

Research to improve primary care for patients with chronic pain and long-term opioid therapy

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Disclosure

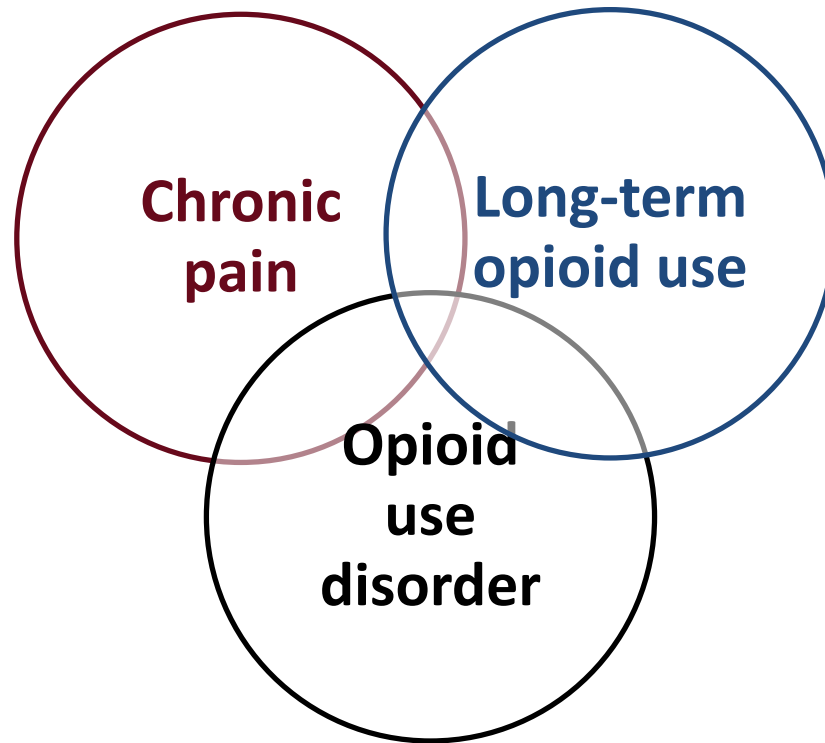
- I have no commercial financial relationships
- I have research funding from VA, NIH, & PCORI
- Views expressed in this presentation do not reflect the position or policy of the US government

THE NATIONAL PAIN STRATEGY: A Vision

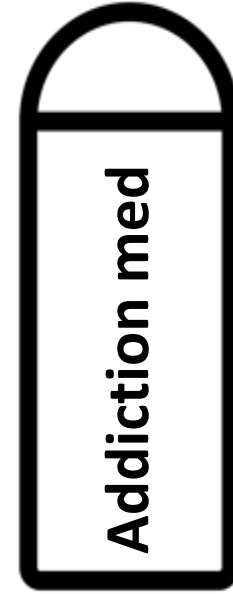
- Patient-centered, accounting for individual preferences, risks, and social contexts
- Comprehensive, meeting biopsychosocial needs
- Multimodal and integrated, using evidence-based treatments



