Crucial Conversations

Surrounding controlled medications and substance use disorders

Your Speaker

Eva Quirion NP, PhD

Pain and Recovery Care

St. Joseph Internal Medicine

900 Broadway, Building #5

Bangor, ME 04401

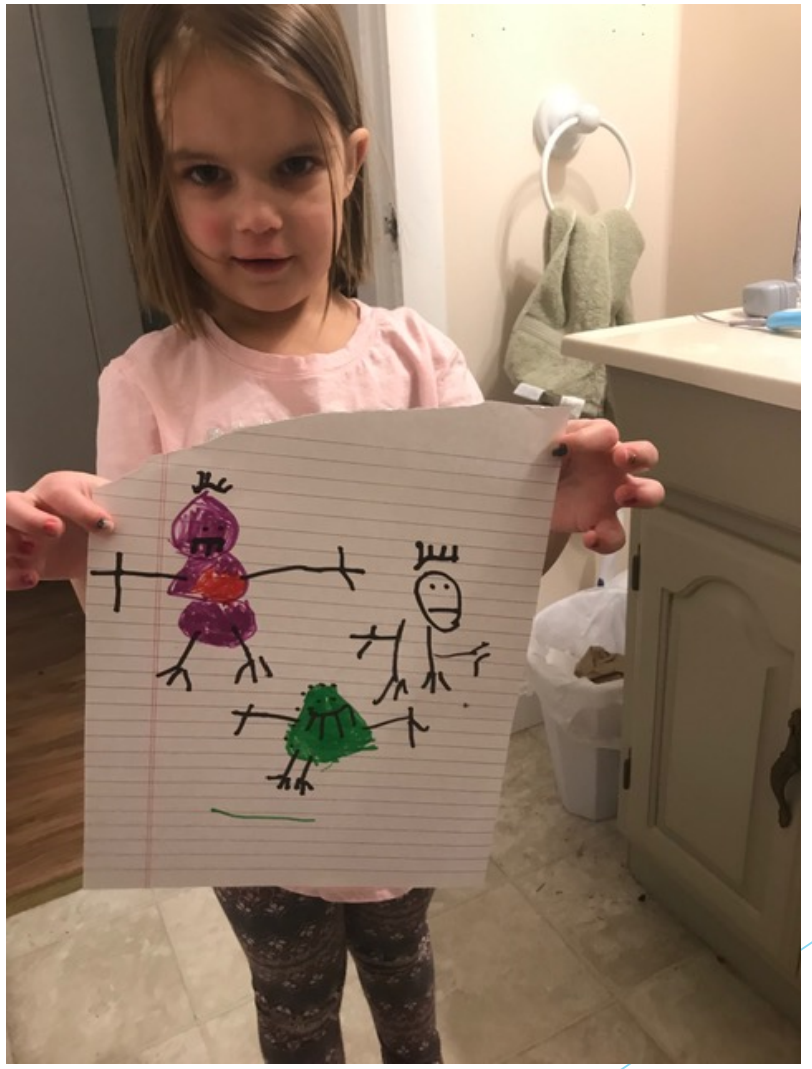
207-907-3300

Eva.Quirion@sjhhealth.com

Disclosures

- Eva Quirion NP, PhD

I am crazy about my granddaughter!



The art of the difficult conversation

ALWAYS

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

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 patient 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 figured 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 an epidemic…”
- Be reassuring, “I will walk beside you.” “I will work with you to treat your pain/anxiety in other ways.”
- Acknowledge that tapering can be difficult work

The conversation

- 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.”

Communication and Listening

- Empathy in listening
- Eye contact
- Active listening
- In order to do this, the provider becomes open to changes

VULNERABILITY CAN BE UNCOMFORTABLE!

