CVCH

The Inherited Opioid Patient

Time, Trust, Taper

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Partnering to achieve optimal health and
Wellness with compassion and respect for all.

SINCE
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You have time to do this well.

Build trust now; leverage that trust later.

(read the handout)

Recognize patient's terror, build their trust

- New patient, doesn't know you
- Assume the patient:
  - Was satisfied with prior care
  - Feels victimized by changes - "they were the only one who cared"
  - Is in a state of heightened anxiety and self-righteous indignation
- Start the first session with "we won't change very much today"
- Review your credentials and your care team's capabilities
- Let them know that you need to:
  - Review all of their prior care
  - Re-evaluate them
  - Practice within the standards of care, "my first job is to keep you safe."

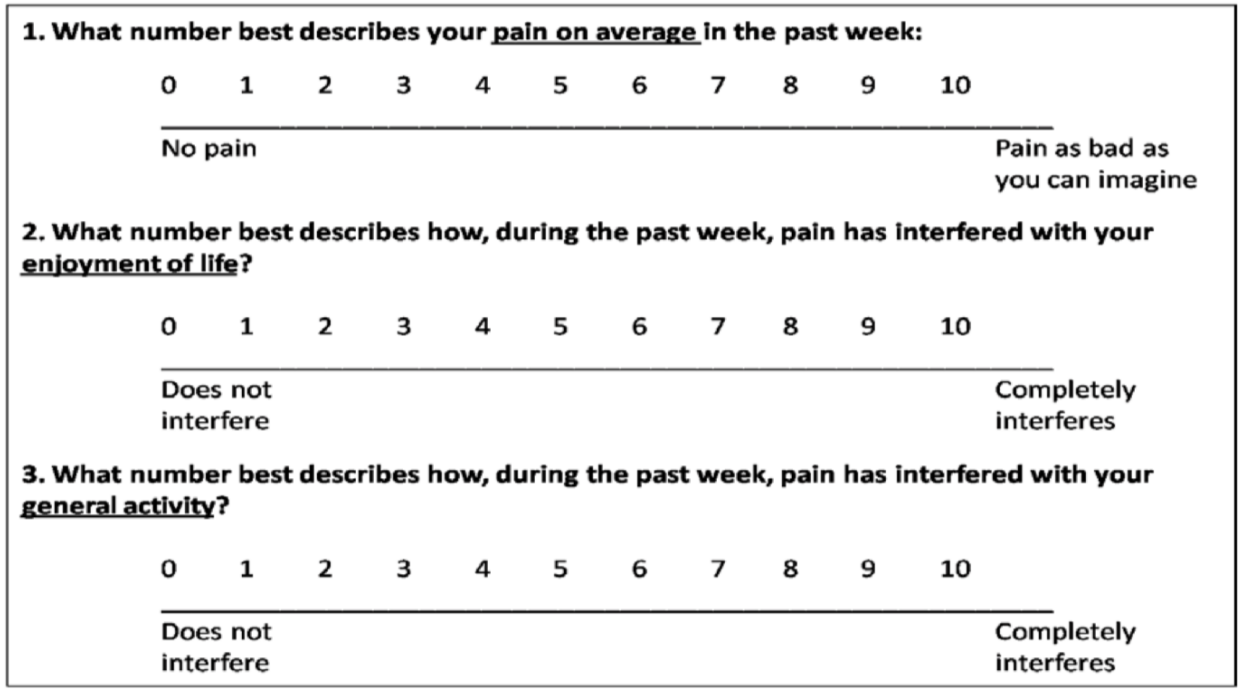
Do the work

Keep them safe

- Assure they have naloxone
- Review concomitant sedatives
  - Advise significant risk of concomitant sedatives
  - Involve them in plan to taper
  - Often, given the choice, they would prefer to taper opioids
- Consider moving toward short acting opioids

Do the work

- Initial bolus – Document:
  - Complete H&P
  - History of pain interventions
  - Functional status (PEG)
  - Opioid risk
  - Substance Use Disorder screen
  - Screen for depression, PTSD, ACE
  - Query Prescription Monitoring Program (PMP)
  - Determine pain related diagnoses
  - Treatment agreement (to include naloxone)



1. What number best describes your pain on average in the past week:

0 1 2 3 4 5 6 7 8 9 10

No pain — Pain as bad as you can imagine

2. What number best describes how, during the past week, pain has interfered with your enjoyment of life?

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes

3. What number best describes how, during the past week, pain has interfered with your general activity?

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes

Do the work

- Treatment plan
  - Document active pain diagnoses
  - Identify comorbid behavioral risk factors
  - Estimate risk of opioid misuse (high, moderate, low)
  - Calculate current MED
    - If above 120mg MED will need to document a plan:
      - Consult with pain specialist. May delay up to 3 months if
        - Has established written agreement
        - Has been on a stable non-escalating dose
        - Has been compliant with recommendations
        - Has documented improved function on opioids
      - Or, taper.

Do the work

- Frame this as an “opportunity to take another look at everything”
- Repeat diagnostics (builds trust)
- Consider referrals to re-evaluate possibly modifiable conditions
- Involve behaviorists
  - “To help them through these changes”
  - Remember pain doesn’t cause depression, anxiety, or alcoholism
  - Opioids are effective at suppressing symptoms of anxiety, PTSD
  - Sleep dysfunction makes everything worse
  - Anger, shame, grief, existential crises

Do the work

- Review central sensitization syndrome
  - “New understanding since you were started on opioids”
  - Correlated with Adverse Childhood Experiences, PTSD
  - Correlated with high dose chronic opioids
  - Fibromyalgia, chronic daily headache, chronic pelvic pain, IBS, interstitial cystitis, chronic fatigue
  - Best managed with behavioral techniques
- Review non-opioid management of chronic pain
  - Activation/fitness/PT/stretching/yoga (#1-#5)
  - Acetaminophen, topicals, intermittent steroid injections, SNRI, etc.

Tapering

- Individualize, based on all of the above
- Don’t even mention tapering prior to the third visit
- Frame in terms of patient safety, “best practice”
  - Invoke state “rules” only if required
- No great evidence on tapering, yet
- 10% per month, based on function (PEG at each visit)
- Firm but empathetic, OK to accommodate life events along the way

Summary

- READ THE HANDOUT
- You have the time you need to build trust, re-evaluate issues
- Keep them safe – stop sedatives, prescribe naloxone
- If above 120mg MED, need pain consult, or to taper
- Three month grace period if “stable on current dose”
- Get them active, involve PT and Behaviorists
- Taper at 10% per month(-ish) based on function