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# Keys to Communication Success in Opioid Management

Erin E. Krebs, MD, MPH



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# Educational Objectives

At the conclusion of this activity participants should be able to:

- Recognize patient perspectives on pain and opioid management
- Identify practical approaches to limiting, reducing, or discontinuing opioids while maintaining a positive patient-physician relationship
- Describe the role of shared decision-making in opioid tapering and discontinuation

# Pitfalls

EDITORIAL

## Long-term Opioid Treatment of Nonmalignant Pain

*A Believer Loses His Faith*

*Mitchell H. Katz, MD*

As a patient-centered internist, I have never wanted a patient of mine to suffer needless pain. During my residency in the 1980s, I was influenced by studies showing that physicians undertreated pain, and I vowed that I would not practice in that way.

Before you know it, the patient is on a high dose of an opioid, and you are unsure whether you have actually helped them. What you know is that you have committed yourself to endless negotiations about increasing doses, lost pill bottles, calls from emergency departments, worries that your patient is selling the drugs, and the possibility that one day, your patient will take too many pills, perhaps with alcohol, and overdose.

# Outline

- Supporting evidence
  - Opioid taper outcomes
  - Patient perspectives
- Practical advice

# Opioid Taper Outcomes

- Low-quality evidence overall on patient outcomes of opioid dose reduction
  - Observational studies of opioid tapering in the context of intensive multimodal pain programs showed improvements in pain and function
  - Studies of opioid tapering with lower intensity support showed improved or unchanged pain and function
- Very low-quality evidence overall on adverse effects of opioid reduction and discontinuation
  - Abrupt discontinuation may be associated with serious harm (e.g., overdose, suicide)

# Patient Perspectives

- Many patients are ambivalent or want to reduce use
- Survey: Among patients who rated opioids as at least moderately helpful, 43% want to stop or cut down

Problems/concerns	Desire to reduce (n = 795)	No desire to reduce (n=942)	P-value
Worry about dependence	48	19	<0.001
Bothersome side effects	41	21	<0.001
Need higher dose for same effect	38	20	<0.001
Feeling less alert when driving	35	19	<0.001
Interfering with work/family/social	30	10	<0.001
Feeling slow/sluggish	23	11	<0.001
Difficulty thinking clearly	23	8	<0.001

# Patient Perspectives - Qualitative Findings

- Patients receiving long-term opioids ...
  - Want to be treated as individuals, feared being seen as drug-seekers or fakers
  - Want doctors to listen and understand their pain
- Quotes on the following slides are from interviews with patients who received long-term opioids for chronic pain

## Patient Quote:

*“This is nothing against [my doctor], but 99% of the conversations we ever have, because it’s only every 6 months or once a year, is my physical, my weight, blood pressures, what number of pain I’m in, but there is no conversation about pain. See my personal belief—and [my doctor] is the best I’ve seen over these four decades—um, is they’re at a loss at this.”*



# Patient Perspectives - Qualitative Findings

- Concerned about dependence and addiction
- Expect doctors to monitor safety

## Patient Quote:

*“I think any patient should have some say but it’s the doctor’s responsibility not to let you become addicted. And, really for me, it’s my responsibility too. Some people don’t look at it that way. They just, I don’t know, just pop pills.”*

# Patient Perspectives - Qualitative Findings

- Have high expectations for opioids that often conflict with their own experience
  - Sometimes continued taking opioids despite lack of benefit

## Patient Quote:

*“I would really expect them to get rid of all the pain there is, but maybe my expectations are maybe more than what it can do. I just trust [my doctor] is all.”*

## Patient Quote:

*“...I tried to explain [to doctor] that they’re really not working for my pain. I mean, my body’s probably gotten used to ‘em, and I get from her that there’s nothing else she can give me.”*

# Patient Perspectives - Qualitative Findings

- Interpreted limitations on opioids in the context of the relationship
  - Positive relationship □ limits attributed to concern for wellbeing

## Patient Quote:

*“I was a little upset at first, but I kind of understood what he did, because I’ve been coming into the emergency room for other issues, and the other doctors were giving me stuff and they weren’t notifying him. I don’t feel it as a punishment – but he just wanted to make sure I wasn’t getting overindulged in what I was using. So I was glad he did what he did. Gotta keep me in check sometimes.”*

