Safely Reducing Opioid Use for Chronic Pain in a Large, RWCA-funded, HIV Primary Care Practice

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BACKGROUND

Many patients living with HIV (PLWH) experience chronic pain from a variety of etiologies and utilize prescribed opioids for pain management. Opioid prescriptions surged in the US from the late 1990s through the early-2010s with concurrent increases in fatal overdoses attributable to opioid use (both prescription and illicit). The 2016 CDC guidelines questioned the efficacy and safety of chronic opioid therapy, highlighting the paucity of data demonstrating efficacy of long-term prescription opioid use and stressing the risks associated with higher dose therapy (>90 morphine milligram equivalents per day (MME)), particularly unintentional overdose and death. The guidelines called for changes in clinician behaviors and prescribing patterns to more safely manage chronic pain, particularly in reducing the frequency, dosage and duration of opioid prescriptions.

SUMMARY OF PROCESS

In response to the CDC recommendations, we examined our practice's prescribing patterns and sought to improve patient safety through a two-phase initiative de-emphasizing prescription opioids for chronic pain and reducing opioid doses in a supportive, trauma-informed manner. Throughout, we focused on managing the multifaceted suffering that occurs in the setting of chronic pain in PLWH:

Phase 1 (12/2016): Distribute unblinded dashboard of all patients on opioid therapy including total daily dose (in MME) and provider, update patient charts to discontinue completed short-term opioid courses, verify appropriateness of chronic opioid use, and update opioid treatment agreements to include random drug screens/pill counts. State PDMP became available in 2017.

Phase 2 (10/2017): Begin multidisciplinary case reviews for patients taking >50 MME with provider, nurse, and behavioral change specialists to establish trauma-informed strategies for dose reduction and symptom management. Management of comorbid behavioral health disorders and emotional support was addressed. Management plans for potential relapse in those with history of substance use were discussed along with emergency naloxone education/prescription.

OUTCOMES

- At baseline, 30 patients were taking >90 MME for a total of 10,360 MME (68.5% of total practice dose). Five patients were taking >500 MME (35% of total practice dose).
- During the intervention, the number of patients taking any prescription opioid dropped from 175 to 87 (-50.3%) in phase 1 and then to 58 patients (-33.3%) in phase 2, an overall decrease of 66.9%.
- The total practice dose decreased from 15,116 to 10,580 MME (-30.0%) in phase 1 and further to 8,306 MME (-21.5%) in phase 2 for an overall decrease of 6,810 MME (-45.1%).
- Patients taking >90 MME decreased from 30 at baseline to 23 (-23.3%). This cohort also saw the largest overall dose reduction from 10,360 to 6,750 MME (-34.8%).
- No known relapses of illicit opioid use occurred in patients initially receiving >50 MME who subsequently underwent dose reduction.
- Patient satisfaction scores (CAHPS) were not impacted and are currently at an all-time high.

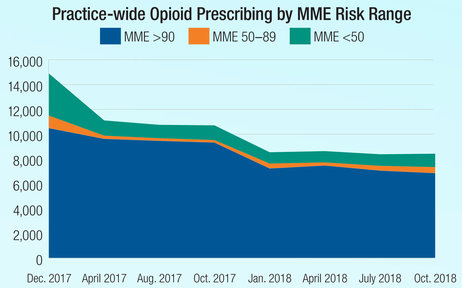

Figure 1: Decline in total prescribed opioid dose for all providers throughout intervention period stratified by overdose risk ranges.

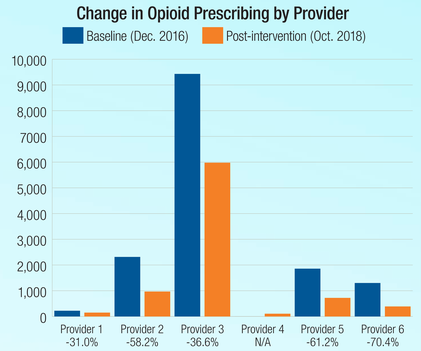

Figure 2: Decline in total prescribed opioid dose (in MME) stratified by provider.

DISCUSSION

- Our experience demonstrates that meaningful reductions in prescribed opioids can be achieved through a supportive, trauma-informed, team-based approach without raising the incidence of relapse to illicit opioid use.
- Our model was successful in changing provider opioid prescribing behaviors as demonstrated in the sustained reductions observed for all providers in the practice.
- Lower dose opioid therapy should improve the safety of pain management in PLWH by reducing risk of overdose and death.
- Future work will continue to focus on patients taking >50 MME and also address concurrent use of high risk medications such as benzodiazepines, sedative hypnotics and muscle relaxers.

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