SAFER MANAGEMENT OF OPIOIDS FOR CHRONIC PAIN:

Principles and language suggestions for talking with patients

Use these principles and language suggestions when discussing opioid risks and safety monitoring or introducing a change in treatment plan.

Principles

Keep the primary focus on outcomes patients care about.

- Conversations should focus on improving overall quality of life, enabling participation in important life activities, protecting patients from opioid-related harm, and achieving their long-term goals, not on eliminating pain. Emphasize concern for the patient's well-being.

When discussing risk, focus on the drugs.

- Make it clear that drug-related harms can happen to anyone, so all patients are monitored for signs that they are having problems with opioids.
- Emphasize that new information on opioid risks and harms are leading clinicians to change when and how opioids are prescribed.
- Particularly if patients are using other sedating substances (sedatives, alcohol), discuss risks of opioids inadvertently endangering their sobriety.

Develop a differential diagnosis for patient behaviors that cause concern.

- If a patient is misusing opioids, expressing concerns about opioid effects, getting opioids from multiple sources, using more than prescribed, or has unexpected urine results, consider it a sign of potential opioid-related harm or an unrecognized serious condition (e.g., substance use disorder, depression)—not as a "treatment agreement violation."
- When deciding on treatment changes, consider all evidence you have about the benefits and harms the patient is experiencing.

Redirect clinical encounters to focus on what patients can do to improve their quality of life.

- Opioids are not a "magic bullet" and should not be the main approach to managing chronic pain. On average, patients can expect a 30% reduction in pain at 12 weeks, but long-term benefits for pain relief are unknown.
- Instead, help patients explore ways to live better and become more engaged in life activities—the ability to do more of what the patient values most. Have patients define treatment goals without using the work "pain". Alternatively, ask what they would be doing do if they had less pain.

- We are learning that active options that patients have more control over can be more effective over the long-run than prescriptions for pain medications that carry greater risks.
- Even with chronic pain, many patients can go for walks or do other pleasant activities that reduce their suffering.
- Help address any unrealistic anxieties or fears patients may have about physical activity.
- If a patient asks for a higher dose, redirect the conversation to strategies more likely to improve their quality of life in the long run.
- Emphasize the potentially temporary nature of pain relief from opioids, but the permanent dependence on opioids to avoid withdrawal symptoms. Over time, it can be difficult to distinguish benefits of pain relief from the avoidance of withdrawal symptoms.
- Your relationship with and empathy for the patient is the most important thing you offer, not the drugs, tests, and procedures you prescribe.

Language suggestions

Introducing a change in practice

Focus on new information and how expert thinking on opioids has changed.	"I want to talk with you about how what we know about opioids has changed based on the latest science and clinical recommendations..."
	"Fifteen years ago, pain specialists taught us that these medications were good for most kinds of pain and almost risk free. But recent evidence has shown us they were wrong."
	"Have you been paying attention to the news about pain meds lately? Do you have concerns or questions about what you've been hearing?"
	"From what you have been telling me, these medications aren't as effective as you would like. Let's think about trying something different." IF PATIENT IS DEFENSIVE: "Patients who expect drugs alone to improve their overall quality of life are usually disappointed. What are other things you do that seem to help you be more active? Let's talk about approaches that I have seen work for other patients with problems like yours."

Introducing monitoring for opioid harms

Focus on the harms opioids can cause.	"These drugs have serious risks even when used as directed, especially at higher doses."
	FOR PATIENTS ON HIGHER DOSES, USING EXTRA FOR FLARE-UPS, OR USING SEDATIVES AND/OR ALCOHOL: "These drugs can stop your breathing which can cause you to die. It happens even when people have been on the same dose for a long time."
	"We used to think people suffering from pain did not become addicted to prescription pain medicines. We now know that you can become addicted to pain killers used for chronic pain, even if you haven't had problems with drugs or alcohol in the past."
	"We used to think the dose didn't matter as long as we went up slowly, but now we know higher doses lead to higher risks of serious injuries and accidental death. And, higher doses don't seem to reduce pain over the long-run."
Reduce stigma by	"Our clinic has a policy recommending against escalation to higher doses