Consider the book: "If I understood you, would I have this look on my face?" by Alan Alda

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
- A 10% cut of the 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

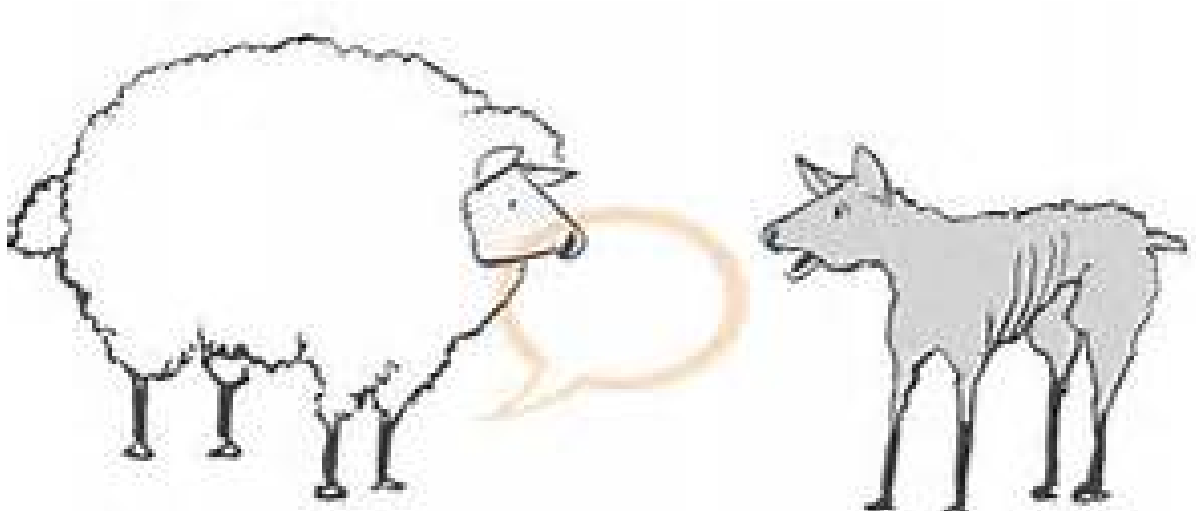
Developing a taper plan

- 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 down “I want to get it right and need 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
  - Surprises frequently become a tug-of-war with support staff

The cast of characters

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

The Negotiator



"The negotiations did not go well."

The Negotiator

- There are patients who will think of every reason they need to stay on the medication being tapered
- 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
  - This is called non-reassuring behavior
- "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

