Effectively Communicating with Patients about Opioid Therapy

Clinician Outreach and Communication Activity (COCA) Call

December 13, 2016
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Planners have reviewed content to ensure there is no bias.

This presentation will include discussion of the unlabeled use of a product or products under investigational use.
Objectives

At the conclusion of this session, the participant will be able to:

- Outline key talking points to communicate to a patient who has been prescribed opioid therapy.
- Provide practical strategies to help motivate a patient’s commitment to opioid therapy adjustment.
- Apply a patient-centered, six-step process to minimize conflict when communicating opioid dosing recommendations.
Guideline for Prescribing Opioids for Chronic Pain Call Series

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TODAY’S PRESENTER

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Disclaimer

The findings and conclusions in this presentation are those of the author(s) and do not necessarily represent the views of the Centers for Disease Control and Prevention/the Agency for Toxic Substances and Disease Registry
CDC Guideline for Prescribing Opioids for Chronic Pain:

Effective communication with patients about opioid therapy

Deborah Dowell, MD, MPH

December 13, 2016
CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016


U.S. Department of Health and Human Services
Centers for Disease Control and Prevention
Effective communication is critical when

• Communicating important information
  ➢ (For example, “Taking opioids with alcohol or other drugs can cause you to stop breathing and die.”)

• Motivating behavior change
  ➢ (For example, committing to taper opioids)

• Addressing conflicts
  ➢ (For example, “I don’t think opioids will help your headaches.”)
Discuss benefits and risks with patients

- Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy.

(Recommendation category A: Evidence type: 3)
Important points for patients about opioids

- We don’t know how well opioids work long-term
- They probably won’t take away your pain completely
- Opioids can cause you to stop breathing and die, especially at high doses, or if taken with alcohol or other drugs
- You could develop a serious, lifelong addiction
- They can cause constipation, dry mouth, nausea, vomiting, withdrawal, drowsiness, and might make driving unsafe
- We’ll meet often to make sure they are not harming you
- I test urine and check a database showing medicines from other doctors to be sure all my patients on opioids are safe
Communicating important information

- Pause and ask the patient what they heard you say
- Correct misunderstandings
- Ask if there are questions
- Allow adequate time
Two principles for effective communication

• Approach patients with compassion

• Use relationship-building skills, including
  – reflective listening
  – empathic statements
What about patients already taking high opioid dosages?

• Explain there is now scientific evidence showing overdose risk increases at higher opioid doses

• Empathically review benefits and risks of continued high-dose opioid therapy

• Offer to work with the patient to taper to a safer dose

• Motivational interviewing can move the patient toward readiness for change
Principles of motivational interviewing

• Express empathy through reflective listening

• Develop discrepancy between clients' goals or values and their current behavior

• Avoid argument and direct confrontation

• Adjust to client resistance rather than opposing it directly

• Support self-efficacy and optimism

Express empathy through reflective listening

• Ask open-ended questions
  ➢ For example, “What concerns do you have about opioids?”

• Listen

• Reflect

• Express appropriate empathy
  ➢ For example, “The idea of changing your opioid dose after all these years must be frightening.”
Develop discrepancy between clients' goals or values and their current behavior

• Reflect back content from the patient
• Elicit ambivalent statements with nonjudgmental, reflective listening
• Ask about goals and how opioids help or don’t help
• Reflect ambivalence back to the patient
  ➢ For example, “You said that opioids used to control the pain, but they aren’t working very well anymore. What makes you want to continue taking them the same way?”
Avoid argument and direct confrontation

• Argument and direct confrontation can reinforce a defensive, oppositional stance

• Recognize patient resistance as a signal
  – listen more carefully
  – change direction
Adjust to client resistance rather than opposing it directly

• Adjust to resistance rather than opposing it directly (also called “rolling with resistance”)

• Reflect what the patient just said in a neutral way
  ➢ For example, “You aren’t ready to think about planning to reduce your dose yet.”

• Reframe the conversation
  ➢ For example, “I care about you and want to help you get back to being as active as you would like.”
Support self-efficacy and optimism

• Reinforce signals that the patient is considering change
  ➢ For example, “I think it’s great that you want to hear more about other ways to manage your pain.”