Complex clinical challenges



Siloed resources

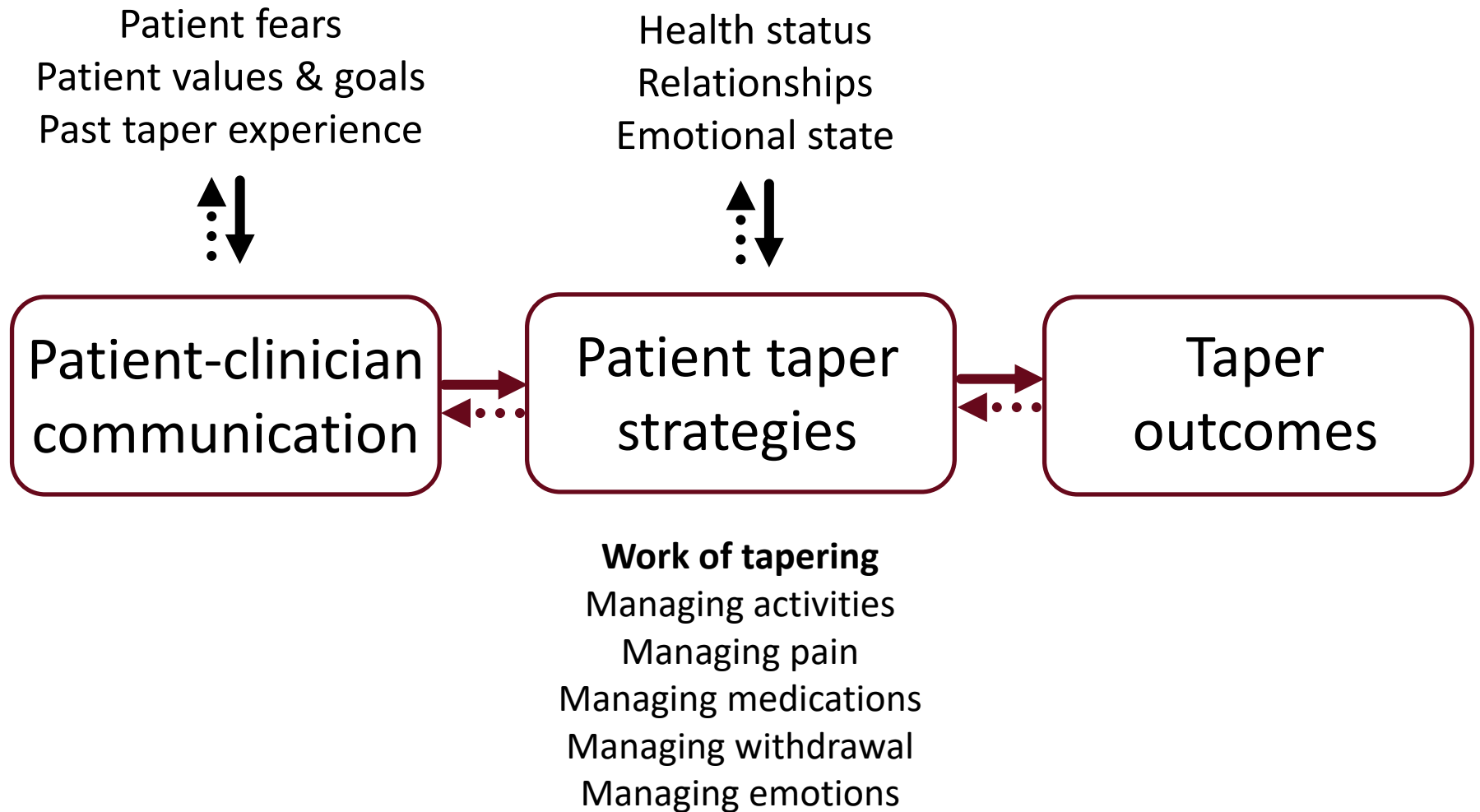


Patient-centered opioid tapering

Patient-centered opioid management

- Patient-centered care is “respectful of and responsive to individual patient preferences, needs, and values”
 - Is not a customer service activity
 - Is not an alternative to evidence-based care
- Patient-centered pain care considers evidence of treatments’ potential benefits and harms in context of patient goals and values