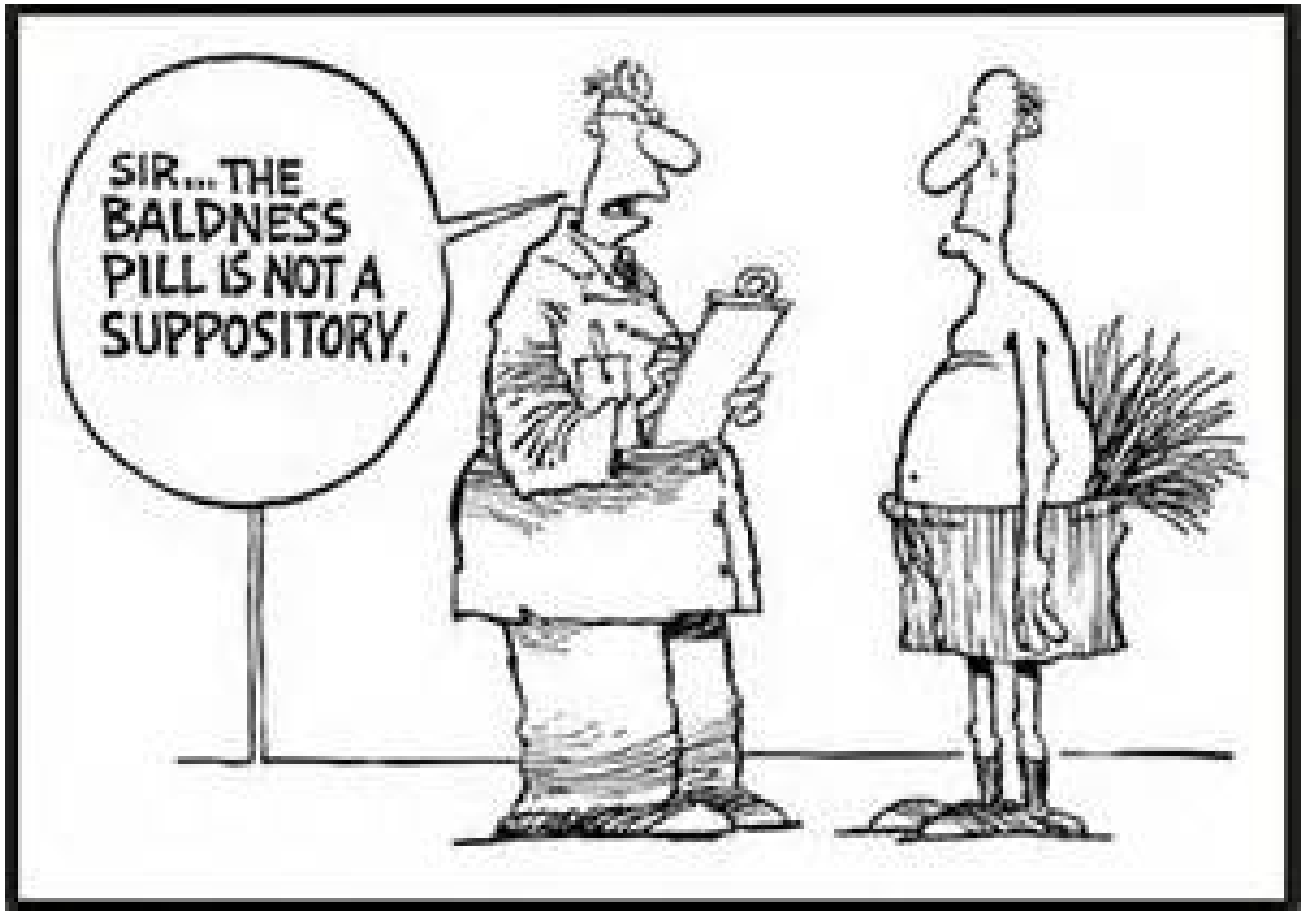
- This can feel like a breech of trust to the patient
- Some patients feel that they are being punished, “I have done everything you told me to do.”
- It’s a betrayal of sorts, “I thought you were different. I thought I could trust you.”
- There could be tears
- Disbelief
- They think that you might not understand just how much they hurt. “But I have BULGING disks!”
- “I care about you and I will help you find sustainable ways to help you manage your pain(anxiety).” “I don’t want to put you on any medications that I might have to take away from you as you get older.”

The Angry Bird

The Angry Bird

- Again, some feel betrayed and may get angry at your for this clinical decision
- Agree that it's OK for a provider and patient to disagree on a clinical decision, but both the patient should agree to be respectful
- Remind the patient that the decision is made to improve medication safety
- Do NOT take the anger personally
- If you encounter abusive behavior, redirection and defusing is best. "It's OK for you to be angry, but you do not have permission to yell at staff."
- Offer reassurance again and again! Be very direct and speak plainly. This personal probably has a history of being traumatized.

The Eager Beavers



The Eager Beavers

- Surprisingly, some patients are happy to think about being free from controlled medications
- 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 changes
- "I think your doctor/NP/PA 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." "I am sure that all your providers have treated you with the desire to help."

Rules of the Road

- 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

Withdrawal Symptoms-Abrupt Stopping

Opioids

- Abdominal cramping, nausea, vomiting, diarrhea
- Body Aches, muscle spasms
- Lack of appetite
- Yawning
- Runny eyes, runny nose
- Irritability
- Dysphoria
- Goose bumps
- Sweating
- Tachycardia

Benzodiazepines

- Rebound anxiety
- Rebound insomnia
- Headache
- Nausea
- Joint and muscle pain
- Seizure
- Psychosis
- Hallucinations
- Jitters

Benzodiazepine Withdrawal, 2 cases

- Here are two actual cases of benzo withdrawal
- One person was an eager beaver and refused to back on benzos
- The other patient over used and would not have been able to follow instructions to taper
- I have NO inpatient detox facility in someone who has not actually had a seizure
- Neither patient had seized when I saw them
- Treated with 0.1 mg clonidine TID PRN + 300 mg gabapentin TID PRN
- Both did very well and are still off benzodiazepines

