Central Oregon Health Council

Background Information, FAQs, and Having Difficult Conversations with Patients

Chronic or persistent non-cancer pain is a dynamic and challenging area of medical care. Treatment often includes opiates and/or other controlled substances. Opiate prescribing in the United States has become a national medical emergency. In July of 2013, the Center for Disease Control and Prevention (CDC) began to highlight the crisis with some staggering statistics:

- Between 1999 and 2010, deaths from prescription painkiller overdoses increased more than 400% among women and more than 265% among men.
- For every woman who dies, 30 go to the ER for painkiller misuse or abuse.
- In 2015, the CDC highlighted this epidemic's relationship to a parallel explosion in heroin use.
    - Heroin-related overdose deaths increased 286% between 2002 and 2013.
    - The single biggest risk factor for heroin addiction is prescription opiate abuse, increasing the risk 40-fold.

In conjunction with national concerns and efforts and in response to Oregon leading the nation in opiate misuse, former Governor Kitzhaber appointed state experts to the National Governors' Association Taskforce on Prescription Drug Abuse in 2012. In 2012, a minimum of 100 million prescription opiates were legally prescribed to a population of 3.9 million Oregonians; equivalent to 26 opiate pills for every citizen in Oregon. Notably increases in death rates appeared to be dose related with more than 40% of deaths occurring in individuals receiving over 120 mg morphine equivalent doses (MED) per day.

In response to the statistics CDC Director Dr. Tom Frieden called for an "all-of-society response". Both the CDC and the National Governors' Association Taskforce on Prescription Drug Abuse made several recommendations to address this national epidemic including the following:

1) Improving opioid prescribing practices & reducing the number of opiate pills in circulation.
2) Making prescription drug monitoring programs more effective.
3) Increasing access to substance abuse treatment services, including medication-assisted treatment for opioid abuse or dependence.
4) Expanding access to and training for administering naloxone to reduce opioid prescribing deaths.
5) Increasing provider & public education regarding treatment for chronic or persistent non-cancer pain.
6) Ensuring people have access to integrated care & prevention services.
7) Creating better avenues for disposal of unused prescription drugs.

Community-Wide Safer Prescribing Standards FAQ

1) **Why are community-wide safer prescribing standards important**?
   - Chronic or persistent non-cancer pain is a dynamic and challenging area of medical care where treatment often includes the use of opioids and other controlled substances.
     - Presently, 20% of Oregonians live with chronic pain. http://orcrm.org/wp-content/uploads/2015/02/nga-Task-Force-Report.pdf
     - In 2012, a minimum of 100 million prescription opiates were legally prescribed within a population of 3.9 million Oregonians. That equals 26 opiate pills for every citizen in Oregon. http://orcrm.org/wp-content/uploads/2015/02/nga-Task-Force-Report.pdf
     - Abuse of prescription opioids rose 71% between 1997 and 2002. See Oregon Health Authority (2012) Oregon Prescription Drug Monitoring Program Fact Sheet. http://public.health.oregon.gov/DiseasesConditions/InjuryFatalityData/Documents/Fact%20Sheets/PDMP_2015v02262015.pdf

2) **Why is the Pain Standards Task Force asking prescribing providers to commit to safer prescribing standards now**?
   - In response to the concerning rise of opioid related deaths & health care costs in our community, we are striving to standardize community guidelines and best practices in treating patients suffering from chronic or persistent non-cancer pain. Here are some alarming statistics:
     - Between 2000 and 2011, the state's rate of death due to unintentional prescription drug overdoses increased by 2.4 times and the rate of hospitalization increased five-fold. See Oregon Health Authority (2012) Oregon Prescription Drug Monitoring Program Fact Sheet. http://public.health.oregon.gov/DiseasesConditions/InjuryFatalityData/Pages/index.aspx
     - Four out of 10 drug related deaths were reported to have more than one drug contributing to their death. Benzodiazepines were most prevalent contributing to 40% of overdose deaths. See Oregon Health Authority (2012) Oregon Prescription Drug Monitoring Program Fact Sheet. http://public.health.oregon.gov/DiseasesConditions/InjuryFatalityData/Pages/index.aspx
   - Oregon ranks number one in the nation for non-medical pain reliever use within the total population aged 12 or older. See Oregon Health Authority (2012) Oregon Prescription Drug Monitoring Program Fact Sheet. http://public.health.oregon.gov/DiseasesConditions/InjuryFatalityData/Pages/index.aspx

Community-Wide Safer Prescribing Standards FAQ

3) Why 120 mg MED?