Model of patients' taper experience



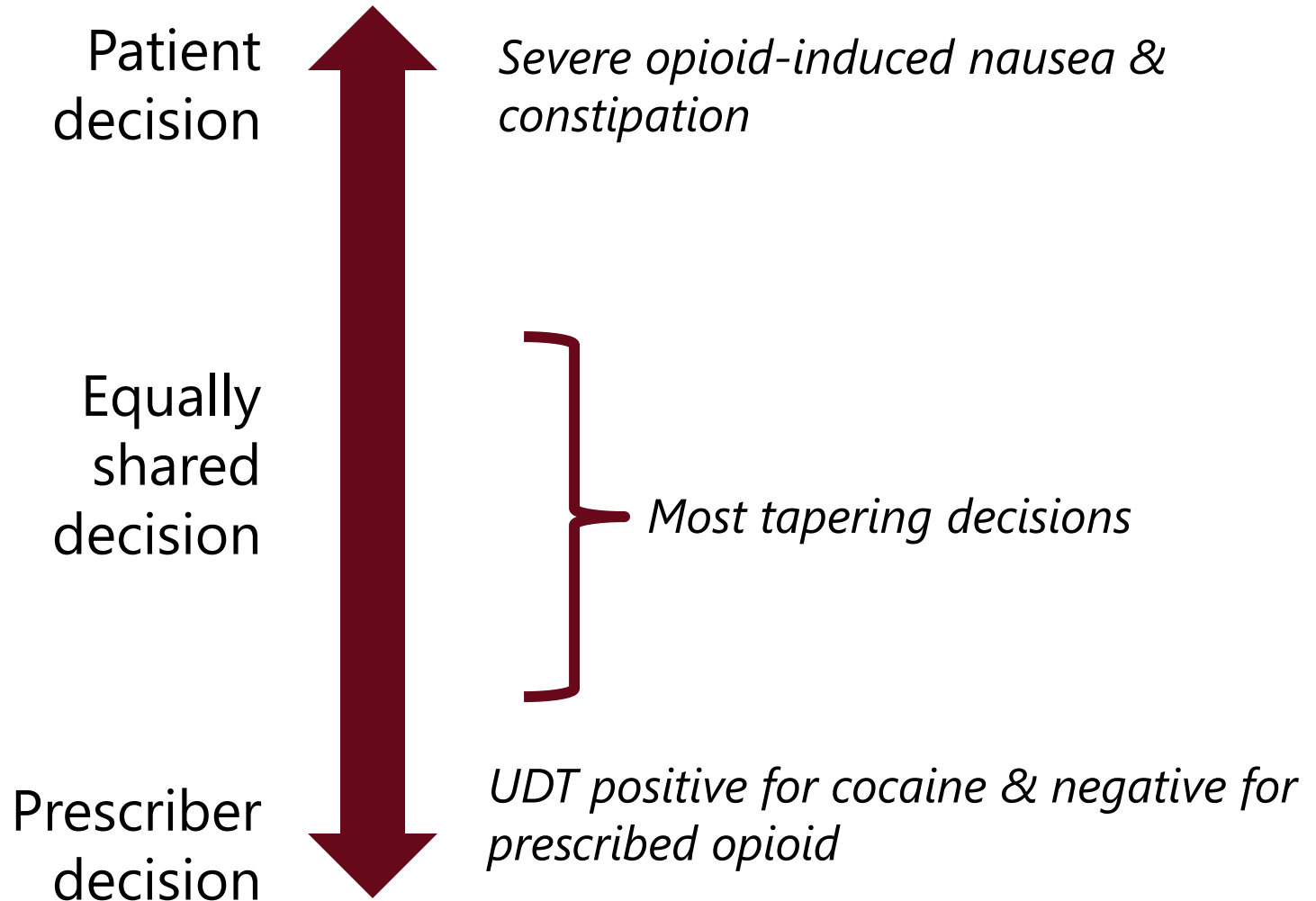
Clarifying patient goals

- “Big picture”/life goals
 - Linked to values and aspirations
 - Not usually achievable in the short term
 - Important for grounding treatment decisions and generating short-term goals
- Short-term goals
 - Linked to “big picture”/life goals
 - Should be achievable in short term and within patients’ control
 - May be Specific, Measurable, Achievable, Relevant, Time-bound
 - Helpful for reframing conversation, promoting behavior change

Shared decision-making

- Involves patient and physician sharing information (both directions), deliberating about options, and agreeing to a course of action
- Does not require physician to give up prescribing decision authority