• Provide credible, clear, actionable information
  ➢ For example, “Most people can function better without worse pain after tapering opioids. Many patients have improved pain after a taper, even though pain might briefly get worse at first.”
Principles of motivational interviewing

• Express empathy through reflective listening

• Develop discrepancy between clients' goals or values and their current behavior

• Avoid argument and direct confrontation

• Adjust to client resistance rather than opposing it directly

• Support self-efficacy and optimism

Remaining patient-centered when there is a conflict

(1) Understand the patient’s concerns and expectations
(2) Validate concerns, emotions – use empathy, normalization
(3) Inform about reassuring features of the history and exam
(4) Explain your recommendation given risks and benefits
   (go back to (2) if needed)
(5) Flexibly negotiate alternatives
(6) Explore for residual concerns

(1) Understand the patient’s concerns and expectations

• Understand the patient’s concerns and expectations before addressing them.

• Ask open-ended questions

• Paraphrase what you hear
  – the patient is more likely to feel understood
  – you are more likely to address what really matters to the patient
(2) Validate concerns and emotions

• Use empathy
  ➢ For example, “I can only imagine how frustrating it must be when the pain keeps you awake”
• Use normalization
  ➢ For example, “many people feel even worse after their pain keeps them awake.”

(3) Inform about reassuring features of the history and exam
(4) Explain your recommendation given risks and benefits

• For example, explain that opioids
  – are unlikely to substantially reduce fibromyalgia pain more than temporarily
  – risks of dependence and overdose outweigh these minimal benefits
• Allow the patient to respond
• If she expresses additional concerns, or emotions, such as anger, go back to step (2):
  – Validate concerns, emotions, using empathy
(5) Flexibly negotiate alternatives

• For example, trial of a tricyclic; and re-evaluation soon

(6) Explore for residual concerns
Six steps congruent with patient-centered care

(1) Understand the patient’s concerns and expectations
(2) Validate concerns, emotions – use empathy, normalization
(3) Inform about reassuring features of the history and exam
(4) Explain your recommendation given risks and benefits
   (go back to (2) if needed)
(5) Flexibly negotiate alternatives
(6) Explore for residual concerns

How to increase effective communication when

• Communicating important information
  – Pause and ask the patient what they heard
  – Correct misunderstandings, check for questions

• Motivating behavior change
  – Express empathy through reflective listening
  – Develop discrepancy between patient goals and behavior
  – Support self-efficacy and optimism

• Addressing conflicts
  – Understand and validate concerns and emotions
  – Explain your recommendation given benefits and risks
CDC Opioid Prescribing Guideline Mobile App

• CDC’s new Opioid Guide App makes it easier to apply the recommendations into clinical practice
• Features include
  – MME Calculator
  – Prescribing Guidance
  – Motivational Interviewing Practice
• Available today, download for free from your app store (iOS or Android)
• For more information, visit: www.cdc.gov/drugoverdose/prescribing/app.html
CDC Guideline for Prescribing Opioids
for Chronic Pain

EFFECTIVE COMMUNICATION WITH PATIENTS ABOUT OPIOID THERAPY

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1. Provide communication strategies for talking with patients about benefits and harms of opioids when considering transition to long-term use.

2. Provide communication strategies for talking with patients about tapering opioids.

3. Compare and contrast the communication challenges presented in the case studies with those encountered in your own clinical practice.
CASE #1
“Whiplash” 8 weeks after Car Crash: 37 y.o. woman
Transition Into Long-Term Opioid Therapy

- PMH/PSH: Negative
- SH: Clerical job, 2 young children, ½ ppd cigarettes, “social drinker.”
- Family history: unremarkable
- +ROS: Fatigue, poor sleep, headaches “from neck”, no weakness or numbness

EXAM: Fit. Neck limited ROM to flex, extend, rotate, and side-bend. Mild tenderness to palpate SCM, levator scapulae, trapezius, paraspinal, and occipital muscles. Neurological: Normal

Prior non-drug treatments: PT x 2 “didn’t help” week 1-3

Imaging: Normal c-spine X-rays from ED (day of injury)

Pain Metrics (“PEG”)
- Pain Intensity: 9/10
- Pain Interference with Enjoyment of Life: 9/10
- Pain Interference with General Function: 9/10

PHQ-4: 8
ORT: 2 “low risk”

Pain related Rx:
- Hydrocodone 10/325 6/d prn
- Methocarbamol 500 QID
- Cyclobenzaprine 10 mg prn
“Please, please refill my pain medications; if I didn’t have them I surely couldn’t manage my job and my family!”

