Declining to Rx Opioids: Approach to the Patient

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Doctor - Patient Relationship

Esquibel, A. Y., & Borkan, J. (2014). Doctors and patients in pain: Conflict and collaboration in opioid prescription in primary care. *Pain*, *155*(12), 2575–2582

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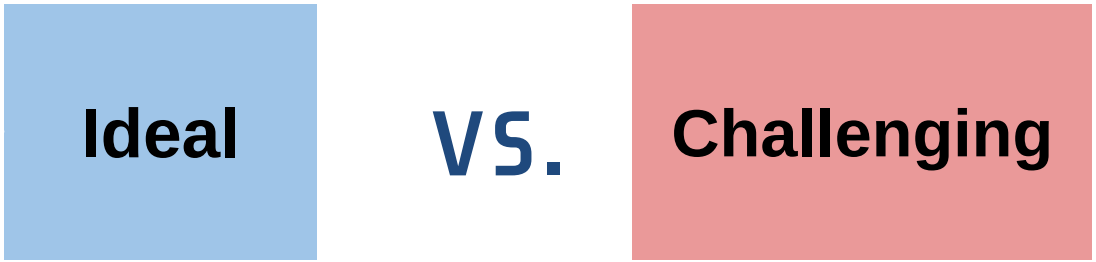
How Clinicians Categorize Patients



Ideal Patient

- Opioids improve function
- Adherent to Rx frequency
- Consistent UDS
- Effort to limit
- No signs of aberrancy

Cheatle et al. Development of the Revised Opioid Risk Tool to Predict Opioid Use Disorder in Patients with Chronic Nonmalignant Pain. J Pain. 2019;20(7):842-851.

Challenging Patient

- Violations of pain contract
- Patterns of requesting increased dose
- Non-consistent UDS & diversion
- High risk of SUD
- Unaware of risk factors for SUD
- A history of d/c from clinics
- Unaware of hyperalgesia

Cheatle et al. Development of the Revised Opioid Risk Tool to Predict Opioid Use Disorder in Patients with Chronic Nonmalignant Pain. J Pain. 2019;20(7):842-851.

The Patient Perspective:

1. Pain relief is priority
2. Pain = suffering
3. Opioid = relief
4. Immunity from addiction
5. Reliant on physicians to access relief

Esquibel, A. Y., & Borkan, J. (2014). Doctors and patients in pain: Conflict and collaboration in opioid prescription in primary care. *Pain*, *155*(12), 2575–2582

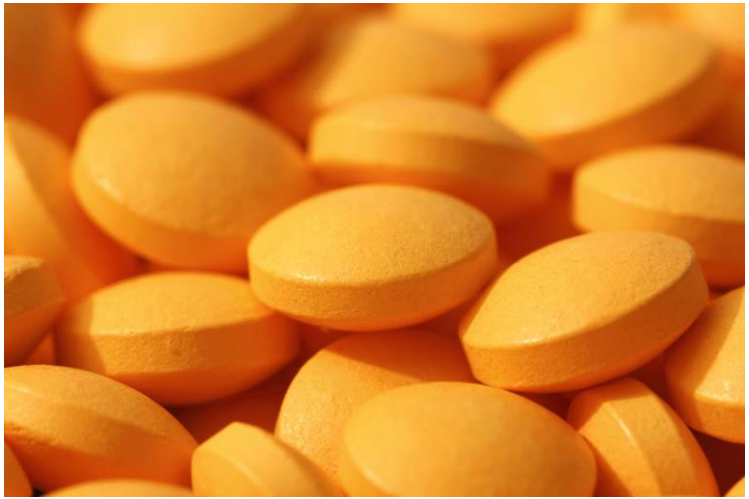
Approach to the Patient

Pattern	Healing/collaborative	Conflictual
Validation of pain	Yes	No
Doctor–patient relationship	Patient centered	Physician centered
Treatment decision making	Shared	Physician
Chronic opioid therapy	Neutral component of treatment/management	Toxic to relationship
Perception		
Patient of physician	Advocate; "friend"; compassionate	"Sheriff"; poor listener; distrustful
Physician of patient	"Friend"; partner	Drug seeker

Esquibel, A. Y., & Borkan, J. (2014). Doctors and patients in pain: Conflict and collaboration in opioid prescription in primary care. *Pain*, *155*(12), 2575–2582

Opioid Side Effects

- Tolerance
- Physical dependence
- SUD
- Itching
- Constipation
- N/V
- Dry mouth
- Impaired cognition
- Depression
- Hyperalgesia
- Low testosterone/decreased libido
- Immune Suppression/Cancer?



