Pain Center, Miami Jewish Health Systems

Dr. Branco is board certified in Physical Medicine and Rehabilitation, Pain Medicine, and Addiction Medicine.
What do they have in common?
What do they have in common?

Death
The Challenges of Narcotic Tapering

Narcotic usage has reached epidemic levels.

More deaths from prescription drugs than illicit drugs!

Conundrums of Medical Care:

- Treat pain
- Avoid addiction
- Impossible to stop tolerance or dependency
- Pseudoaddiction
Narcotics have their place, but also have numerous complicating factors associated with their use.

Most effective for very short term use

Acute pain, cancer pain, end of life care

Short Term – after major surgery or trauma
Addiction is a primary, chronic, neurobiological disease with genetic, psychosocial and environmental factors influencing its development and manifestations.

A clinical syndrome:
- Loss of control
- Compulsive use
- Continued use despite harm
- Craving

Drug Addiction vs. Drug Abuse?
No difference. Excessive use of a drug for purposes for which it is not medically intended.
Who is at Risk?

Known risk factors for addiction to any substance are good predictors for opioid abuse.

Published rates of abuse and/or addiction in chronic pain populations are 3-19%

1. Past cocaine use, history of alcohol or cannabis use
2. Lifetime history of substance use disorder
3. Family history of substance abuse
4. History of legal problems and drug and alcohol abuse
5. Tobacco dependence
6. History of severe depression and anxiety

Pseudoaddiction

Much is made of “pseudoaddiction.”

- Opiophobia
- Overestimate potency and duration of action
- Fear of being scammed
- Fear of addiction potential

Morgan J 1985; Smith 1989
Our brains conspire in the addictive process as pleasure/reward pathways are activated by addictive drugs.
The way the brain reacts facilitates the process of addiction.

Eliminate production of your own body’s ENDORPHINS

Shut the endorphin system down

Lead to HYPERalgesia and HYPERsensitivity to pain
Narcotic Cycle

A vicious cycle of narcotic use/dependence begins.

Patients need higher doses to achieve results = TOLERANCE

Eventually lack of pain relief may lead to steady increases in amount and types of pain medication

Long term use of narcotics leads to “OPIOID INDUCED ABNORMAL PAIN SENSITIVITY”
Over time, narcotics have a doubly problematic impact.

Patients actually experience MORE pain and sensitivity... therefore requiring more medications... which leads to increased pain and sensitivity... which requires more medication... which leads to increased pain and sensitivity... which requires more medications

You get the idea!
Exacerbating the Problem

When doctors prescribe drug combinations, the problem is further exacerbated.

- **Hydrocodone + Ibuprofen:** Vicoprofen, Ibudone
- **Hydrocodone + acetaminophen:** Vicodin, Lorcet, Lortab, Maxidone, Xodol, Zydone
- **Oxycodone + acetaminophen:** Percocet, Magnacet, Tylox
- **Oxycodone + aspirin:** Percodan
- **Oxycodone + ibuprofen:** Combunox
- **Propoxyphene + acetaminophen:** Darvocet, Balacet
Some look to replacement drugs.

**Methadone – miracle drug?**

**Buprenorphine**

Is it safer than Methadone?

How does it differ from other narcotic medications?

Is it really new?
So What Can We Do?

The first step is to correctly diagnose the problem.

Screener and Opiate Assessments for Patients in Pain (SOAPP)

5-item version: Asks, “How often:”

1) How often do you have mood swings?
2) How often do you smoke a cigarette within an hour of awakening?
3) How often have you taken medications other than as prescribed?
4) How often have you used illicit drugs in the past five years?
5) How often have you had legal problems or been arrested?

Score: 0=Never, 1=Seldom, 2=Sometimes, 3=Often, 4=Very Often, >4 Positive, <4 Negative

Evaluate for relative risk for developing problems: 86% sensitive 67% specific
There are common “flags” that indicate problems.

**YELLOW FLAGS**

- Complaints of more medications needed
- Drug hoarding
- Requesting specific pain medications
- Openly acquiring similar medications from other providers
- Occasional unsanctioned dose escalation
- Non-adherence to other recommendations for pain therapy

**RED FLAGS**

- Deterioration in functioning at work and socially
- Illegal activities – selling, forging, buying from nonmedical sources
- Injecting and snorting medication
- Multiple episodes of “lost” or “stolen” scripts
- Resistance to change therapy despite adverse effects
- Refusal to comply with random drug screens
- Concurrent abuse of alcohol or illicit drugs
- Use of multiple physicians and pharmacies
As we begin the treatment process, there are several important goals.

- Improve quality of life
- Restore optimum levels of function
- Reduce or eliminate pain
- Reduce or eliminate addictive pain medications
- Enable to become independent of the healthcare system (related to pain)
What is the Solution?

The best solution is to taper the use of narcotics and stimulate the body’s own natural pain management mechanisms.

**Tapering Narcotics**

- Medication dose is reduced **SLOWLY**
- Maintaining consistent levels of medication in the blood
- Monitored by medical professionals
- Watch for signs of withdrawal
- Provide medications / treatments to help relieve symptoms of withdrawal if needed
- Drug testing
Endorphins = Natural Pain Relief

Stimulating natural pain relief is very important.