# Summary

- Limited research on processes or outcomes of opioid reduction
- Many patients have concerns about opioids, fail to receive expected benefit, or desire to reduce use
- Qualitative research supports importance of a patient-centered approach
  - Treating patient as an individual
  - Listening and expressing empathy



# Outline

- Supporting evidence
  - Opioid taper outcomes
  - Patient perspectives
- Practical advice

# Practical Advice

- Three steps to patient-centered opioid reduction
  1. Develop individual benefit and harm assessment
  2. Share decision making about options
  3. Implement a taper trial

# The Risk Benefit Framework: Judge the Opioid Treatment, Not the Patient

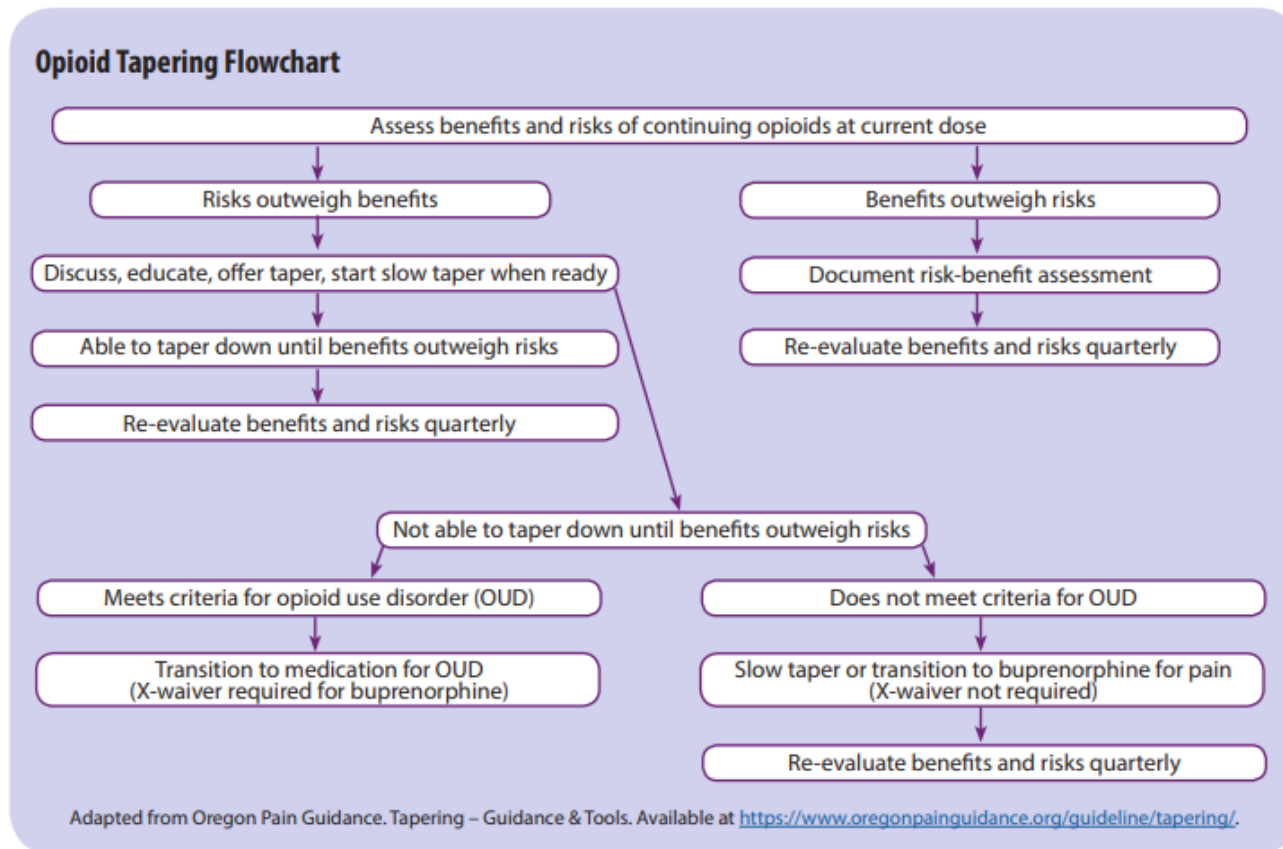
## **NOT...**

- “Is the patient good or bad?”
- “Does the patient deserve opioids?”
- “Should this patient be punished or rewarded?”
- “Should I trust the patient?”

