BOOTS ON THE GROUND

CRUCIAL CONVERSATIONS RELATED TO MEDICATION TAPERING

YOUR SPEAKER

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DISCLOSURES

I am crazy about my granddaughter. Otherwise, I have no disclosures.

THE ART OF THE DIFFICULT CONVERSATION

ALWAYS

- Center around the patient
- Take responsibility
- Be kind and patient
- Be direct and honest

NEVER

- Center around anyone else
- Blame anyone else
- Get emotional
- Dance around the topic

OH, THOSE PILLS!

OPIOIDS

- Most recent recommendations are to avoid except for the most extreme circumstances
- Less is best, shorter duration is best
- Not indicated for chronic non-cancer pain

BENZODIAZEPINES

- Not intended for more than 1-2 weeks of therapy
- Effectiveness goes away
- Alters brain chemistry
- Lends itself to refractory anxiety

SOME FUNDAMENTAL CONCEPTS

- Your patients did not prescribe opioids and benzodiazepines to themselves
- Someone told them that they NEED these medications
- Maybe YOU told them that they need this medication
- Pain and Anxiety = Fear
- The threat of MORE pain and Anxiety = MORE fear

HOW TO BREAK THE NEWS…

- The decision to taper has been made, what next?
- Before you speak with the patient, know your rationale and be confident
- Meet your patient face to face to discuss their medications
- Have a plan figure out to the best of your ability, but be flexible
- The more you do this, the better you will get!

THE CONVERSATION

- Frame the ENTIRE conversation around the patient and their SAFETY
- Do not frame the conversation around other things like, "I am not comfortable…" or "the law says…" or "there is a heroin epidemic…"
- Be reassuring, "I will walk beside you." "I will work with you to treat your pain in other ways."
- Acknowledge that tapering can be difficult work

THE CONVERSATIONS

- Reframe the purpose of their opioid medication during the taper
  - "You no longer take Percocet for pain, you are taking it to avoid being sick while we get you off this medication"
- Normalize and anticipate sensations and difficulties that the patient may have
  - "Many people feel anxious, have trouble sleeping, feel achy. These things are normal and will regulate in time."

DEVELOPING A TAPER PLAN

- There are tapering calculators, meh…
- Develop a plan that you think your patient can handle, but something that will not stagnate
- Think of it in percentages
- 10% cut of original dose is reasonable
- Weekly decreases are reasonable
- My style is usually no faster than every TWO weeks and less than 10%

DEVELOPING A TAPER PLAN

- Look back to why you are tapering
- If it's related to contract issues or a safety emergency, choose a more rapid taper
- If it's related to the long-term health of a patient who is not having difficulty, you may wish to take more time
- It can be like ripping off a bandage and the patient may want to just get things over with

DEVELOPING A TAPER PLAN

- It's great if you have a taper plan all written out with dates and doses at the time of the visit
- However, it's ok to tell a patient that you need to write it all down "I want to get it right and take time to concentrate" and mail it to them
- Before the patient leaves you, be sure that they know what the dose will be for their NEXT prescription, no surprises

THE CAST OF CHARACTERS

- The Negotiator
- The Sad Face
- The Angry Bird
- The Eager Beavers
- The Inheritance

THE NEGOTIATOR

THE NEGOTIATOR

- There are patients who will think of every reason they need to stay on opioids
- Some will tell you they don't care if they die
- Some will tell you that they will start buying opioids on the street
- Some will tell you that they will start drinking again
- Some will offer veiled or overt threat of suicide
- "I care about you and do not want to see you harmed." "We do not treat suicidal thoughts with opioids."

THE SAD FACE


Crabby Road
8-1-12
If you're happy and you know it, thank your meds!
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THE SAD FACE

