2025 Early Career Scholar Program

An Intensive Multi-day Opioid REMS Initiative in Pain Management

CME OUTFITTERS

This activity is supported by an independent educational grant from the Opioid Analgesic REMS Program Companies.

Please see https://www.opioidanalgesicrems.com/Resources/Docs/List_of_RPC_Companies.pdf for a listing of REMS Program Companies. This activity is intended to be fully compliant with the Opioid Analgesic REMS education requirements issued by the U.S. Food and Drug Administration (FDA).

Difficult Conversations

Opioid-Related Counseling in Chronic Pain

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Learning Objective

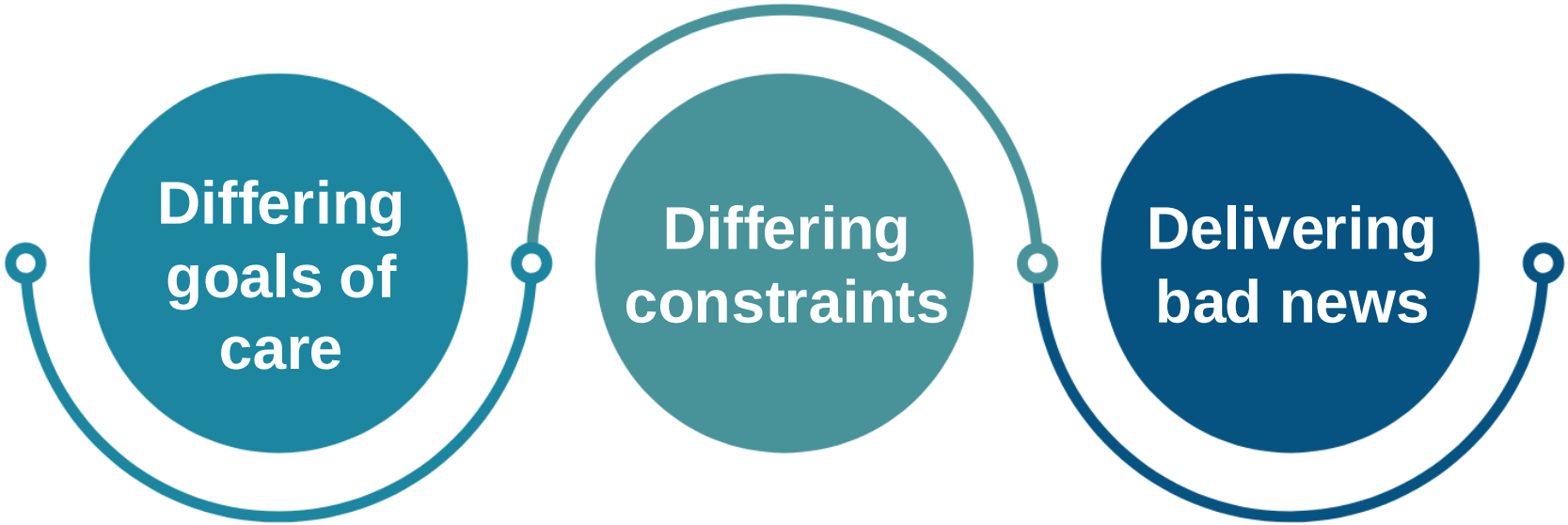
- Utilize best practices in discussing potential opioid use disorder (OUD) diagnosis and treatment with patients

Practical Goals

Learn how to:

- Be compassionate but firm in difficult patient conversations
- Apply the Columbia-Suicide Severity Rating Scale to a patient to help guide clinical decision making
- Describe morphine equivalents, respiratory depression, and other hard-to-explain side effects/concepts to patients in digestible components
- Respond to common but challenging opioid-related patient care scenarios

Why are Difficult Conversations Difficult?



Prober CG, et al. *Acad Med*. 2022;97(7):973-976.

So, How Do We Address?

Step 1

- Align goals of care

Step 2

- Address constraints directly

Step 3

- Provide good news/hope

Prober CG, et al. *Acad Med*. 2022;97(7):973-976.

Audience Poll

Have you found an effective way to approach conversations about opioid use or misuse with your patients?

A. Yes
B. No
C. Maybe, I think it could be better
D. Each patient is different, I can't find a standard way to approach this

Core Principles of Prescribing

You're Not a Lackey

Your opinion is from experience – it matters.

