Effectively Communicating with Patients about Opioid Therapy

Clinician Outreach and Communication Activity (COCA) Call

December 13, 2016

Office of Public Health Preparedness and Response
Division of Emergency Operations

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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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Date	Topic
June 22	Guideline for Prescribing Opioids for Chronic Pain
July 27	Non-Opioid Treatments
August 3	Assessing Benefits and Harms of Opioid Therapy
August 17	Dosing and Titration of Opioids
November 29	Assessment and Evidence-based Treatments for Opioid Use Disorder
December 6	Risk Mitigation Strategies
December 13	Effectively Communicating with Patients about Opioid Therapy

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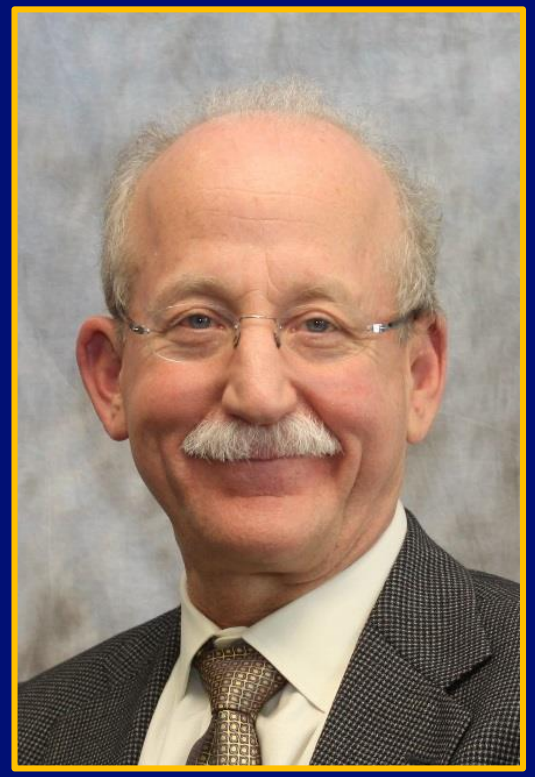

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CDC Guideline for Prescribing Opioids for Chronic Pain:

Effective communication with patients about opioid therapy

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December 13, 2016

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

Continuing Education Examination available at http://www.cdc.gov/mmwr/cme/conted.html.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

Clinical Review & Education

Special Communication

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

Deborah Dowell, MD, MPH; Tamara M. Haegerich, PhD; Roger Chou, MD

IMPORTANCE Primary care clinicians find managing chronic pain challenging. Evidence of long-term efficacy of opioids for chronic pain is limited. Opioid use is associated with serious risks, including opioid use disorder and overdose.

OBJECTIVE To provide recommendations about opioid prescribing for primary care clinicians treating adult patients with chronic pain outside of active cancer treatment, palliative care, and end-of-life care.

PROCESS The Centers for Disease Control and Prevention (CDC) updated a 2014 systematic review on effectiveness and risks of opioids and conducted a supplemental review on benefits and harms, values and preferences, and costs. CDC used the Grading of Recommendations Assessment, Development, and Evaluation (GRADE) framework to assess evidence type and determine the recommendation category.

EVIDENCE SYNTHESIS Evidence consisted of observational studies or randomized clinical trials with notable limitations, characterized as low quality using GRADE methodology. Meta-analysis was not attempted due to the limited number of studies, variability in study designs and clinical heterogeneity, and methodological shortcomings of studies. No study evaluated long-term (≥1 year) benefit of opioids for chronic pain. Opioids were associated with increased risks, including opioid use disorder, overdose, and death, with dose-dependent effects.

RECOMMENDATIONS There are 12 recommendations. Of primary importance, nonopioid therapy is preferred for treatment of chronic pain. Opioids should be used only when benefits for pain and function are expected to outweigh risks. Before starting opioids, clinicians should establish treatment goals with patients and consider how opioids will be discontinued if benefits do not outweigh risks. When opioids are used, clinicians should prescribe the lowest effective dosage, carefully reassess benefits and risks when considering increasing dosage to 50 morphine milligram equivalents or more per day, and avoid concurrent opioids and benzodiazepines whenever possible. Clinicians should evaluate benefits and harms of continued opioid therapy with patients every 3 months or more frequently and review prescription drug monitoring program data, when available, for high-risk combinations or dosages. For patients with opioid use disorder, clinicians should offer or arrange evidence-based treatment, such as medication-assisted treatment with buprenorphine or methadone.

CONCLUSIONS AND RELEVANCE The guideline is intended to improve communication about benefits and risks of opioids for chronic pain, improve safety and effectiveness of pain treatment, and reduce risks associated with long-term opioid therapy.

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Deborah Dowell, Tamara Haegerich, and Roger Chou

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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

Miller, W.R., and Rollnick, S. Motivational Interviewing: Preparing People To Change Addictive Behavior. New York: Guilford Press, 1991

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.”

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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

Fenton JJ et al. Promoting Patient-Centered Counseling to Reduce Use of Low-Value Diagnostic Tests: A Randomized Clinical Trial. *JAMA Intern Med*. 2016;176(2):191-197

(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

Fenton JJ et al. Promoting Patient-Centered Counseling to Reduce Use of Low-Value Diagnostic Tests: A Randomized Clinical Trial. *JAMA Intern Med*. 2016;176(2):191-197

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
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CDC Guideline for Prescribing Opioids
for Chronic Pain

EFFECTIVE COMMUNICATION WITH PATIENTS ABOUT OPIOID THERAPY

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Case Learning Objectives

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")

- **P**ain Intensity: 9/10
- Pain Interference with **E**njoyment of Life: 9/10
- Pain Interference with **G**eneral 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

The Patient-Provider Dialogue (case 1)

"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?"

The Patient-Provider Dialogue (case 1, continued)

"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 Metrics ("PEG" tool)
- **P**ain Intensity: 9/10
- Pain Interference with **E**njoyment of Life: 9/10
- Pain Interference with **G**eneral Function: 9/10

PHQ-4: 6
ORT: 6 "moderate risk"
UDTs: compliant
PDMP: consistent

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

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

Discontinuation of Long-term Opioid Therapy (continued)

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"**

The Patient-Provider Dialogue (case 2)

"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?"*

The Patient-Provider Dialogue (case 2 continued)

"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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  - Listen for the operator to call your name
  - State your organization and then ask your question

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