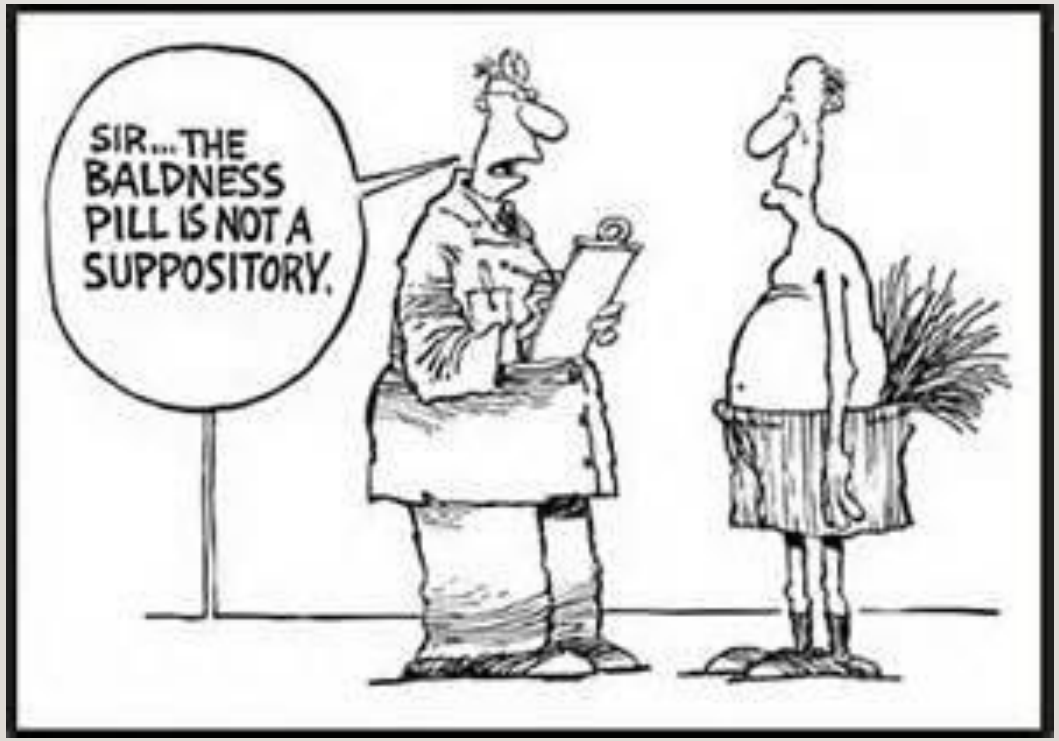
- This can feel like a breech of trust to the patient
- Some patients feel that they are being punished
- It's a betrayal of sorts
- There could be tears
- Disbelief
- They think that you might not understand just how much they hurt
- "I care about you and I will help you find sustainable ways to help you manage your pain."

THE ANGRY BIRD

THE ANGRY BIRD

- Again, some feel betrayed and may get angry at you for this clinical decision
- Agree that it's ok for a provider and patient to disagree on a clinical decision, but both the patient and prescriber should agree to be respectful
- Remind the patient that the decision is made to improve medication safety
- Do NOT take the anger personally
- Offer reassurance again and again!

THE EAGER BEAVERS



THE EAGER BEAVERS

- Surprisingly, some patients are happy to think about being free from opioids
- I have a patient who refers to controlled substances as "chemical cuffs"
- They are excited
- Caution them to not get too far ahead of the taper or they may unintentionally sabotage their own efforts
- Opioid withdrawal is uncomfortable, but not life threatening
- Benzo withdrawal can be life threatening

THE INHERITANCE

THE INHERITANCE

- These patients may have abandonment issues
- These patients may have hero worship for their previous provider
- DO NOT just continue with someone else's plan as a matter of routine
- Explain to patients that you will be different than their previous provider and that you plan to help them through their changes
- "I think you doctor was an awesome provider, we just do things differently." "I don't think that this medication is helping you as much as we would like for something so high risk."

UNEXPECTED THINGS WHILE TAPERING

- NO early refills
- If a patient is going to go without opioids for a few days and will withdraw…
- DO NOT REFILL in order to just continue the taper
- Provide comfort medications
- If the patient will withdraw from benzodiazepines, they may need inpatient detox
- You can also shorten the # of pills that they get and they would have to fill every couple of days

COMFORT MEDICATIONS

- Clonidine 0.1 mg TID (helps with benzo w/d too)
- Promethazine 25 mg 3-4 times a day OR hydroxyzine 50-100 mg 3-4 times a day OR diphenhydramine 25-50 mg 3-4 times a day for N/V
- Loperamide 4 mg first dose, then 2 mg after every loose stool (NTE 16 mg/24 hours)
- Cyclobenzaprine 5 mg TID for aching
- Trazodone 50 mg QHS for sleeping
- Ibuprofen 200 mg + acetaminophen 500 mg 3-4 times a day for aching
- Sometimes I use gabapentin for restless legs

THE UNEXPECTED

- Sometimes patients wish to pause their taper for a month
- “I have had a hard time”
- Sometimes it is humane to pause for a month, but be very careful about repeated requests – make sure that you communicate the intention to restart the taper
- Also, remember that we don’t use opioids to treat stress, grief, and bad weather
- There are times when the provider must gather some tough love

THE UNEXPECTED – REVERSAL REQUESTS

- Never reverse a taper
- This is like letting your grounded teenager go to a movie
- Pause is appropriate
- If there is an acute injury, treat that independently while pausing the taper
- Once healing has happened, stop the acute medications and resume the taper
- "I know that this is difficult for you, how about you come in and we can have a conversation about other ways to help you."

WORDS FROM EXPERIENCE

- The majority of your patients will do just as well
- The pain generally regulates to exactly what it was when the patient was on opioids
- Sometimes … the pain is BETTER
- “I thought I had Alzheimer’s, turns out I was just medicated.”
- “I thought you were crazy when you said that we should stop my pain medications. Now I am so much better!”
- Function generally improves. Sometimes you have to draw this out of people.