Don't get bullied… by patients or any entities!

Patient Safety First

Best interest to start, continue, or taper opioids?

Frame your answers in this context

Risks versus Benefits

Every choice we make is a risk-benefit analysis.

Explain this calculation clearly to the patient

Wyse JJ, et al. *J Gen Intern Med*. 2019;34(7):1200-1206.

Things to Say – A Translation of these Core Principles

"In my professional medical opinion, this isn't a good idea because of X, Y, and Z."

"There's a drug-drug interaction between the alcohol you're drinking and these pain meds."

"I hear you, Mr. Jones. I want to help treat your pain and improve your quality of life, but your safety always comes first."

"All of these treatments have risks and benefits, and I'm not sure this lands on the favorable side of that. Remember that there are all kinds of treatment for pain, and they usually all help a little bit. Let's discuss some other options."

Things NOT to Say

"The hospital/government says that we can't prescribe these medications anymore."

→ **UNTRUTH**

"Prescribing these medications is a bad idea."

→ **NON-SPECIFIC**

"Your urine drug screen didn't match what I prescribed. Unfortunately, I can't care for you any longer."

→ **ABANDONMENT**

Tobin DG, et al. *J Gen Intern Med*. 2021;36(3):790-791.

So, HOW Do We Explain Complicated Topics?

Respiratory depression

"The normal human respiratory rate is 12–20 breaths per minute, and opioids tell your brain to breathe a fewer number of times. If you take too much, this is what could happen."

Morphine equivalents

"We compare all of the opioids to morphine to determine how strong they are relative to each other, and the total gives us some idea of how much you're taking every day."

Where do opioids work?

"Opioids work primarily on changing the way your brain experiences pain and not on your back, or your knee, or your shoulder. They don't really treat the source of the pain."

Side effects

"Although they are helpful, opioids can actually affect your mood, your libido, and even your immune system. There's some evidence that opioids may contribute to cancer risk as well."

Oh TK, Song IA. *Epidemiol Biomarkers Prev*. 2020;29(10):1962-1967. Benyamin R, et al. *Pain Physician.* 2008;11(2 Suppl):S105-S120. Dowell D, et al. *MMWR Recomm Rep*. 2022;71(3):1-95.

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Case #1:
The inappropriate UDS

UDS = urine drug screen

Case #1

How it started:

Patient's urine drug screen is negative for prescribed opioids – for the second time!

How it's going:

Patient states, "I need more medicine, so I take more than you give me"

What to expect:

Some pushback…

So, what do I do/say?

Be curious:
Ask what happened instead of accusing

Alternative treatments:
Continue to treat with other strategies

Opioid rotation:
Maybe it's this particular opioid that's not helpful?

Schuster M, et al. *Dtsch Arztebl Int*. 2018;115(9):135-142. Krebs EE. *Safer Management of Opioids for Chronic Pain: Principles and Language Suggestions for Talking with Patients.* https://depts.washington.edu/fammed/sixbuildingblocks/wp-content/uploads/sites/12/2018/02/Principles-and-language-suggestions-for-talking-with-patients.pdf.

Case #2:
The depressed/suicidal patient

Case #2

How it started:

New patient is requesting opioids for knee pain – not a good candidate

How it's going:

Patient states, "If you don't prescribe this, I'll kill myself"

What to expect:

Active vs. passive suicidality

Posner K, et al. *Am J Psychiatry*. 2011;168(12):1266-1277.

So, what do I do/say?

Learn more:
"Tell me more about what you just said"

Alternative treatments:
"I really want to help you, but need to do it safely"

Enlist help:
Mental health professional, family member

Wyse JJ, et al. *J Gen Intern Med*. 2019;34(7):1200-1206. Krebs EE. *Safer Management of Opioids for Chronic Pain: Principles and Language Suggestions for Talking with Patients.* https://depts.washington.edu/fammed/sixbuildingblocks/wp-content/uploads/sites/12/2018/02/Principles-and-language-suggestions-for-talking-with-patients.pdf.

Suicidality Scale

Step 1

- Assess active vs. passive

Step 2

- You MUST take active suicidality seriously

Step 3

- Provide resources for patient based on responses

U.S. Veteran Affairs/Dept. of Defense [VA/DOD]. *Clinical Practice Guideline for the Assessment and Management of Patients at Risk for Suicide.* 2014. https://www.healthquality.va.gov/guidelines/MH/srb/VASuicidePreventionPocketGuidePRINT508FINAL.pdf. Columbia Lighthouse Project. 2016. https://cssrs.columbia.edu/the-columbia-scale-c-ssrs/about-the-scale/.