treating everyone the same.	because there is no evidence of benefits, but risks and harms are much greater."
	"Our clinic is making changes for all of our patients so that pain medication prescribing is safer than it has been in the past."
	"It's my job to consider potential benefits and harms and prescribe treatments only when they are safe and the benefits are greater than the potential harms. I can't prescribe drugs that may cause someone to die or develop an addiction."
	"Our clinic suggests monitoring opioid safety using standard approaches for all patients."
	"People don't choose to develop an addiction, and I have no way to predict who might have trouble with these medications."
Be your patient's ally by expressing empathy and support for their concerns and uncertainties.	"Do you know anyone who has had an opioid problem, such as becoming addicted, or been hurt by these medications, such as an overdose?"
	"I promise to be honest with you if I have any concerns about how you are using your medications. In turn, I ask you to let me know right away if you develop any cravings or other concerns about how the drugs are affecting you. It is common to experience these problems, they aren't your fault, so let me know right away."

Responding to unexpected findings (UDS or PDMP results, or concern for substance use disorder or diversion)

Keep the focus on the patient's well-being.	"I called because I'm concerned about you. There was something I didn't expect in your [urine/ pharmacy records], so I wanted to check in with you about how you're doing..." [Followed by silence to allow patient to talk.]
	"This pattern can sometimes be a sign that a person is at risk for opioid addiction, which is a serious disease that needs treatment." [Followed by assessment questions and offer of resource/referral.]
	"It's my job to weigh up the potential benefits and potential harms, and to prescribe medications only when the benefits are greater than the harms. In your situation, I'm worried the risks outweigh the benefits, so I can't keep prescribing them for you."

Avoid backing the patient into a corner	"I know that medications get lost and stuff just happens. But this pattern can also look like there is a problem developing—like someone getting hold of your medicines or loss of control over how much you are using. As a doctor, I just can't prescribe if I'm not 100% sure where the medications are going and how they are being used."
	"I'm not a cop or a detective, so it's not my job to figure out exactly what's going on. As a doctor, my job is to be careful with these medications and to watch out for your health."
	"I'm not sure what's been happening with you, but I'm concerned for your well-being."
Redirect the conversation while maintaining the relationship.	"These drugs aren't the best treatment for pain in the long term, anyway. For most people, their effects wear off over time. I'd like to try some new approaches to see if we can do better."
	"Patients who expect drugs to control their pain are usually disappointed. With or without chronic pain, my patients who are doing better use multiple approaches. Let's talk about what might help you become more active and do more things that you enjoy." [Consider walking, pleasant activities, relaxing activities, mindfulness meditation, avoiding thoughts that everyday pain means you are harming your body.] IT CAN BE DIFFICULT TO TALK ABOUT ALTERNATIVES IF OPIOIDS ARE BEING CUT OFF OR REDUCED AGAINST THE PATIENT'S WISHES. IN DIFFICULT CIRCUMSTANCES, TAKING THE TIME TO LISTEN TO CONCERNS (UP TO A POINT) AND EXPRESSING EMPATHY WITHOUT CHANGING YOUR DECISION CAN BE HELPFUL FOR THE FUTURE.
Redirect the conversation while maintaining the relationship. (cont.)	"I want to work with you to find a better pain management plan."
	"When can you come back to see me?"

Introducing dose reduction or tapering

Provide information and redirect the conversation.	"We call them 'pain killers,' but they don't work that well for most people with back pain. Studies show that 4 out of 5 people do not have a good response to these medications." "My experience is that patients who taper opioids end up with clearer thinking and more energy to engage in positive activities that help them focus less on their pain."

	"It seems the body just gets used to the long-acting, around-the-clock medicines and they quit working. Many of my patients seem to do better taking the short-acting meds only when they need them."
	"For most people, the benefits wear off as the body gets used to the medications. Then they're stuck on a medicine that isn't really doing much for them. They often assume they'd be worse off without it, but it turns out that's not true. Let's talk about what you can do to live a better life, so all your eggs aren't in one basket."
	"These drugs have risks for everyone who takes them. You are more likely to have a serious harm because you [have been taking them for a long time; are taking them every day; are taking > 50 mg morphine equivalent dose a day; are taking sleeping pills too; have a family history of alcoholism; have depression; etc.]. We can't do much about your family history, but you could reduce your risk by [going down on the dose, stopping the sleeping pills, taking them less often]."
Ask about the patient's concerns.	"Do you ever worry about harmful effects of your pain medications?"
	"You're on a very high dose and have been for [number of] years. Do you ever wonder if the drugs are still working for you?"
	"How would you feel about taking these medications for the rest of your life?"
	"Have you ever thought about trying to cut back?"
Suggest a change.	"You're telling me that your pain is really terrible, and I hear you. It seems to me that what we're doing just isn't working. I know they helped you at first, but I think the effect of the medications has worn off. We should make some changes."
Suggest a change. (cont.)	"I wonder if you really need to be on this high a dose. In my experience, most people can cut their doses back quite a bit without any increase in pain. I'd like to try going down just [5 mg, 1 pill a day, etc.] and see if you notice a difference. What do you think?"
	"I want to start making changes to make sure this medication is safe for you. There are several different things we could start with...[provide options]. Where would you like to start?"