Comfort Medications of Opioid W/D

- Clonidine 0.1 mg TID (opioids and benzos). Be sure that BP is robust enough for this.
- 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 (opioids and benzos only if GI issues are present)
- Loperamide 4 mg first dose, then 2 mg after every loose stool (NTE 16mg/24 hours) (opioids only)
- Cyclobenzaprine 5 mg TID for aching (opioids only)
- Trazodone 50 mg QHS for sleeping (opioids usually, but may use for benzos if the person cannot sleep)
- Ibuprofen 200 mg + acetaminophen 500 mg 3-4 times a day for aching (opioids only)
- Sometimes I use gabapentin to restless legs and almost always to benzo withdrawal

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
- Anxiety is not an indication for long term benzodiazepines
- There are times when the provider must gather some tough love

Reversal Requests

- **NEVER** reverse a taper
- This is like letting your grounded teenager go to a movie
- Pause if 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?”

Tidbits

- The majority of your patients will do just as well
- Their pain and anxiety generally regulates to exactly what it was when the patient was on controlled medications
- Much of the time … they do 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!”
- “I didn’t realize how benzos made me irritable.”
- Function generally improves. Sometimes you have to draw this out of people.

Tidbits

- 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** = compassion

Goals of Care

- 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

OK, but my patient is a MESS!

- What happens when a patient is having issues with non-reassuring behavior as you taper them?
  - Calls for early refills, running out of medications, agreement issues, etc.
- Perhaps they have a substance use disorder
- Experts disagree in the literature, but about 35% of people on chronic opioids do develop a substance use disorder
- In my work, I have found that it seems about a 50/50 (purely anecdotal and observational)
- Why do you think that is? What types of patients are on chronic opioids and chronic benzodiazepines?
  - There tends to be ADVERSE selection for patients on controlled substances
  - Think about lifetime trauma

DSM-5 Criteria for Opioid use Disorder (OUD)

A problematic pattern of opioid use leading to clinically significant impairment or distress, as manifested by **at least two** of the following, occurring within a 12-month period:

1. Opioids are often taken in larger amounts or over a longer period than was intended.
2. There is a persistent desire or unsuccessful efforts to cut down or control opioid use.
3. A great deal of time is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects.
4. Craving, or a strong desire or urge to use opioids.
5. Recurrent opioid use resulting in a failure to fulfill major role obligations at work, school, or home.

DSM-5 Criteria for OUD

6. Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids.
7. Important social, occupational, or recreational activities are given up or reduced because of opioid use.
8. Recurrent opioid use in situations in which it is physically hazardous.
9. Continued opioid use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.
10. Tolerance, as defined by either of the following:
    a. A need for markedly increased amounts of opioids to achieve intoxication or desired effect
    b. A markedly diminished effect with continued use of the same amount of an opioid

    (Note: this criterion is not considered to be met for those taking opioids solely under appropriate medical supervision.)

DSM-5 Criteria for OUD

11. Withdrawal, as manifested by either of the following:
    a. The characteristic opioid withdrawal syndrome.
    b. Opioids (or a closely related substance) are taken to relieve or avoid withdrawal symptoms.

    (Note: this criterion is not considered to be met for those taking opioids solely under appropriate medical supervision.)

Specifiers

- In early remission
- In sustained remission
- On maintenance therapy
- In a controlled environment
- Mild: Presence of 2-3 symptoms
- Moderate: Presence of 4-5 symptoms
- Severe: Greater than 6 symptoms

Let’s Talk About Treatment

- Opioid use disorder is something that can be APPROPIATELY treated by primary care providers
- Like any other disease, providers must learn and do (sometimes simultaneously)
- What is MAT?
  - Medication Assisted Therapy or Treatment

A Mini History Lesson on MAT

- Methadone invented in 1937 by Germans during a morphine shortage
- Heroin came into large American cities starting in the 1950's
- Methadone was used to detox heroin addicted patients over 7-10 days, but there was a 90% relapse rate
- In early 1960's researchers at the Rockefeller Foundation developed methadone dosing protocols and suggested that NYC establish treatment programs
- 1970's saw the first methadone clinics

Isn’t MAT just replacing one addiction with another?