Columbia Suicide Severity Rating Scale

Questions	Past Month	
1. Have you wished you were dead or wished you could go to sleep and not wake up?	Yes	No
2. Have you actually had any thoughts about killing yourself?	Yes	No
If **YES** to 2: Ask questions 3, 4, 5, 6 If **NO** to 2: Go directly to question 6		
3. Have you thought about how you might do this?	Yes	No
4. Have you had any intention of acting on these thoughts of killing yourself (as opposed to having the thoughts but definitely would not act on them)	Yes	No
5. Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?	Yes	No
Always ask question 6	**Lifetime**	**Past 3 months**
6. Have you done anything, started to do anything, or prepared to do anything to end your life? (*Examples: collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, held a gun but changed your mind, cut yourself, tried to hang yourself, etc.)* If **YES**, ask if this occurred within the past 3 months	Yes	Yes

Low risk **Moderate risk** **High risk**

Columbia Lighthouse Project. 2016. https://cssrs.columbia.edu/the-columbia-scale-c-ssrs/about-the-scale/.

When the situation goes awry:

Chaperone patient:

Keep them in your sight

Call for help:

5150 or psych hotline

AMA support:

Call police to do a wellness check on patient at home (if all else fails)

Mann JJ, et al. *Am J Psychiatry*. 2021;178(7):611-624. VA/DOD. *Clinical Practice Guideline for the Assessment and Management of Patients at Risk for Suicide*. 2014. https://www.healthquality.va.gov/guidelines/MH/srb/VASuicidePreventionPocketGuidePRINT508FINAL.pdf

Case #3:
Despite lack of efficacy, patient is resistant to tapering opioids

Case #3

How it started:

54 y/o patient with PTSD is prescribed oxycodone 15 mg four times per day x 20 years; pain level goes from 8/10 to 6/10, function not improved

How it's going:

Patient states, "It takes the edge off, and it helps me – please don't stop it!"

What to expect:

Opioids may actually be treating the PTSD symptoms

PTSD = post-traumatic stress disorder

So, what do I do/say?

Be flexible:

Slow taper (often over months/years), pause if necessary

Alternative treatments:

- Treat the pain
  - Stellate?

Motivational interviewing:

What are the downsides of using opioids for the patient?

Hah JM, et al. *EClinicalMedicine*. 2020;28:100596. Sullivan MD, et al. *J Gen Intern Med*. 2020;35(3):687-695.

Why Taper?

Lack of improvement in function

"Mr. Brown, you're saying that the hydrocodone 10 mg pill four times daily reduces your pain from 7/10 to 6/10, and you're still in too much pain to leave the house. It's not clear that the benefits outweigh the risks here."

Side effects

"Mrs. Smith, these high-dose opioid medications you're on are probably contributing a lot to that constipation, and maybe even your depression. Let's think about where to go from here to address your pain."

Concern for non-medical use/SUD

"Mrs. Johnson, we got your urine drug screen back, and it was positive for cocaine and negative for your prescribed medications. Can you explain this result to me?"

SUD = substance use disorder

So, HOW Do We Explain the Taper?

Patient should show negative aspects

"Mr. Michaels, I get that you think this hydrocodone is helping you. Has it caused any problems for you, whether in getting it at the doctor's office, or at the pharmacy, or with family?

Set clear, incremental goals

"I think we need to see if your pain changes after decreasing by one pill per day. I strongly suspect that it won't."

Be compassionate but firm

"Mr. Michaels, it would be irresponsible and unethical for me to continue this same treatment that is obviously only giving very temporary relief and not really helping you. It's time for us to make a change."

Summarize

"Over the next year, we are going to decrease the hydrocodone and set up some more PT and injections. This road may not be easy, but better days are ahead."

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SMART Goals

Specific, Measurable, Attainable, Relevant, Timely

Put information into action! Consider the following goals; then *set a time frame* that fits with your work environment and *a reasonable improvement target* that aligns with your patient population.

- Approach all patient conversations with a “safety first” mentality
- Set clear, incremental goals with the patient when discussing your opioid tapering plan

For more difficult conversations

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