## **RATHER...**

Do the benefits of this treatment outweigh the harms and risks?

# Step 1: Benefit-harm Assessment



# A Quick Poll

- Please take a moment to think of the last patient for whom you wrote an opioid renewal prescription...
- *How confident are you the patient is experiencing substantial benefit that is clearly outweighing potential harms?*
  - Highly confident
  - Somewhat confident
  - Not at all confident

# Individual Benefit Assessment

- Assessing benefit is difficult, but important
  - In the absence of benefit, no risk of harm is acceptable
- Some patients continue opioids without benefit
  - Reasons: Doctor's advice, fear they would be worse off without it, belief that higher dose/stronger medicine is needed, experience of increased pain with brief withdrawals, experience of not feeling well before doses

# What to Ask?

- Asking about activities & limitations
  - *Tell me about a typical day for you.*
  - *Compared to 5 years ago, how is your life now?*
  - *Are there things that are important to you that you don't do anymore because of pain?*
- Clarifying specific opioid effects
  - *Tell me about how your pain med is working.*
  - *What do you mean when you say it helps?*

# Individual Benefit-Harm Assessment

- Assessing harm
  - Evaluate adverse symptoms
  - Assess risk factors for major harm
  - Evaluate for evidence of problematic opioid use/misuse
- Most salient harms often differ for patients and prescribers



# Adverse Symptoms

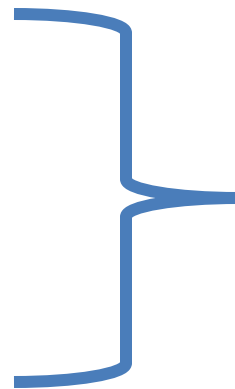
- Could opioids be causing or contributing to bothersome symptoms?
  - Poor concentration, focus, memory
  - Fatigue, low motivation
  - Depressed mood
  - Constipation, nausea
  - Dry mouth
  - Headaches (analgesic overuse?)
  - Sexual dysfunction
- Could opioids be interfering with life and goals?

# Risk Factors for Major Harms

	Overdose	Trauma	Opioid use d/o
Opioid dose > 50 ME mg/day	X	X	X
Concurrent sedative-hypnotic	X	X	X
Substance use disorder (past or now)	X	X	X
Depression or anxiety disorder	X	X	X
Tobacco Use			X
High pain severity or impairment			X
Younger age (<45 yo)			X
Family hx of substance use disorder			X

# Evidence of Problematic Opioid Use

- Evaluate for behavior that suggests increased risk for harm (to patient or community)
  - Drug testing +/- pill counts
  - State prescription monitoring programs
  - Medical record review
- Consider differential diagnosis for behaviors
  - Substance use disorder
  - Mood or personality disorder
  - Dysfunctional pain coping
  - Opioid-induced behaviors
  - Social chaos



All suggest increased risk for opioid-related harm

# A Case of a Transfer Patient

- 40 year-old woman with chronic low back pain, obesity, diabetes, depression, and tobacco use disorder
  - Establishing new primary care
  - Needs medications (1 week left): morphine SR 30 TID, hydrocodone/APAP PRN (8 tablets/day), zolpidem 10 QHS
- History
  - Not working; receiving disability payments
  - Single parent of two; can't attend soccer games anymore
  - No good friends, no hobbies other than TV
  - Opioids “take the edge off”
  - Reports no alcohol or drug use, opioid use as prescribed

# Case: First Visit

- Assessment: Chronic mechanical/non-radicular LBP with severe pain, functional limitations, and physical deconditioning
  - Benefit of opioids: unclear
    - Poor occupational, social, physical function
    - Ineffective pain self-management
  - Risk factors for harms: high dose, concurrent sedative-hypnotic, depression, tobacco use disorder
- Plan:
  - Discuss assessment
  - Discuss safety monitoring (before first prescription)
  - Schedule short-term follow-up