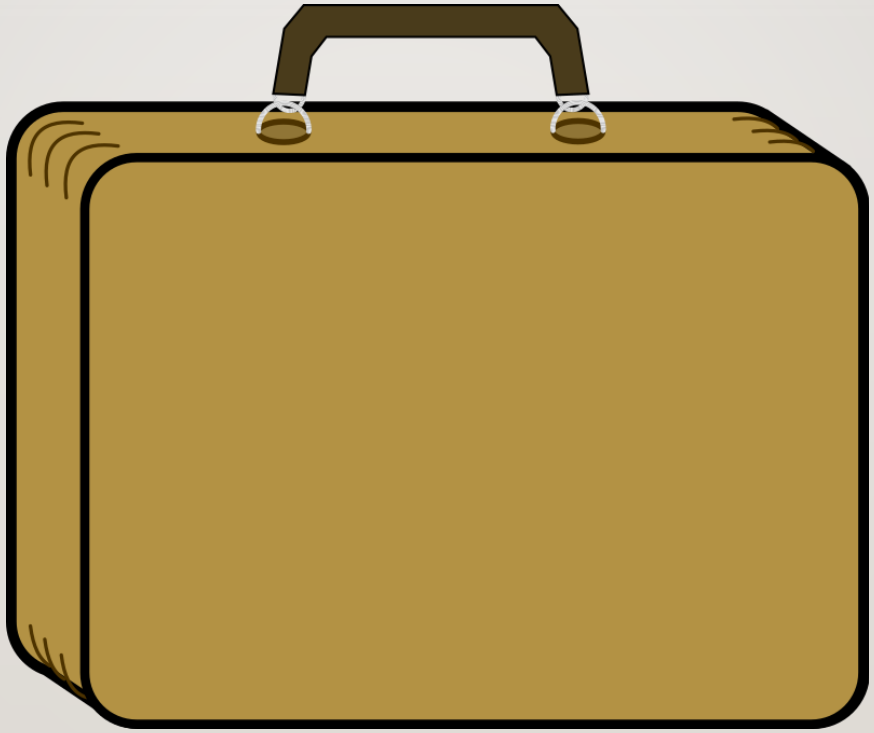
WORDS FORM EXPERIENCE

- Work to gather a team around the patient
- Be sure that treatments are exhausted
- Work with your patient in the spirit of "lifestyle medicine."
- Anti-inflammatory diet, yoga, exercise, weight loss, stop smoking (***!!!***)
- Cognitive behavioral therapy, biofeedback, acupuncture, counseling, massage, chiro, OMT, PT.
- Pills DO NOT equal compassion

GOALS

- Maintain or gain function
- Improve health and prognosis
- Restore the spirit, the personality, the relationships if possible
- Teach your patient to find things that bring them joy

CASE STUDIES



52 YEAR OLD FEMALE PATIENT

- Rheumatoid arthritis (in remission)
- Obesity
- Anxiety and Depression
- Type II diabetes
- Cervical radiculopathy r/t cervical stenosis
- Apnea
- Asthma

MEDICATIONS

Flexeril	Potassium	Clonidine
Fluconazole	Atenolol	Atorvastatin
Lisinopril	HCTZ	Omeprazole
CPAP	Diclofenac gel	Albuterol
Insulin	Oxycodone	Clonazepam

DOSES OF THE CS

- Oxycodone 10 mg x 6 daily
  - Prescribed for body pain related to RA
- Clonazepam 1 mg x 4 daily
  - Prescribed for anxiety

THE PATIENT

- Chronically ill with a difficult home life
- 2 kids in college and a controlling husband
- She has been trying to lose weight and has been somewhat successful
- She has a very reactive personality
- She is a legacy patient and seeing you for the first time. She is accompanied by her husband who does much of the talking.

WHAT DO YOU DO AT HER FIRST APPOINTMENT?

36 YEAR OLD MALE PATIENT

- A veteran who was in a MVA and sustained a back injury
- His pain is in his low back and right leg
- He is status post lumbar laminectomy
- He also has a primary care provider at the VA, but they will not prescribe his pain medications and is asking for help
- He has recently moved to your area from Florida

CURRENT DIAGNOSES

- Lumbar radiculopathy
- PTSD
- Insomnia

CURRENT MEDICATIONS

- Methadone 10 mg tablets, 4 tablets 3 times a day
- Ambien 20 mg QHS
- Alprazolam 2 mg BID

THE PATIENT

- He walks into your office and is limping
- He jumps away from light touch when you try to examine him
- He seems to lose track of the conversation
- He tells you that his pain is a “twelve” on a 10-point scale
- He tells you that he has not slept for 3 nights
- He has a wife and a 3-year-old at home
- He is not working

WHAT WILL YOU DO FOR THIS PATIENT?

- What is your approach to his care?
- BTW, 120 mg of methadone is 1,440 MME

IN CLOSING

- Once you start having these conversations with patients, you will get BETTER at it!
- It feels scary because you will have some patients who are articulate and will make you question your clinical decisions
- However, once you have a few successes under your belt, you will want to help more patients

THANK YOU!

- For your kind attention
- I hope you found this helpful!