- The death rate increases substantially based on the amount of daily morphine equivalent doses where more than 40% of deaths occur in individuals receiving over 120 mg morphine equivalent doses (MED) per day. See Policy Impact (2012) Prescription painkiller overdoses. Retrieved from http://www.cdc.gov/homeandrecreationalsafety/rxbrief.

4) What is the Pain Standards Task Force?

- The Pain Standards Task force is an engaged multidisciplinary group of thoughtful and compassionate health care professionals that was formed by the Central Oregon Health Council to accomplish the following:
  - Engage community partners and health care professionals on the current opioid problem in our region.
  - Promote education in our region to learn evidenced based and best practices for managing chronic non-cancer pain to bring them to more general use.

5) Who are the members of the Pain Standards Task Force?

Name	Organization
Kim Swanson, PhD (Chair)	St. Charles Family Care
Gary Allen, DMD, MS	Advantage Dental
Wil Berry, MD	Deschutes County Behavioral Health
Muriel DeLaVergne-Brown, RN, MPH	Crook County Health Department
Shanna Geigle, FNP	Veterans Administration
Maria Hatcliffe, RN, MPH	PacificSource Community Solutions
David Holloway, MD, CPE, FAAFP	Bend Memorial Clinic
Jennifer Laughlin, DO	St. Charles Medical Group
Jessica LeBlanc, MD	Mosaic Medical & Bend Treatment Center
Alison Little, MD, MPH	PacificSource Community Solutions
Sharity Ludwig, BS, RDH, EPP	Advantage Dental
Steve Mann, DO	Central Oregon IPA
Kyle Mills, PharmD	Mosaic Medical
Laura Pennavaria, MD	La Pine Community Healthy Center
Christine Pierson, MD	Mosaic Medical
Kerie Raymond, ND	Hawthorn Healing Arts Center
Robert Ross, MD	St. Charles Medical Group
Marie Rudback, DC	Endeavor Chiropractic
Scott Safford, PhD	St. Charles Family Care
Divya Sharma, MD, MS	Central Oregon IPA & Mosaic Medical
Julie Spackman	Deschutes County Health Services
Pamela Tornay, MD	Central Oregon Emergency Physicians
Rick Treleaven, LCSW	BestCare Treatment Services
Tom Watson, PT, DPT, DAAPM	Rebound Physical Therapy

Community-Wide Safer Prescribing Standards FAQ

6) Where else are community-wide safer prescribing standards being adopted in Oregon?

- Due to the alarming rise in unintentional prescription drug overdoses and deaths in our state, several efforts have been made to adopt safer prescribing patterns:
  - Jackson and Josephine County: http://www.oregonpainguidance.com/
  - Eastern Oregon CCO
  - Multnomah County
  - National Governors Association Taskforce on Prescription Drug Abuse http://orcrm.org/wp-content/uploads/2015/02/nga-Task-Force-Report.pdf
  - All CCO's are being required by the Oregon Health Plan to conduct a new statewide performance improvement project on opioid management.

7) What is the Oregon Prescription Drug Monitoring Program and Who Can Access it?

- The Oregon Prescription Drug Monitoring Program (PDMP) is a tool to help healthcare providers and pharmacists provide patients better care in managing their prescriptions. (http://www.orpdmp.com/health-care-provider/)
- The following health care providers can access the PDMP
  - Oregon-licensed Health Care Providers (physicians, physician assistants, nurse practitioners, pharmacists, state medical examiners).
  - Designated representatives who are authorized by the licensed provider or pharmacist (registered nurses, medical assistants, community health workers, mental health professionals, chemical dependency professionals).