- Identify “Resistance Talk”
- Avoid arguing with her; elicit “Change Talk”
  1. “Tell me how they are helping you?”
  2. “What are your other concerns/fears/worries?”
  3. “Have you had any side-effects?”
“Well, you’re not just going to take away my pain pills, are you?”

“• ‘Our shared goal is to help you take care of your family, and to keep you working.’
• ‘What are you concerned might happen if we reduced them very slowly?’
• ‘Would you mind if I told you what my concerns are?’
• ‘We are both looking at this together: the up-sides and the down-sides together.’
ASE #2

48 y.o. Man with CLBP 6 yrs after Spinal Fusion

Discontinuation of Long-term Opioid Therapy

PSH: L4-5 Discectomy/Laminectomy
PMH: HTN, Borderline DM, Hyperlipidemia, OSA
SH: Disabled stevedore x 6 years, married, 3 children (8,12,14), 20 pack yr tobacco, denies alcohol
FH: DM, HTN, Lung cancer
+ROS: Fatigue, poor sleep, cough, constipation, poor libido

Pain Rx:
Opioids: Morphine ER 60 mg BID, Hydrocodone 10/325 x8/d
Non-opioids: Carisoprodol 300 TID, Lorazepam 2 mg prn sleep

Pain Metrics (“PEG” tool)
• Pain Intensity: 9/10
• Pain Interference with Enjoyment of Life: 9/10
• Pain Interference with General Function: 9/10
PHQ-4: 6
ORT: 6 “moderate risk”
UDTs: compliant
PDMP: consistent
Physical Exam: BP 154/94, BMI 32
• Limping and grimacing when moves
• Gait normal
• Spine: Palpation tenderness axial and paravertebral lumbo-sacral back; ROM limited due to pain; SLRs LBP only; SIJ palpation and FABERE normal
• Neurologic: Cognition and affect normal; No motor atrophy or weakness to LE motor testing, reflex exam normal; non-dermatomal dysesthetic light touch.

Imaging:
• X-Ray (flex/ext) c/w described surgery, no migration of screws, no fracture, no abnormal motion
• Magnetic resonance image (MRI) 8 weeks ago: “…s/p L4-5 lam'y, disc space narrowing, moderate degenerative facet disease…”
“Established patients already taking high dosages of opioids, as well as patients transferring from other clinicians…”

Centers for Disease Control and Prevention MMWR March 15, 2016; 65:p23

- “…tapering opioids can be especially challenging after years on high dosages.” Go slow if safety allows.

- **Offer the opportunity** to re-evaluate continued use of higher dose opioids in light of recent evidence regarding risks

- “empathically review benefits and risks of continued high-dosage opioid therapy” and “offer to **work with the patient to taper** opioids to safer dosages”

- “**very slow opioid tapers as well as pauses** in the taper to allow gradual accommodation to lower opioid dosages.”

- Be aware that **anxiety, depression, and opioid use disorder** “might be unmasked by an opioid taper”
“But doc, I can’t even manage on my current dose; I really do need more, not less!”

- Identify “Resistance Talk”—pushing hard will lead to:
  - “No way I can taper!”
  - “My life is as bad as it can be”
  - “What do you want me to do, lay in bed all day?”
“But doc, I can’t even manage on my current dose;
I really do need more, not less!”

• Avoid arguing with him; elicit “Change Talk”
  ① “Tell me how they are helping you?”
  ② “What are your other concerns/fears/worries?”
  ③ “Have you had any side-effects?
    • Elicit: Symptoms of depression or addiction without using these words
    • Elicit: Tolerance, withdrawal, control problems
Skillful Empathic Communication

1. Reflective listening is an opportunity for understanding your patient’s story.
2. Non-judgmental language supports collaborative treatment planning.
3. Affirmative statements enable change by persuasion, not by argument.
4. An agreed upon opioid taper plan for your patient can result from shared medical decision-making.
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- **Using the Webinar System**
  - “Click” the Q&A tab at the top left of the webinar tool bar
  - “Click” in the white space
  - “Type” your question
  - “Click” ask

- **On the Phone**
  - Press Star (*) 1 to enter the queue
  - State your name
  - Listen for the operator to call your name
  - State your organization and then ask your question
Thank you for joining!

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When: A few days after the live call

What: All call recordings (audio, webinar, and transcript)

Where: On the COCA Call webpage

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