- MAT reduces and/or eliminates the use of heroin and reduces death rates and crime associated with heroin use
- Patients improve their health and social productivity
- Decreased cravings and withdrawal
- Less HIV and hepatitis infections
- Better pregnancy outcomes
- Remember, there is a 90% relapse rate without medication at least in the earlier stages of recovery
- Some people will be on MAT forever
- Some people will eventually get off MAT
- Compare this to diabetes – some people get off insulin, some do not!

A little more history

- Sublingual buprenorphine/naloxone became approved in 2002 to treat SUD
- CARA act in 2016 allowing the ADDITION of NPs and PAs to provide SUD treatment to patients in the primary care setting
- Providers need a special DEA number (called an X-waiver) in order to prescribe buprenorphine to treat SUD
- Physicians require an 8 hour training course and NPs/Pas require a 24 hour training course.

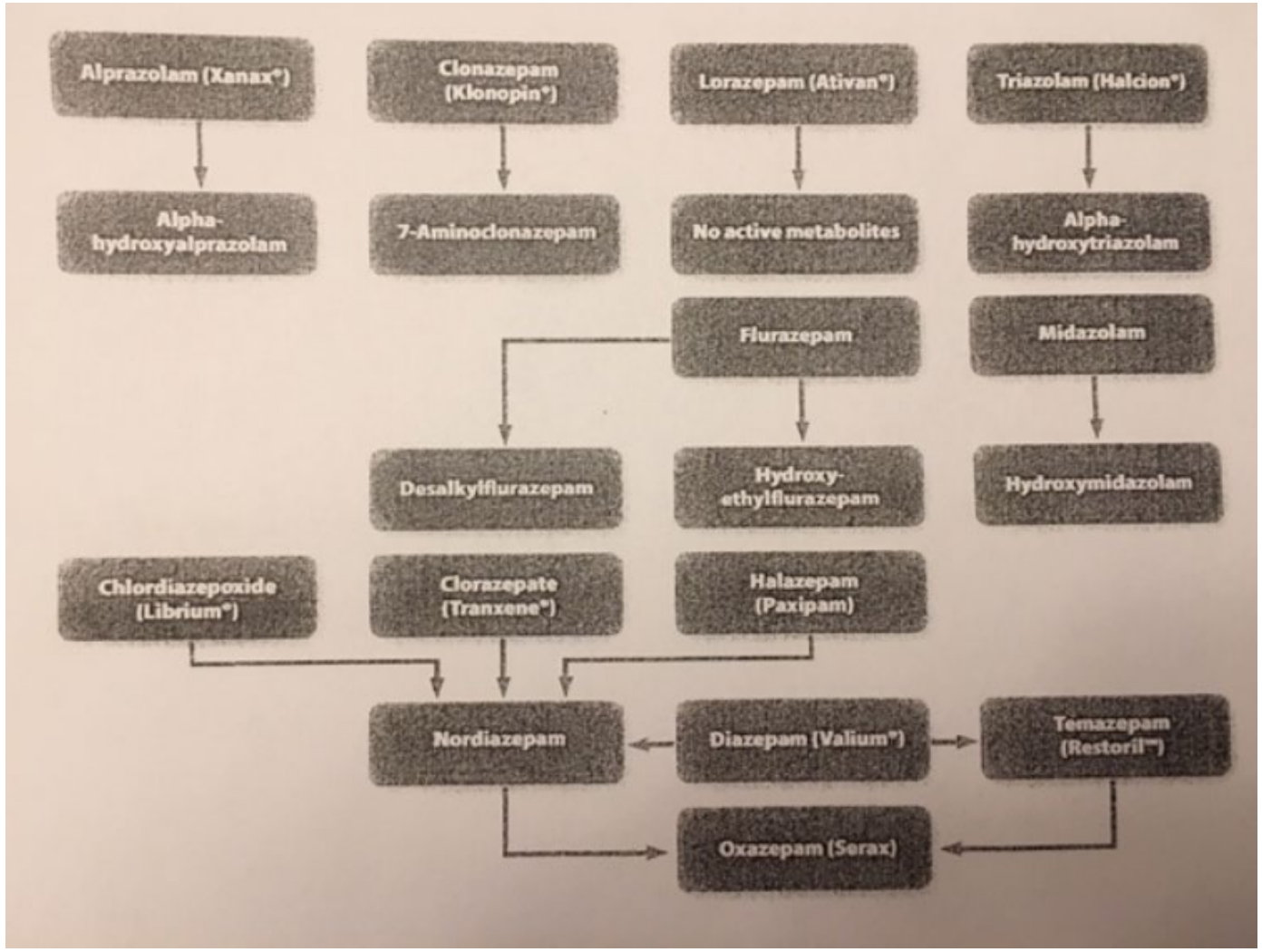
The Ingredients of Treatment

- I dream of the day that primary care providers assess for, diagnose and treat substance use disorders as a matter of routine
- Trust me, you already have patients you care for who have substance use disorders, you just might not know that you do
- Treating patients who have opioid use disorder is some of the most difficult and most satisfying work I have ever done
- Most of the time, this is really fun to see people get BETTER