8) I would like to have a conversation with someone about these standards. Whom may I contact?

- Please contact Kim Swanson, Ph.D., Chair of the Pain Standards Taskforce via Rebeckah Berry, M.S., Operations & Project Manager at Central Oregon Health Council rebeckah.berry@cohealthcouncil.org, General Office Line: 541-306-3523

9) Where can I go for more information about the safer prescribing efforts taking place in Central Oregon?

- Please explore our recently launched website at: www.copainguide.org
- The website contains:
  - Tools and prescribing guidelines for providers
  - Opportunities for CME
  - A summary of useful resources from around the U.S.
  - A community entrance with basic information

DIFFICULT CONVERSATIONS

Questions to Use with Patients

Consider questions like these when evaluating patients being considered for Chronic Opioid Treatment (COT) or monitoring patients already receiving COT.

Assessment/Monitoring Questions

In the past month:

- In general, how would you say your health has been? (On a scale of poor, fair, good, very good, or excellent.)
- How much has pain interfered with your daily activities?
- Use a scale from 0 to 10, where 0 is "no interference" and 10 is "unable to do any activities."
- On average, how would you rate your pain?
- Use a scale from 0 to 10, where 0 is "no pain" and 10 is "pain as bad as could be."

Assessing Goals for Pain Management

- Other than reducing pain, what is the most important goal (or goals) you hope to achieve to improve your quality of life?
- To what extent have you reached this goal (or these goals)? (0-100%.)

Assessing Medication Effects and Expectations

- How well has the opioid pain medicine worked to relieve your pain?
- Have you been bothered by any side effects?
- How long do you expect to continue using this medicine?

Assessing Patient Problems and Concerns

Problems with Opioids	Concerns about Opioids
Have opioid pain medicines caused you to: Lose interest in your usual activities? Have trouble concentrating or remembering? Feel slowed down, sluggish, or sedated? Feel depressed, down, or anxious? Have difficulty thinking clearly? Have side effects that interfered with work, family, or social responsibilities? Be sleepy or less alert when driving, operating machinery, or doing things when you needed to be alert?	Have you been preoccupied with or thought constantly about using opioid pain medicine? Have you felt you could not control how much or how often you used the medicine? Have you needed to use a higher dose of the medicine to get the same effect? Have you worried that you might be dependent on or addicted to the medicine? Have you wanted to stop using the medicine or to cut down on the amount that you use? Has the medicine caused you to have problems with family, friends, or co-workers? Have family members or friends thought you might be dependent on or addicted to this medicine?

Source: Group Health, Chronic Opioid Therapy for Chronic Non-Cancer Pain Guideline, 2010.

Assessing Patient Psychological Well-Being

Over the last two weeks, how often have you been bothered by:

- Little interest or pleasure in doing things?
- Feeling down, depressed, or hopeless? (Not at all, several days, more than half the days, nearly every day.)

Recommendations for Approaching and/or Responding to Potentially Challenging Patient Interactions

It is understandable and predictable for patients to express concern when they are presented with the information that they may need to reduce or eliminate opioids for the treatment of their pain. Sometimes, their reactions become more desperate as the conversation persists. Consider:

Instead of feeling "responsible" for your patient's pain and suffering, do all you can do to remain "response-able" and show your patient you care about his or her health.

Common Patient Responses to the Request to Change Their Treatment Regimen

I First-line negotiations:

- "You are telling me to _____ (exercise, go to therapy, etc.), and I am telling you that without the pills I can't even get out of bed."
- "You know this means I won't be able to go to work. Is that what you want for me, to lose my job?"
- "Taking these pills is the only way I can manage to take care of my children. You do understand that you are taking their mother/father away from them?

II Second-line negotiations:

- "Are you saying you are just going to let me suffer?"
- "You have no idea how much pain I am in. You are not in my body."
- "This isn't fair. You promised you wouldn't reduce my medications, and you are going back on your word."