# What to Say?

- Discussing risk for harms
  - *We used to think the dose didn't matter as long as we went up slowly, but now we know higher doses cause more serious injuries and accidental deaths.*
  - *These drugs can cause addiction in people with pain, even if they have not had problems with drugs or alcohol in the past.*
  - *Your risk is higher than average because...*
- Discussing safety monitoring
  - *I use a standard safety monitoring practice for all my patients.*
  - *I will be honest with you if I have any concerns about how you are using your medications. In turn, let me know if you have any concerns about how the drugs are affecting you.*

# Step 2: Share Decision Making

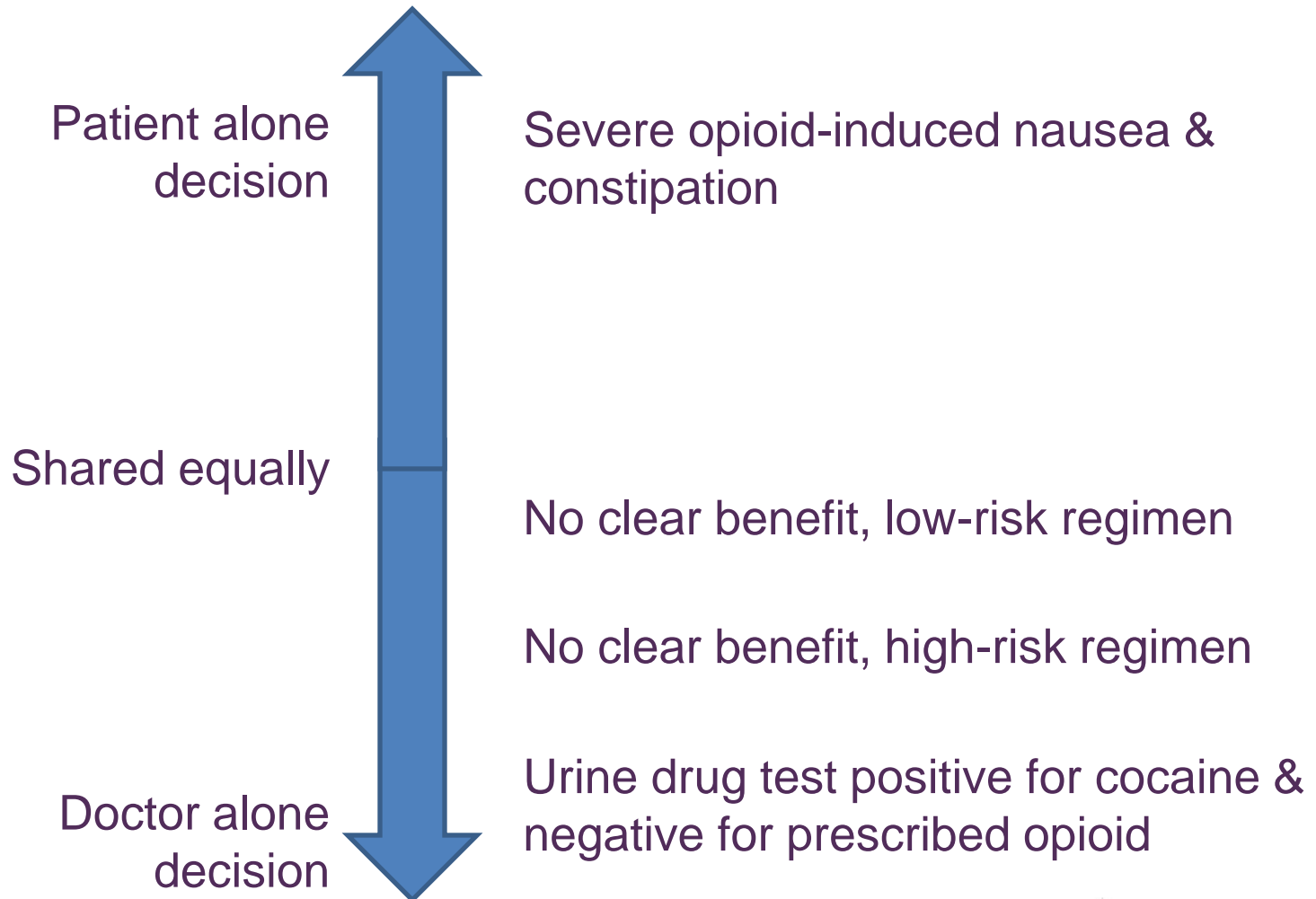
- Shared decision making
  - Involves both patient and physician sharing information and expressing preferences
  - Does not require physician to give up prescribing decision authority