	"While we're working on the medications, I also want to work on some of the underlying things that are contributing to your pain. For you to get better, you'll need to [get stronger, start being more active, get back to your social life]. I'd like to talk about some goals we can keep track of together, so we know how well our plan is working."
Continually revisit readiness to change.	"Last time, we talked about [the safety of your pain meds, whether the opioids are really working]. I still recommend [making some changes, going down on the dose]. Have you thought more about whether you're ready for that?" [If yes, suggest options. If no, remind of reasons, suggest potential options, ask again next visit.]
Be honest and reassuring about what patients can expect.	"We can push the pause button any time you need to."
	"I don't want to make any Substance use disorderden moves—just one baby step at a time. Then we'll talk about the results together."
	"I promise I'm going to stick by you."
	"Remember, you might feel a little worse before you feel better. I want to see you again in four weeks to check how you're doing. By then, your pain should be evened out again."
	"Since your body is used to having this drug in your system, you might feel withdrawal symptoms after we decrease your dose. This might mean you feel more pain or get worse sleep. But it will be temporary. It doesn't mean the drug is actually helping—it's just that your body needs to get used to the new dose."
	"As a back-up plan, in case of a seriously bad day, I could give you some extra [short-acting opioid]."
	WHEN TAPERING, AFTER A SMALL DOSE REDUCTION, CHECK IN WITH THE PATIENT ABOUT ANY <u>POSITIVE</u> CHANGES—INCREASED ENERGY, ALERTNESS, ABILITY TO BE ACTIVE, SLEEP. IT HELPS TO HAVE PATIENTS FOCUS ON BENEFICIAL OUTCOMES. IT MAY ALSO BE HELPFUL TO NOTE EXPECTED NEGATIVE EFFECTS THAT DID NOT HAPPEN: "From what you are saying, your pain seems to be about the same as before."

Respond to setbacks and focus on problem solving.	"Remember how miserable you were on the medications? If your pain was really well controlled back then, we wouldn't be doing this at all."
	"Let's just hold on the current dose and not try to make more changes right now. How are things going with your goal to [walk every day, keep a regular sleep schedule, join the gym...]?" [Focus on ways to problem solve and help the patient reach their goals.]
	"Usually these flare-ups only last a few days. Is there anything that would help to take your mind off it in the meantime? I know you mentioned that [you do better when you're with other people; that it feels good to float in the pool...]"
	"I'm not holding out on you. If I had an easy solution for the pain today, I'd give it to you right now. I still think this is going to be worth it in the long run. [Remind the patient of their long-term goals.] How can you get back on track with [your short-term goal]?"

Introduce non-drug approaches to managing chronic pain

Introduce materials on alternative approaches to chronic pain management. *e.g. Managing Chronic Pain by John Otis* *5 minute YouTube video on chronic pain management*	"This workbook has helped other patients of mine with chronic pain. It gives a lot of different ideas for ways to manage chronic pain" TRY GIVING A LIMITED AMOUNT OF READING MATERIAL THAT IS DISCUSSED AT THE NEXT VISIT. INFORMATION ON SLEEP AND PACING ARE HELPFUL FOR MANY PATIENTS. CHECK IN ON PROGRESS AT EVERY VISIT.
	"There are a lot of things that make pain worse, like not sleeping well, or doing too little or too much exercise. When the pain is really bad, people do things that make it worse, like shallow breathing, tensing muscles, and thinking that the pain will never get better. This provides a menu of options" FOCUSING DISCUSSION ON THESE KINDS OF OPTIONS CAN CHANGE THE CONVERSATION FROM WHAT THE DOCTOR IS DOING TO CONTROL PAIN, TO WHAT THE PATIENT IS DOING TO IMPROVE QUALITY OF LIFE.

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