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ASSESSING AND MONITORING LONG-TERM OPIOID USE FOR PEOPLE WITH CHRONIC AND DISABLING ARTHRITIS PAIN

MAKING RESEARCH RELEVANT

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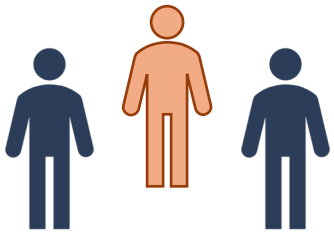
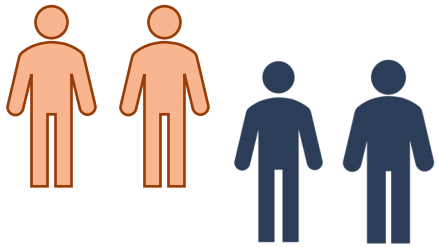
Arthritis, a prevalent condition, can lead to disability and severe pain

Arthritis Prevalence[1]

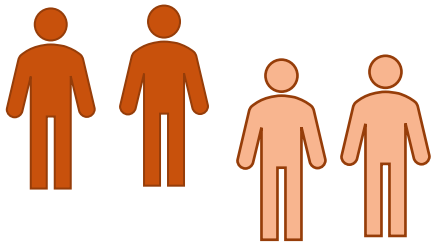


1 in 3 adults aged 45 to 64 live with arthritis

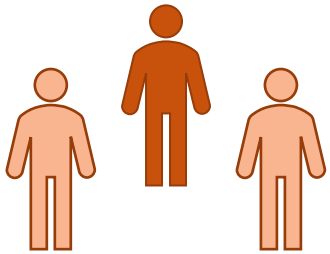


2 in 4 adults over 65 live with arthritis

Severe Pain and Arthritis



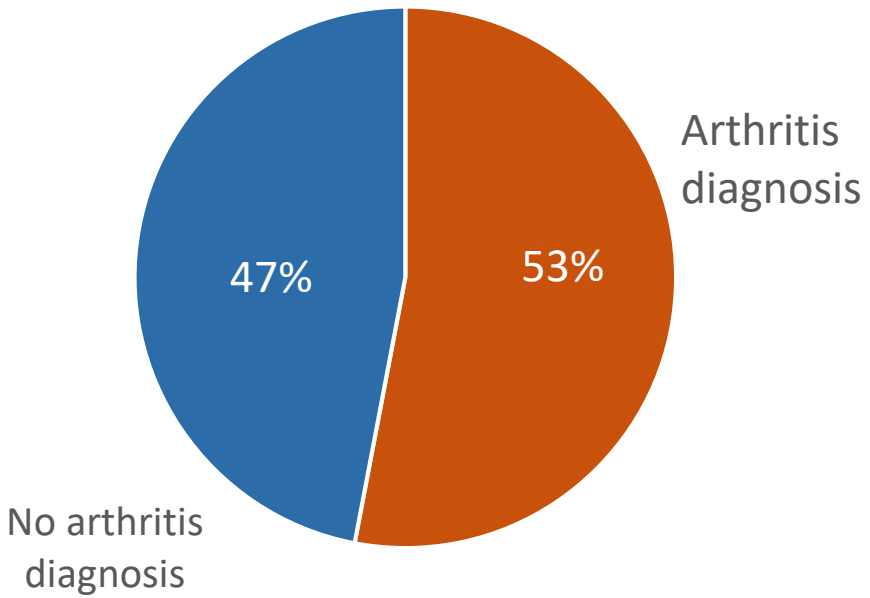
2 of 4 people with OA and RA report activity limitations[2,3]



Nearly 1 in 3 adults with arthritis report severe pain[4]

People With Arthritis Have High Rates of Opioid Use

People filling 1 or more opioid prescriptions, 2013[7]



- 1 in 3 people with rheumatoid arthritis take opioids regularly[8]
- 15% to 48% of people with osteoarthritis take opioids regularly[9,10]
- 66% of people with spinal stenosis took opioids continuously 1 year after surgery[11]

Prevalence of misuse and addiction among people with chronic pain[6]

Misuse: Use of the drug contrary to the prescriber's directions

- Opioid misuse rate: 21% to 29% (95% CI: 13% to 38%)

Addiction: Continued opioid use despite impaired control, compulsive use, craving or demonstrated potential harm

- Addiction rate: 8% to 12% (95% CI: 3% to 17%)

Research study goal and approach

Goal: Support the accurate assessment of OUD in people with disabilities taking chronic opioids while using the best evidence to minimize over- and under-diagnosis of OUD

Research Activities

- Literature review
- Interviews with 56 providers, people with disabilities and counselors
- Develop OUD screening instrument

Understand providers and PWD experiences related to opioids, identification of OUD and transition into treatment