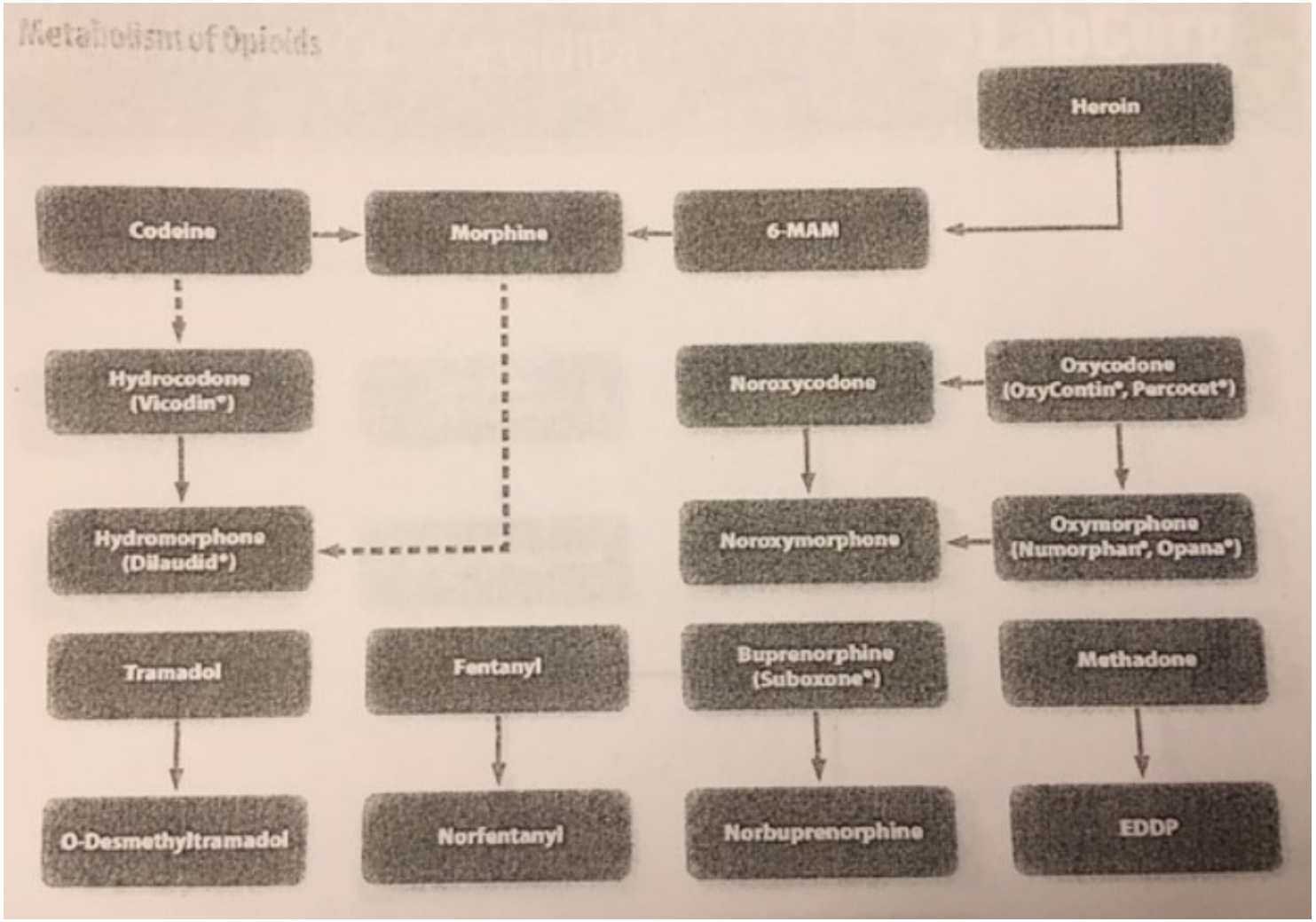
What do you Need

- X-Waiver training
  - Courses offered through ASAM web site
  - For NP's, the AANP has a free course
  - Apply to the DEA for your number (30 max to start, then 100, then 275)
- Trained support staff
  - Must do urine screens
  - Need staff who can set boundaries with patients
  - Need to coach patients to be ready for treatment
- Access to behavioral health
  - Integrated or community
- Recovery community with peer supports
  - Help with housing, food, employment, paper work, insurance

Urine Screening



Urine Screening



Perceived and Actual Barriers to Being a MAT provider

- I don’t want to bring a lot of “those people” into my office
- Time for training
- Properly trained staff
- This does not interest me

Tapering Math Problem #1

- 10 mg methadone tablets, 20 mg tid
- 10 mg oxycodoe tablets, up to 6 per day

Tapering Math Problem #2

- 40 mg Oxycontin TID
- 10 mg oxycodone TID

Tapering Math Problem #3

- Percocet 10/325 1-2 tabs tid prn
- (Patient is taking 6 tabs a day on a schedule)

Tapering Math Problem #4

- Percocet 10/325 1-2 tabs tid prn (patient is taking this scheduled)
- Xanax 1 mg tid prn (patient taking scheduled)

Tapering Math Problem #5

- Percocet 10/325 1-2 tabs tid prn (patient taking scheduled)
- Xanax 1 mg tid prn (patient taking scheduled)
- Ambien 10 mg QHS
- Ritalin 20 mg tid

Conversations #1

67 yo female patient presents to you for the FIRST visit and she is on 10 mg oxycodone, taking 6 per day. She is also on 10 mg Ambien every night and takes 1 mg clonazepam twice a day.