Degree of decision sharing



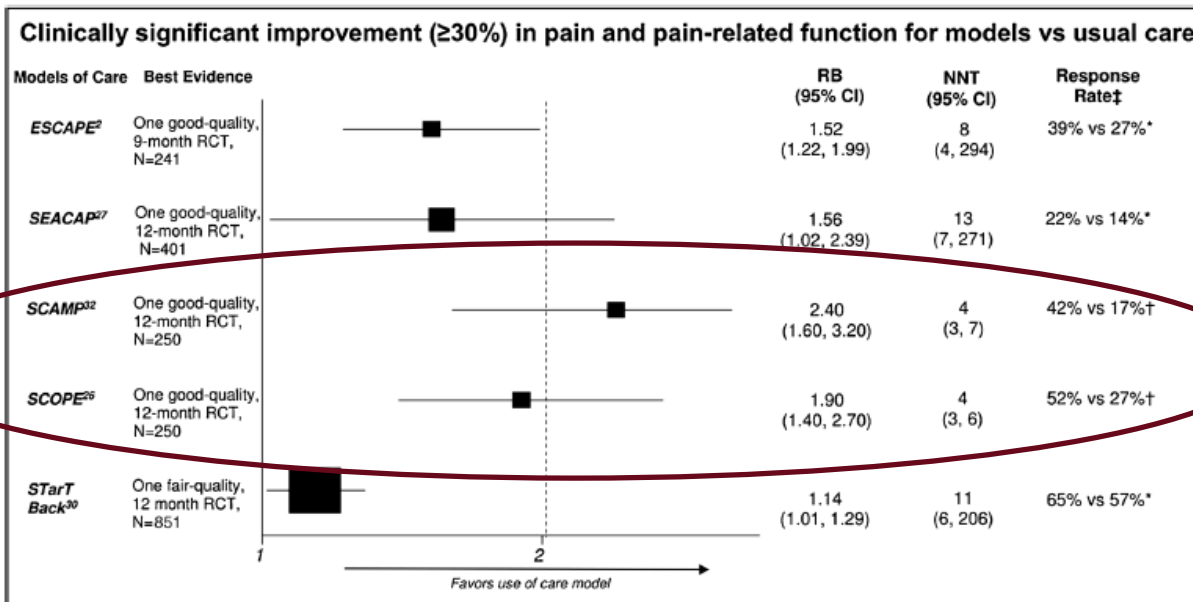
Delivering patient-centered pain care

Effectiveness of Models Used to Deliver Multimodal Care for Chronic Musculoskeletal Pain: a Rapid Evidence Review

Kim Peterson, MS, Johanna Anderson, MPH, Donald Bourne, MPH, Katherine Mackey, MD, and Mark Helfand, MD, MS, MPH

Department of Veterans Affairs, VA Portland Health Care System, Evidence-based Synthesis Program (ESP) Coordinating Center, Portland, OR, USA.

- Included 8 RCTs of mostly fair to good quality with 9-12 month f/u
- Best evidence from 5 trials (4 conducted in VA)
- 2 singled out as most promising based on quality & effect size