III Final desperation negotiations/threats:

- "Do you want me to go get drugs from the street?"
- "Well, I am just going to go to the ER."
- "I will be finding nother provider, who believes me and cares!"

Such patient reactions can be very challenging for healthcare providers to manage. This area of medicine is often highly anxiety-provoking, and providers are often not sure what is the right thing to do. It is even possible for highly confident providers to begin to second guess themselves when it comes to making decisions that patients won't like, but are in their safest and best interest.

Suggestions on How to Compassionately Manage Patients Who Are Confronting These Situations

I. Before going into the patient room

1. Pause and consider what value this challenging conversation will be in the service of: Perhaps it is related to your commitment to practice safe medicine, "Primum Non Nocere," to follow "best practices", to be in alignment with your colleagues, community, and/or practice in this area?
2. Be clear on the outcome you hope to reach. If possible, come up with at least three choices you can live with.
3. Decide if you will "hold the line" with your goal. Flexibility is valuable as long as it adheres to safety principles.
4. If the patient senses any hesitation and/or ambivalence from the provider, the patient is likely to move into "negotiation," which is lengthy and frustrating for all involved.

II. While in the room with the patient

1. Elicit patient perspective on how their chronic pain care is going.
2. Share your concerns, framed around safety (consider having a prepared and practiced, concise description of the new and safe opioid prescribing guidelines for CCNP).
3. Ask the patient to relay back understanding and clarify misconceptions.
4. Identify a shared goal, if possible, and/or agree to disagree on course of treatment.
5. Set limits/Clarify boundaries. Focus on what you are willing to do, rather than on what you refuse to do.

III. Helpful hints

1. Speak slowly and keep it simple. Brief explanations are usually preferred, at least for initial conversations. Avoid the temptation to overexplain or get into rationalizing/negotiating/arguing with the patient about anything.
2. If your intent is to take something away (e.g., a taper or remove a medication), consider what you will offer your patient. It may be as simple as, "I will continue to be your healthcare provider as you move through these changes." You may want to have some preprinted non-opioid treatment suggestions to give to the patient at the end of the visit. In particular, behavioral strategies such as CBT or peer-directed counseling can be very effective adjunctive treatments. It is common for patients to state that they have tried all such treatments to no avail and are not interested. The patient can have this response, and you can give the patient the information at the same time.
3. When a patient becomes highly emotional (angry, desperate, tearful, etc.) it is unreasonable that you will be able to talk the patient into being okay with the changes you are proposing. Be prepared to leave the visit with the patient who is not agreeing to the changes and/or continuing to be highly emotional. As the medical provider, it is your charge to make the changes in the name of safe medicine.
4. Suggest early on that no changes need to be made that day, allowing the patient to adjust to information and consider what supports they may need in order to embark upon the treatment changes.
5. It is highly recommended that you schedule a follow-up appointment before the patient leaves the office. The patient may state they plan to find another provider but it is still recommended that an appointment be set and that a member of the medical team call the patient the following day to check in on the patient and remind them of his or her follow-up appointment.

6 Don't be defensive, as it escalates emotion. Instead, make a statement about the patient's experience, e.g., "The look on your face tells me you are afraid. Is that the right emotion?"

7 Share control. It models collaboration and empowers patients to make changes. This is why offering three options is a good place to start, as it gives the patient control over which option to choose.

8 Focus on function not pain. This permits progress despite ongoing pain.

9 Although it may seem obvious, it is very helpful to state how much you care for your patient and that you have confidence in his or her capacity to make the changes being proposed (even if you don't have high confidence right now, it will increase the more you make these changes and see the resilience of your patient).

Examples of What You Might Want to Say to Your Patients

I. Deal with the patient's emotions by making the following types of statements:

Reflection: "You seem _____ (upset, anxious, fearful, scared), by what I have said."

Validation: "It is understandable that you feel _____ in regard to me not prescribing narcotics when that is the main reason you came in."

"This is a lot of information; it would be understandable if you were experiencing _____ (anger, fear, betrayal, anxiety, hopelessness). As your provider, it is important for me to practice within safe guidelines. Therefore, some treatment adjustments need to be made."