She comes to you concerned about fatigue and memory problems. She is transferring to you from a very respected physician who recently retired.

The oxycodone was prescribed to her for a knee replacement she had 6 years ago. She lives alone but her daughter lives nearby. She drives herself to her appointments and is independent.

She was in the ED last year due to a fall.

Conversations #2

38 yo female patient with fibromyalgia.

Taking Tramadol 100 mg, 4 times a day.

She comes to you for a flare up in her pain and she cannot sleep.

You find out her 16-year-old daughter is pregnant.

Conversation #3

55 yo male patient. Works in construction. Taking Oxycontin 60 mg tid and oxycodone 10 mg tid. He operates heavy equipment.

Says that he “ruined my back” by working construction.

His pain is axial and has been present since he was in his 20s. Imaging revealing for mild disk degeneration in the lumbar spine.

Went to PT for 1 visit and says that it “didn’t work” and doesn’t have time to go to appointments.

BMI 37, smokes 1.5 PPD.

He is mad you called him in for a medication count. He is short on the Oxycontin by 12 pills and short on the oxycodone by 20 pills. Says he needed more because “you don’t prescribe me enough.” He reveals that he buys more when he runs out each month early.

Conversation #4

89 yo male patient with severe OA. Taking hydrocodone/APAP 5/325 x 2 a day (56 pills last him 2 months). Says that he doesn't take it every day, but takes it when he is going out of the house and needs to be on his feet.

His son drives him to appointments and take him to the grocery store once a week.

He says that his legs feel weak and wonders if he should be exercising.

QUESTIONS???