Qualitative Methods

- **Recruitment sources:** Advisory group referrals, recruitment firm, and an online health media company
- **Approach:** Phone Interviews
- **Analysis:**
  - Created preliminary codes based on interview aims and set of questions we asked the participants
  - Met regularly, discussed coding, and added new codes throughout the process
  - Mapped codes to the task aims and decided on the 13 topics for memos
  - Collectively reviewed and revised memos

People with disabilities due to arthritis (PWD), n=24

Characteristics	Currently Taking Opioids	Treated for OUD	Total
Impairment- Difficulty with			
Mobility ***AND*** use of fingers ***AND*** ability to lift, carry, or move everyday objects	7	7	14
1-2 impairments noted above	5	5	10
Chronic Condition [1]			
Osteoarthritis	8	9	17
Rheumatoid arthritis	10	5	15
Spinal stenosis or severe osteoporosis	5	6	11
Other	2	4	6
Gender			
Male	4	3	7
Female	8	9	17
Age, years			
30-49	2	2	4
50-69	7	8	15
Over 70	3	0	3
Unknown			2
Years on Opioids			
3 month -5 years	5	--	5
5-10 years	3	--	3
More than 10 years	4	--	4

Focus of interview

- Experiences managing chronic arthritis pain with opioids, receiving medical care, and, for half the sample, receiving treatment for an OUD

[1] Some PWD had more than 1 condition

Providers, *n* = 24

Characteristics	Number
Provider Type	
Physician	19
Nurse practitioner or physician assistant	5
Specialty	
Primary care providers	5
Rheumatologists	5
Physiatrists	1
Pain medicine specialists	13
Location	
Northeast and MidAtlantic	6
South	7
Midwest	7
West	3
Unknown	1

Focus of interview

- Experiences prescribing opioids, managing opioids and monitoring patients with a disability due to arthritis

PWDs had a long history of chronic pain and opioid use

- Many experienced chronic pain for many years and took opioids for 1 to 10 years.
- Most had exhausted other methods of controlling pain prior to use of opioids.
- Many experienced recent changes in their opioid management.
  - Difficulties accessing opioids due to insurance, state requirements, and providers unwilling to prescribe opioids
  - Had taken Vicodin or Percocet but were switched to Tramadol or Norco, which was not always as effective
  - Reduction in opioid dosage

Providers follow the CDC's chronic pain guidelines

Opioid Prescribing

- Stepped treatment approach
- Detailed assessment
- Consider length of relationship and trust level
- Avoid prescribing to younger patients, or to those with history of substance use disorder

Opioid Monitoring

- Assess adherence to opioid use contracts
- Regular visits and drug screens
- Opioid misuse screening tools and state drug monitoring databases
- Pill counts
- Review of safe storage
- Discussions with patients and families/caregivers

Providers and PWDs recall opioid risk and benefit discussion differently

- **People with disabilities**
  - Ranged from no discussion at all to discussing opioid side effects and the warning signs of OUD
- **Providers**
  - Detailed conversation about opioid risks—respiratory depression, drug contraindications, side effects, and the risks of OUD and overdose
  - Benefits of the medication and why it was the best choice at the time
  - Instructions on safe use and storage

Providers rely on pain specialists

- Primary care providers and rheumatologists make pain program referrals for a variety of reasons.
  - Uncomfortable prescribing opioids and unsure how to manage uncontrolled chronic pain
  - Person has reached an opioid dose threshold
  - Suspect opioid misuse

Rheumatologist

"I'm not writing for morphine. I used to use it sometimes…. I've quit because of all the concerns about opioids."

Providers' responses to concerns about opioid misuse and OUD

- **More confrontational approach**
  - Describe (minor or major) behaviors not in compliance with opioid agreement
  - Either discharge the person without offering alternatives or "warn" them to change their behaviors or will cease prescribing of opioids
- **Less confrontational approach**
  - Deeper assessment that includes discussing observed behaviors, concerns and pain control with person
  - Discuss for OUD treatment options, including buprenorphine or suboxone, if needed

Rheumatologist

"After a second offense, it would mean a permanent discharge from the practice and discharge from any further opioid prescriptions."

PWD eventually sought OUD treatment and some self-identified an opioid use problem

- Information from family and friends often led people to seek out treatment
- Fear about where use was leading was a motivating factor

Persons Treated for OUD

" "My friend had been on suboxone because she had pain and went to the same doctor. I didn't know her. She was a neighbor. She went on suboxone and I noticed she was working and looking a lot better, and not being dependent or counting on pills. I got thinking about it and I reached out, because I really didn't know that there was help available."

I was afraid I was going to start using heroin because of the pain. You know, using too many sometimes…and the addiction…it became really addictive, so that was when I reached out and got treatment."