# Share Decision Making

- Taper-related decisions can often be shared
  - Which medication to reduce first
  - How rapidly to taper
  - When to start
  - When to schedule follow-up
  - Self-management goals
- Degree of sharing depends on urgency of safety issues



# Degree of Shared Decision Making



# If benefits do not outweigh harms

- Make a recommendation tied to patient's wellbeing
- Empathize with patient's situation
  - Frustration that pills don't work as advertised
  - Effects of pain on multiple life domains
- Emphasize function and life goals over analgesia
  - Approach to “getting life back” differs from approach focused on pain relief or cure
- Show commitment to caring for patient
  - Schedule close follow-up during and after taper

# If opioid use disorder is likely

- Give specific and timely feedback about why you are concerned: *I'm worried about you because...*
  - Blame the drug, not the patient: *I can't continue prescribing this, because I think it's hurting you more than it's helping.*
- State your plan and any options clearly
  - If concerning symptoms/signs, but unclear diagnosis, consider taper with closer monitoring and support
  - If addiction is clearly present or emerges during taper, offer addiction treatment
- **Never abandon the patient**

# Case: Second Visit

- 40 year-old woman with chronic low back pain, obesity, diabetes, depression, and tobacco use disorder
  - No change in pain or function
  - No evidence of misuse, UDT and PMP appropriate
- Assessment/Plan
  - No clear improvement, high-risk regimen, no evidence of non-adherence  Doctor led decision with patient input
  - Recommendation: *“I want to start making some changes to improve the safety of your medications.”*
  - Shared decisions
    - First step: morphine, hydrocodone, or zolpidem?
    - Rate of taper

# Step 3: Implement a Taper Trial

- Discuss goals of taper trial—how and when will we know if it is successful?
  - Achieve initial dose target
  - No sustained worsening in pain/function
- Discuss potential withdrawal symptoms
  - Temporary increase in pain or anxiety
  - Discuss how to contact
  - Schedule follow-up
- Identify at least one self-management goal
  - Emphasize focus on long-term goals/function

# What to Say?

- Discussing expectations
  - *You may have temporarily increased pain or other withdrawal symptoms after dose reductions*
  - *As long as we go down slow, I don't expect any overall change in your level of pain*
  - *Most people eventually feel better—more clear, more energetic—on a lower dose, but that usually takes time*
- Discussing self-management
  - *You said you want to be able to... What would be a good first step towards that?*

# Case: One Year Later

40 year old woman with chronic low back pain, obesity, diabetes, depression, and tobacco use disorder

- Morphine SR decreased by 15 mg per month to zero
  - Hydrocodone decreased to 4 tablets/day
  - Zolpidem decreased to 5 mg QHS
- 
- Pain and function not clearly changed
  - Focusing visits on lifestyle change efforts

# Summary

- Patient-centered opioid management
  - Commitment to respecting patient preferences, needs, and values
  - Not a commitment to continue potentially harmful or ineffective therapy
- Three steps to patient-centered opioid reduction
  1. Develop individual benefit and harm assessment
  2. Share decision making about options
  3. Implement a taper trial



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# PCSS Mentoring Program

- PCSS Mentor Program is designed to offer general information to clinicians about evidence-based clinical practices in prescribing medications for opioid use disorder.
- PCSS Mentors are a national network of providers with expertise in **addictions, pain, evidence-based treatment including medications for opioid use disorder (MOUD)**.
- 3-tiered approach allows every mentor/mentee relationship to be unique and catered to the specific needs of the mentee.
- No cost.

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