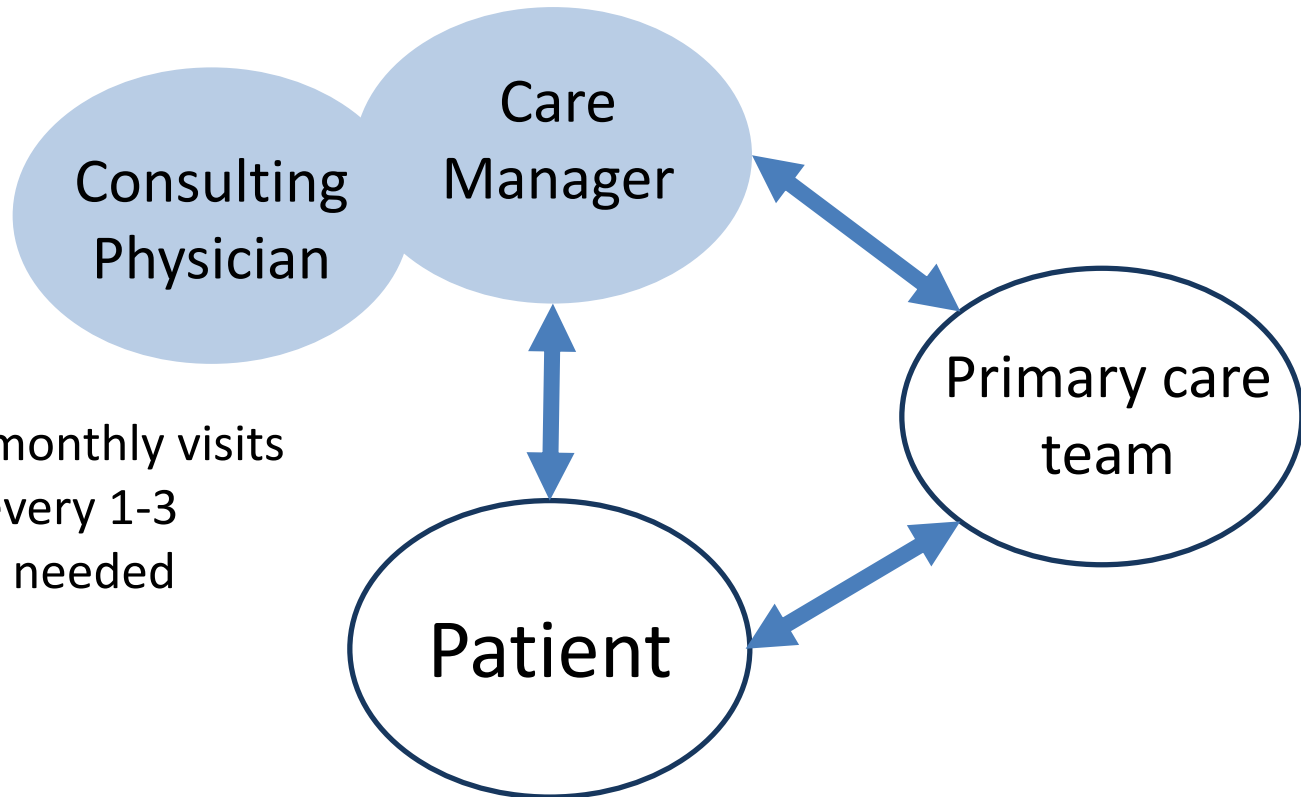
Telecare Collaborative Management of Chronic Pain in Primary Care

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

- Compared Telecare Collaborative Management (TCM) model to usual primary care for chronic pain
- Three key features of TCM model:
 1. Nurse care manager with expert physician back-up
 2. Structured reassessment
 3. Medication prescribing algorithm
- Results: Response 52% intervention vs. 27% usual care

Feature 1: Care manager



Protocol: monthly visits
x 3, then every 1-3
months as needed

Feature 2: Structured reassessment

- Progress toward individual functional goals
- Pain (PEG)
 - **PEG:** Past week rating of...
 - **Pain** on average
 - Pain interference with **enjoyment** of life
 - Pain interference with **general** activity
- Depression (PHQ-2)
 - **PHQ-2:** Frequency in past 2 weeks of...
 - Feeling down depressed or hopeless
 - Little interest or pleasure in doing things
- Anxiety (GAD-2)
 - **GAD-2:** Frequency in past 2 weeks of...
 - Feeling nervous, anxious, on edge
 - Unable to stop or control worrying

Feature 3: Prescribing algorithm

- Shared decision-making approach based on preferences and change in follow-up measures
- VA formulary medications in 3 steps
 - All commonly used in chronic pain
 - Actively trialed, discontinued if not effective

Effect of Opioid vs Nonopioid Medications on Pain-Related Function in Patients With Chronic Back Pain or Hip or Knee Osteoarthritis Pain