Treatment for OUD and recovery

- Providers did not play a significant role in coordinating OUD treatment and follow-up care.
- Barriers to access to OUD treatment
  - Prescribing provider does not have a buprenorphine waiver
  - Fear of uncontrolled pain
  - Lack of knowledge about options and available resources
  - Lack of fit with treatment program
  - Lack of insurance coverage and cost

Ways providers can help people access treatment

- Striking the "right" tone when discussing behaviors indicative of a use disorder
- Ensure person is referred into an appropriate treatment program and has pain managed while in recovery
- "Warm handoff" when referring to treatment
- Involve the person's support system

Persons Treated for OUD

"Do not to leave your patients hanging when they do become addicted or dependent. They need the additional support and those conversations with you to make sure they get the support and the follow-up care they need."

Project web page

https://www.air.org/project/improving-assessment-opioid-use-disorder-people-disabilities-related-chronic-musculoskeletal

Notes

1. Smith SM, Dart RC, Katz NP, Paillard F, Adams EH, Comer SD, et al. Classification of misuse, abuse and related events in clinical trials: Barbour KE, Helmick CG, Boring M, Brady TJ. Vital Signs: prevalence of doctor-diagnosed arthritis and arthritis-attributable activity limitation—United States, 2013–2015. MMWR Morb Mortal Wkly Rep. 2017;66:246-53. doi: http://dx.doi.org/10.15585/mmwr.mm6609e1
2. Barbour KE, Moss S, Croft JB, Helmick CG, Theis KA, Brady TJ, et al. Geographic variations in arthritis prevalence, health-related characteristics, and management—United States, 2015. MMWR Morb Mortal Wkly Rep Surveill Summ. 2018;67(No. SS-4):1-28. doi: http://dx.doi.org/10.15585/mmwr.ss6704a1
3. Barbour KE, Boring M, Helmick CG, Murphy LB, Qin J. Prevalence of severe joint pain among adults with doctor-diagnosed arthritis—United States, 2002–2014. MMWR Morb Mortal Wkly Rep. 2016;65:1052-6. http://dx.doi.org/10.15585/mmwr.mm6539a2
4. Barbour KE, Helmick CG, Boring M, Brady TJ. Vital signs: prevalence of doctor-diagnosed arthritis and arthritis-attributable activity limitation—United States, 2013–2015. MMWR Morb Mortal Wkly Rep. 2017;66:246-53. doi: http://dx.doi.org/10.15585/mmwr.mm6609e1
5. Hootman JE, Cisternas M, Murphy L, Losby J. Prevalence and trends in prescribed opioid use in among U.S. adults with arthritis, 2008–2013, Medical Expenditure Panel Survey [abstract]. 2016 ACR/ARHP Annual Meeting; 2016 Nov 11-16; Washington, DC: 2016. Available from: https://acrabstracts.org/abstract/prevalence-and-trends-in-prescribed-opioid-use-among-us-adults-with-arthritis-2008-2013-medical-expenditure-panel-survey/
6. Smith SM, Dart RC, Katz NP, Paillard F, Adams EH, Comer SD, et al. Classification of misuse, abuse and related events in clinical trials: ACTTION systematic review and recommendations. Pain. 2013;154(11):2287-6.

Notes

7. Hootman JE, Cisternas M, Murphy L, Losby J. Prevalence and trends in prescribed opioid use in among U.S. adults with arthritis, 2008–2013, Medical Expenditure Panel Survey [abstract]. 2016 ACR/ARHP Annual Meeting; 2016 Nov 11-16; Washington, DC: 2016. Available from: https://acrabstracts.org/abstract/prevalence-and-trends-in-prescribed-opioid-use-among-us-adults-with-arthritis-2008-2013-medical-expenditure-panel-survey/

8. Landsman-Blumberg PB, Katz N, Gajria K, D'Souza AO, Chaudhari SL, Yeung PP, et al. Health care resource use and cost differences by opioid therapy type among chronic noncancer pain patients. *J Pain Res.* 2017;10:1713-22. doi: https://doi.org/10.2147/JPR.S130913

9. Power JD, Perruccio AV, Gandhi R, Veillette C, Davey JR, Lewis SJ, et al. Factors associated with opioid use in end-stage knee, hip and spine osteoarthritis [abstract]. 2017 ACR/ARHP Annual Meeting; 2017 Nov 3-8; San Diego, CA: 2017. Available from: https://acrabstracts.org/abstract/factors-associated-with-opioid-use-in-end-stage-knee-hip-and-spine-osteoarthritis/

10. Wright EA, Katz JN, Abrams S, Solomon DH, Losina E. Trends in prescription of opioids from 2003 to 2009 in persons with knee osteoarthritis. *Arthritis Care Res.* 2014;66(10):1489-95. doi: https://doi.org/10.1002/acr.22360

11. Adogwa O, Davison MA, Vuong V, Desai SA, Lilly DT, Moreno J, et al. Gender differences in opioid use in patients with symptomatic lumbar stenosis or spondylolisthesis undergoing lumbar decompression and fusion. Spine. 2018. Available from: https://www.ncbi.nlm.nih.gov/pubmed/30601354

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