**Neurotransmitter in the brain that have pain-relieving properties similar to morphine**

“Runner’s High”
Intense Physical Activity
Chocolate
Chili Peppers
Massage therapy
Acupuncture
Meditation / Relaxation Therapy
Laughter
Sex
Treating Withdrawal Symptoms

There are multiple options for how one addresses withdrawal symptoms.

Car Wash – Aqua PT

Different types of Massage and Modalities

Working with your Psychologist

Medication to help relieve the symptoms: CLONIDINE PATCH (Catapress) --- NOT klonopin. Decreases heart rate & relaxes blood vessels – treats withdrawal symptoms effectively in most patients.
Medications for Withdrawal

There are medications for withdrawal.

Klonopin (clonazepam)
Buspar

Antidepressants:
  – Cymbalta
  – Wellbutrin
  – Chantix

Gabapentin
Physical therapy is a useful tool in the narcotic weaning process.
Ice and heat are also very useful.
Neuromuscular Massage

Neuromuscular massage works.
We even employ tools such as aqua physical therapy.
And education can be a valuable asset in preventing further injury.
We know these alternatives work!
We have had fantastic results.

90% of RCPC patients are NOT using narcotic pain medications at discharge.

77% of patients are NOT using narcotics 1 year after discharge.
Results are documented in the literature.

“Significant pain reduction in chronic pain patients after detoxification from high-dose opioids” – Sept/Oct 2006

21 of the 23 patients showed marked decrease in pain following tapering from narcotics!!

Also:

- Adverse effects of chronic opioid therapy for chronic musculoskeletal pain – National Rev of Rheumatology 2010
Statistically Significant Outcome Differences

**ROSMOFF COMPREHENSIVE PAIN CENTER**
**PROGRAM EVALUATION SYSTEM**
November 1989 through May 2010
**OUTCOME RESULTS AT DISCHARGE (N=2952)**

<table>
<thead>
<tr>
<th>Category</th>
<th>Improvement in Functional Status</th>
<th>Reduction in Pain</th>
<th>Improvement in Quality of Life</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>93%</td>
<td>69%</td>
<td>82%</td>
</tr>
<tr>
<td>Goal 75%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Goal 40%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Goal 65%</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Goal 50%</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Goal 70%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Goal 70%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employed / Work Ready</td>
<td>69%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not using Narcotic Pain Medications</td>
<td>31%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Satisfied with Treatment at RCPC</td>
<td>94%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Goal 75%</td>
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Fernando Branco M.D. F.A.A.P.M.R.
Statistically Significant Outcome Differences

ROSOMOFF COMPREHENSIVE PAIN CENTER
PROGRAM EVALUATION SYSTEM
November 1989 through May 2010
OUTCOME RESULTS AT 3 MONTHS POST DISCHARGE (N=1008)

<table>
<thead>
<tr>
<th>Outcome Category</th>
<th>Percentage</th>
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</thead>
<tbody>
<tr>
<td>Improvement in Functional Status</td>
<td>81%</td>
</tr>
<tr>
<td>Reduction in Pain</td>
<td>70%</td>
</tr>
<tr>
<td>Improvement in Quality of Life</td>
<td>75%</td>
</tr>
<tr>
<td>Employed / Work Ready</td>
<td>60%</td>
</tr>
<tr>
<td>Not Using Narcotic Pain Medications</td>
<td>81%</td>
</tr>
<tr>
<td>Satisfied with Treatment at RCPC</td>
<td>80%</td>
</tr>
</tbody>
</table>

19% 30% 25% 40% 19% 20%
Statistically Significant Outcome Differences

**ROSMOUFF COMPREHENSIVE PAIN CENTER**
**PROGRAM EVALUATION SYSTEM**
November 1989 through May 2010

**OUTCOME RESULTS AT 1 YEAR POST DISCHARGE (N=649)**

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improvement in Functional Status</td>
<td>71%</td>
</tr>
<tr>
<td>Reduction in Pain</td>
<td>66%</td>
</tr>
<tr>
<td>Improvement in Quality</td>
<td>71%</td>
</tr>
<tr>
<td>Employed / Work Ready</td>
<td>57%</td>
</tr>
<tr>
<td>Not Using Narcotic Pain Medications</td>
<td>77%</td>
</tr>
<tr>
<td>Satisfied with Treatment at RCPC</td>
<td>79%</td>
</tr>
</tbody>
</table>
Statistically Significant Outcome Differences

Paradigm has seen outcome differences due to a combination of medical placement and the use of Systematic Care Management SM.

Source: Paradigm Management Services
Summary

We hope you will join us for future webinars, and leave knowing the following:

Narcotics addition is a prevalent and costly problem in workers compensation

Effective treatment must be multi-faceted and customized to the patient

Best practice requires measuring outcomes and monitoring for durability

Paradigm has successfully proven the value of these models during the past 20 years
Question and Answer Session

Please submit your questions for our panelists in the Q&A window on the right.

Today’s speakers:

Stuart Sweetser
Senior Vice President
Paradigm Management Services

Fernando Branco M.D. F.A.A.P.M.R.
Medical Director
Rosomoff Comprehensive Pain Center
Miami Jewish Health Systems

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Check out Outlook on Outcomes, Paradigm’s new blog!
- Updated weekly
- Insight into other complex care
- Written by Paradigm Chief Medical Officer

www.paradigmcorp.com/blog