Academy of Integrative Pain Management

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July 30, 2018

Value-based Benefits Subcommittee
Health Evidence Review Commission
Oregon Health Authority

RE: Proposed changes to Guideline Note 60, Opioids for Conditions of the Back and Spine and Chronic Pain

I write today on behalf of the Academy of Integrative Pain Management in opposition to proposed changes to Guideline Note 60 under consideration by the Value-based Benefits Subcommittee, specifically with respect to the proposal to require all patients using long-term opioid therapy to taper and end that therapy within one year. AIPM believes this proposal is unsupported by evidence, inconsistent with recent clinical practice guidelines, and logically incompatible with other aspects of this guideline note. We believe that implementing this policy will cause increased pain and decreased function for many people with chronic pain, that it will likely lead some to seek illicit opioids, and that it will result in increased patient deaths through accidental overdoses and suicides. We ask the subcommittee to reconsider this proposal and to implement a much less drastic plan.

Guideline Note 60 specifically allows for the possibility of providing opioid therapy to patients for up to 90 days following an initial injury or surgery, provided there is "documented evidence of improvement of function of at least thirty percent as compared to baseline based on a validated tool." This criterion for continued therapy clearly implies that improved function is an indicator of successful opioid therapy, and is consistent with recommendations in the CDC Guideline for Prescribing Opioids for Chronic Pain, that opioid therapy be continued only if the patient exhibits improvements in both pain and function as a result.[1] However, in mandating that all patients receiving long-term opioid therapy taper their dose to zero, the proposed changes to Guideline Note 60 appears to abandon this criterion as an indicator of successful therapy. Under this proposal, on Day 90 following an injury or surgery, a patient could receive opioid therapy because it was improving his or her function; however, on Day 91, while that benefit is still evident, opioid therapy would no longer be allowed. There is no logical reason why improved function justifies opioid therapy one day but does not justify it the following day. As long as the patient's benefit/risk ratio remains positive, successful therapy, including opioid therapy, should be allowed to continue.

Additionally, the proposed changes do not mention what action should be taken if the patient begins to experience clinically significant increases in pain and decreases in function upon tapering the opioid dose. This again presents a logical contradiction within the guideline note, given that in one place, improved function is regarded as an indicator of successful therapy, while in another place, decreased

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function that could result from an opioid taper is not regarded as an indicator that that therapeutic intervention has failed. If a taper is to be required, it is imperative that the policy provide for the taper to be paused, stopped, and possibly reversed, based on documentation of detrimental changes to the patient's functioning resulting from the taper.

Both the CDC guideline and the 2017 Canadian Guideline for Opioids and Chronic Non-Cancer Pain[2] suggest tapering patients to the lowest effective dose, a suggestion we support. Both guidelines, however, recognize that compliant patients whose risks are managed while on opioid therapy may lose function or experience increased pain because of the taper, and recommend that, in those cases, the taper be stopped. In a published article, two of the CDC Guideline's authors note that the guideline does not provide "support for involuntary or precipitous tapering. Such practice could be associated with withdrawal symptoms, damage to the clinician–patient relationship, and patients obtaining opioids from other sources."[3] Your proposal has no provision for a response to increased pain and decreased function resulting from the taper, meaning that patients who have that experience would be subjected to ongoing suffering and disability without the possibility of re-obtaining the relief provided by opioid therapy. Under these circumstances, it would be understandable if the affected patients turned to illicit opioids or considered suicide.

There is no evidence that forced tapering of long-term opioid therapy provides any benefit, but considerable evidence of harms, ranging from medical decline, to suicide, to seeking illicit opioids as a replacement. When the Department of Veterans Affairs initiated a policy requiring involuntary opioid tapering, it found that suicide mortality increased, while overdose mortality was unchanged.[4] It is unclear to what extent the increase in suicide was attributable to increased pain and decreased function, or to the re-emergence of mental health conditions, including opioid use disorder, that were being partially "treated" (however inappropriately) by opioid therapy. This experience points out the need for any policy requiring any opioid taper to be accompanied by adequate access to medication-assisted opioid abuse treatment and mental health treatment.

AIPM promotes a model of integrative pain management that envisions clinicians using every therapy that can relieve pain, improve function, and restore wellness in a person with pain. We promote the use of non-pharmacological and non-opioid pharmacological treatments as a means of minimizing opioid exposure, but we also advocate for appropriate access to opioids for patients who need them. The proposal being considered by the VbBS removes one tool from the toolbox of pain care providers, and we fear that doing so will result in the unintended consequence of increased pain and suffering, opioid use disorder and overdose, and suicide. Please reconsider your policy as we have suggested.

Sincerely,

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References

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