"I hear that you are in real pain and you have every right to _____ (find a new provider, go to the ER, get your Rx from the streets, neighbor, etc.). I hope that you will continue to let us care for you."

You don't have to agree to express understanding.

Support: "I'm sure it has been difficult to keep going to your provider and repeatedly have these tug-o-wars about a prescription"

"I am certain I do not want you to suffer. I care about your health a great deal. I am confident that you are capable of making the adjustments I have outlined."

Or, for example, instead of speaking, hand the crying patient a tissue.

II. Identify the Impasse

"It seems as though we have reached an impasse."

"You and I have very different views on how to best manage your pain."

"At this point, maybe we can agree to disagree. Why don't you take some time to consider the three options wehave discussed, and next week when you come in we will start with the adjustments."

III. Clarify boundaries

What you will do: "I'd like to be your provider and continue to help you with your pain, despite our disagreement."

"I certainly do not want you to _____ (stay in bed, not go to work, neglect children), and due to the safety reasons I have outlined, it is important for us move forward with treatment adjustments."

What you won't do: "Prescribing more of this medicine is something that is not in your best, long-term interest. It is something I feel uncomfortable with and cannot do."

"Unfortunately, I will not be able to _____ (raise the dose, give you a prescription, etc.). I would like you to consider the non-narcotic treatment options we discussed. I hear you have tried them in the past with no success, but I am asking you to consider trying them again."

IV. Manage your reactions

When you say "no," you may:

- Question your judgment, and if you are doing the right thing
- Feel you have failed as a provider
- Feel your behavior is unethical
- Feel mean, unsupportive, and uncaring

Consider looking at your patient's behavior through the lens of "physical dependence":

- It is normal for patients to have heightened emotional reactions, fear of the pain and other physical symptoms when they face opioid withdrawal.
- It is the role of the provider to take charge and safely guide the patient's treatment.

V. Learn to soothe yourself

Breathe. Self-talk. Talk to a colleague who shares your philosophy of pain management.

Gather strength from your core beliefs.

Let your values and core principles of practicing good and safe medicine guide your practice. This will ease your way as you embark on these challenging conversations with your patients.

Potentially Challenging Conversations

As OPG guidelines are implemented, potentially challenging patient conversations may arise.

1 Introducing the new guidelines to new and existing patients.

a "After having reviewed your medical record and gathering some further information, let me start by telling you about some of the things we can offer you (non-opioid treatments)."

b "For safety reasons, I rarely prescribe controlled substances on the first visit (or on the first appointment when a patient has a new request for controlled substances).

c "I would like to offer you some new information we have about treating complex, chronic pain with opioids. Would that be okay with you?" (If patient refuses, suggest that you do so on the next visit. Let the patient have some control over this scary situation for them.)

d. After evaluating a patient and finding some risk of opioid misuse: "Your level of risk limits our treatment choices. We still have some good options and I would like to share some of the things we can offer you for your chronic pain. Would now be a good time?"

2 Compassionate refusal of opioid prescriptions to new patients and existing patients requesting an increase in dose.

a. "Would you be interested in learning some new information about using opioids for chronic complex pain?"

b. "Due to recent information on the safety and effectiveness of using opioids for treating chronic pain, unfortunately, I am not able to offer that medication at this time."

3 The need to reduce or stop opioids (with the intent of keeping the patient in the practice):

a. "I have just shared with you a lot of information. It would be understandable if you were having a strong reaction…(pause)… can you tell me what you are the most concerned about right now?" (You may be surprised by the answer: Don't assume you know.)

b. "It has come to my attention that these medications (or these doses of medications) are not a safe choice for you at this time. Would this be a good time to discuss ways we could work together to begin reducing your dose safely?"

Further Resources

Below are links to websites that offer ideas on how to effectively talk to your patients on this topic:

www.scopeofpain.com/tolls-resources

www.agencymeddirectors.wa.gov/guidelines.asp

www.cdc.gov/primarycare/materials/opioidabuse/index.html

www.supportprop.org/index.html