The SPACE Randomized Clinical Trial

Erin E. Krebs, MD, MPH; Amy Gravelly, MA; Sean Nugent, BA; Agnes C. Jensen, MPH; Beth DeRonne, PharmD; Elizabeth S. Goldsmith, MD, MS; Kurt Kroenke, MD; Matthew J. Bair; Siamak Noorbaloochi, PhD

- Main results: 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 side effects

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- SPACE used TCM as care delivery model in both groups
 - ~60% in both groups had response in function
 - Change from original model: Pharmacist care manager
 - Extension: Tapered opioids at end of trial

TCM model advantages

- Well-liked by patients
- Efficient/easy to implement
- Adaptable to resources/needs of clinical setting
- Easily extended to support opioid tapering

- *Is TCM enough for complex patients with chronic pain and long-term opioid use?*



V O I C E

Veterans' Pain Care Organizational Improvement Comparative Effectiveness Study

- Objective: To improve effectiveness and safety of pain management for Veterans on long-term opioids by...
 - Improving follow-up and coordination of pain care
 - Increasing use of evidence-based pain therapies
 - Providing support for opioid dose reduction

Research aims



- Aim 1: Compare two care delivery models to improve pain outcomes and reduce opioid use
 - Telecare Collaborative Management: Lower-intensity intervention delivered by pharmacist care manager
 - Integrated Pain Team: Higher-intensity intervention delivered by interdisciplinary team of clinicians
- Aim 2: Test effect of *offering* rotation to buprenorphine-naloxone (Suboxone) in high-dose subgroup
- Aim 3: Identify strategies to enhance implementation

VOICE overview



- Multisite pragmatic randomized trial comparing care delivery strategies for VA patients on long-term opioids



- Eligibility: Moderate-severe pain despite opioids ≥ 20 ME mg/day
- Interventions delivered by volunteer VA clinicians under usual care conditions
- Outcomes assessed by masked research staff
- Patient-centered communication & shared decision-making are common elements across study interventions

TCM intervention background & rationale



- The “low intensity” arm
- Based on collaborative care model tested versus usual care in Indianapolis VA trial
- Key features: Care manager with expert back-up, structured reassessment, stepped approach to medication optimization
 - Care managers refer/coordinate care following usual processes
 - Initial visit is face-to-face, all others may be telephone visits

IPT intervention background & rationale



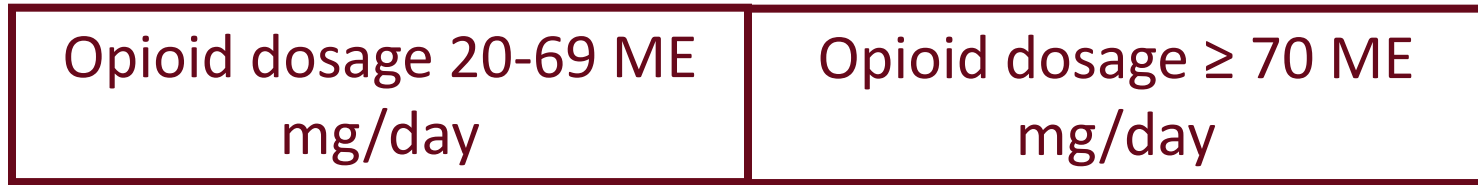
- The “high intensity” arm
- Based on clinical program at San Francisco VA
- Key features: interdisciplinary team, multi-modal care with emphasis on nondrug therapies, behavioral (CBT/MI) intervention
 - 3 required face-to-face visits (1 interdisciplinary & 2 medical)
 - Monthly calls by mental health provider

Buprenorphine intervention background & rationale



- Based on clinical program at VA Connecticut
- Buprenorphine-naloxone has strong evidence for efficacy and improved functioning in opioid use disorder but is not approved for opioid dependence without OUD
- Buprenorphine-naloxone option potentially addresses barriers to high-dose opioid tapering
 - May increase patient willingness to attempt dose reduction
 - May facilitate more rapid dose reduction
 - May address physiological consequences of high-dose long-term opioid use (craving, withdrawal, prolonged abstinence syndrome)