2022 CDC Opioid Prescribing Draft Guidelines

McDonagh et al., April 2020; Skelly et al., April 2020). In particular, studies have been published on misapplication of the 2016 CDC Guideline (Kroenke et al., 2019); benefits and risks of different tapering strategies and rapid tapering associated with patient harm (K. S. Gordon et al., 2020; James et al., 2019; Mark & Parish, 2019; U.S. Food and Drug Administration, 2019c); challenges in patient access to opioids (U.S. Department of Health and Human Services, 2019b); patient abandonment and abrupt discontinuation of opioids (U.S. Department of Health and Human Services, 2019b); a seminal randomized clinical trial comparing prescription opioids to nonopioid medications on long-term pain outcomes (E. E. Krebs et al., 2018); the association of characteristics of initial opioid prescriptions with subsequent likelihood for long-term opioid use (Deyo et al., 2017; Shah, Hayes, & Martin, 2017); and that many patients use a small proportion of opioids prescribed to them for postoperative pain (Hill,

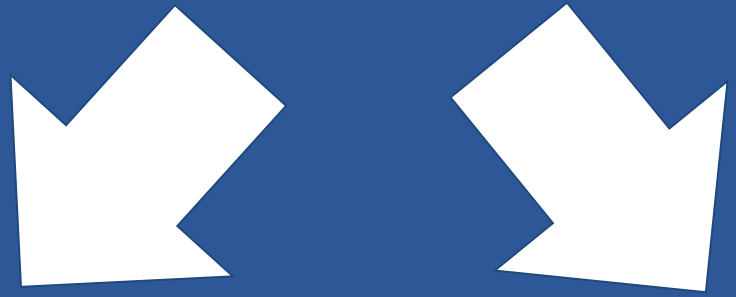
2022 CDC Opioid Prescribing Draft Guidelines

No trial compared different rates of opioid tapering, though one observational study found an association between longer time to opioid discontinuation in patients on long-term, high-dose opioid therapy and decreased risk of opioid-related emergency department visit or hospitalization (Mark & Parish, 2019) (evidence type 3). The review did not identify any study that evaluated the effectiveness of risk mitigation strategies, such as use of risk assessment instruments, opioid management plans, patient education, urine drug screening, PDMP data review, monitoring instruments in patients prescribed opioids, more frequent monitoring intervals, pill counts, abuse-deterrent formulations, or avoidance of co-prescribing of benzodiazepines on risk of overdose, addiction, abuse or misuse.

- Slow taper = better outcome
- 10%/month if long term, 10%/week if short term

Anecdote: Aggressive Patient

De-escalation Techniques



Staff Skills

Process of Intervening

Key components of de-escalation techniques: A thematic synthesis - Price - 2012 - International Journal of Mental Health Nursing - Wiley Online Library

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Staff Skills

- Characteristics of effective de-escalators
- Maintaining personal control
- Verbal and non-verbal skill

Intervention

- Engaging with the patient
- When to intervene
- Ensuring safe conditions for de-escalation
- Strategies for de-escalation
  - Two sub-themes
    - autonomy confirming interventions
    - limit-setting vs. authoritative interventions

Opioid Prescription Guidelines

Definition & Awareness

01

Use

02

Attitudes

03

Kilaru AS, Gadsden SM, Perrone J, Paciotti B, Barg FK, Meisel ZF. How Do Physicians Adopt and Apply Opioid Prescription Guidelines in the Emergency Department? A Qualitative Study. *Annals of Emergency Medicine*. 2014;64(5):482-489.e1. doi:10.1016/j.annemergmed.2014.03.015

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Definition & Awareness

1. Hospital based guidelines
2. Relationships between local, state and national guidelines
3. Variation between nearby hospitals
4. Guideline development
5. Lack of awareness or engagement

Use

1. Communication; support for limiting prescriptions and adjusting patient expectations
2. Handouts and posters containing guidelines

Attitudes

1. Public health
2. Liability
3. Patient diversion

Approach to Aggressive Patient

1. Warn the patient
2. Offer alternative treatments
3. Bring in the clinic manager
4. Call security if you feel threatened
5. Document what occurred in the chart
6. Submit incident reports

Anecdote: Suicidal Patient

Approach to Suicidal Patient

1. Communication – Reflect and talk back
2. Determine intent – Do they have a plan?
3. Columbia-Suicide Severity Rating Scale (C-SSRS)
4. Call your counties Mobile Crisis Team

Posner K, Brown GK, Stanley B, Brent DA, Yershova KV, Oquendo MA, Currier GW, Melvin GA, Greenhill L, Shen S, Mann JJ. The Columbia-Suicide Severity Rating Scale: initial validity and internal consistency findings from three multisite studies with adolescents and adults. *American Journal of Psychiatry.* 2011;168(12):1266-77 doi:10.1176/appi.ajp.2011.10111704.