Veterans with moderate-severe chronic pain despite opioids



Aim 1

TCM

IPT

TCM

IPT

Aim 2

Std taper

Bup-nx option

Std taper

Bup-nx option

12 months

Improvement in pain, reduction in opioid dosage

Veterans with moderate-severe chronic pain despite opioids



Aim 1

TCM

IPT

TCM

IPT

Aim 2

Std taper

Bup-nx option

Std taper

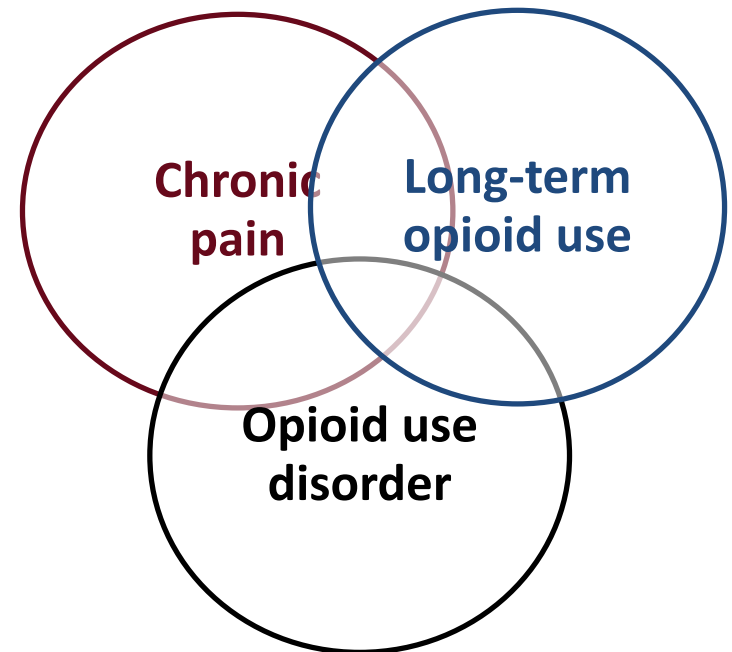
Bup-nx option

12 months

Improvement in pain, reduction in opioid use

VOICE OUD approach

- VOICE interventions do not meet standard of care for OUD, but are compatible with OUD treatment
- Patients with known moderate to severe OUD are not eligible for enrollment
- Protocol for patients diagnosed after enrollment
 - Diagnose and arrange for treatment
 - Continue non-opioid pain management
 - Retain in study



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http://voice.dl.umn.edu/

The screenshot shows the top portion of the VOICE Study website. At the top left is the University of Minnesota logo with the text "UNIVERSITY OF MINNESOTA Driven to Discover™". To the right are links for "One Stop" and "MyU: For Students, Faculty, and Staff", along with a "Custom Search" input field. Below this is the VOICE Study logo, which includes a microphone icon and the text "VOICE Study Veterans' Pain Care Organizational Improvement Comparative Effectiveness Study". A dark navigation bar contains the following menu items: "Home", "VOICE Study Staff and Locations" (with a dropdown arrow), "Frequently Asked Questions", "Meet the Veteran Engagement Panel" (with a dropdown arrow), "VOICE Success Stories", and "Voice Study Materials".

Use your VOICE to help improve pain care for Veterans



The VOICE study is testing whether different ways of working with Veterans and their primary care providers can help get pain under better control.

What is the study's goal?

To improve the effectiveness and safety of pain management for Veterans.

Who is eligible for VOICE?

The study will enroll Veterans receiving care at select VA sites who meet the following criteria:

- severe pain despite treatment with opioid medications
- willingness to be assigned by chance to either of the study's two pain care groups
- availability to participate for one year

Thank you! Questions?

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