Conversations As Medicine
Compassion-Based Difficult Conversations

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Objectives

• Understand the steps necessary to plan a successful opioid taper
• Offer 5 Navigation Strategies to ease the course with potentially challenging patient conversations.
• Describe several opioid taper case scenarios
• Provide opportunities to practice “compassion-based” conversations
# How to approach an opioid taper/cessation

<table>
<thead>
<tr>
<th>Indication for Taper</th>
<th>Recommended Length of Taper</th>
<th>Degree of Shared Decision Making about Taper</th>
<th>Intervention/Setting</th>
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</table>
| **Substance Use Disorder** | No taper, immediate referral | None – provider choice alone | **Intervention**: Transition to medication assisted treatment (MAT, i.e. buprenorphine or methadone) for OUD, Naloxone rescue kit  
**Setting**: Detox, inpatient or outpatient treatment with MAT |
| **Diversion** | No taper to rapid taper (days) | None – provider choice alone | Determine need based on actual use of opioids, if any |
| **At risk for severe harms** | Weeks | Moderate – provider led & patient views sought | **Intervention**: Supportive care  
Naloxone rescue kit  
**Setting**: Outpatient opioid taper or inpatient withdrawal management  
**Option**: Buprenorphine (OBOT) |
| **Therapeutic failure** | Months to year | Moderate – provider led & patient views sought | **Intervention**: Supportive care  
Naloxone rescue kit  
**Setting**: Outpatient opioid taper  
**Option**: Buprenorphine (OBOT) |
| **At risk for less severe harms** | Months to Years | Moderate – provider led & patient views sought | **Intervention**: Supportive care  
Naloxone rescue kit  
**Setting**: Outpatient opioid taper  
**Option**: Buprenorphine (OBOT) |
Outpatient Tapering Options

• Gradual taper:
  – 5-10% decreases of the original dose every 5-28 days
    • Once 30% of the original dose is reached, then decrease each taper step by 10% of the remaining dose every 5-28 days
  – You may elect to taper Extended release (ER) or Immediate release (IR) first
    • generally taper ER first and use IR for breakthrough pain
  – Provide the patient a copy of the taper plan for reference and to help keep patient moving forward

Resource: Courtesy of Melissa Weimer, DO, MCR
Outpatient Tapering Options

• Rapid taper:
  – Daily to every other day reductions over 1-2 weeks as appropriate

• Medication assisted taper:
  – Adjuvant opioid withdrawal medications only
  – Office based buprenorphine withdrawal assistance (i.e. detox) or maintenance transition
  – Referral for Methadone maintenance treatment

Resource: Courtesy of Melissa Weimer, DO, MCR
Medication Assisted Treatment

• Some patients will be “unable” or intolerant of taper
  – Methadone >30mg
  – MED >200mg
  – Long term use > 5 years
  – Mental illness, history of adverse childhood experiences (ACEs), history of substance use disorder, poor social supports

• Buprenorphine/naloxone is an important resource for these patients

• Interdisciplinary pain programs +/- MAT have good outcomes

Resource: Courtesy of Melissa Weimer, DO, MCR
Case: Substance Use Disorder

• 50 yo male prescribed hydromorphone 4mg every 3 hours and fentanyl 50mcg patch for chronic pancreatitis. You detect alcohol on a routine urine drug screening, and he admits that he has relapsed on alcohol.

• What do you do?

• Decide that the risks greatly outweigh the benefit
• Refer for detoxification from alcohol and opioids
• Stop prescribing opioids immediately
• Consider buprenorphine/naloxone, if alcohol abstinent

Resource: Courtesy of Melissa Weimer, DO, MCR
Case: Suspect Diversion

• 28 yo female prescribed opioids for chronic abdominal pain. She states she has lost her opioid prescription for the third time. She has had two negative urine drug tests for the opioid that is prescribed and refuses to come in for a pill count.

• You suspect diversion.
• Check PDMP
• **Taper Plan:** None. You stop prescribing opioids immediately.

Resource: Courtesy of Melissa Weimer, DO, MCR
Case: At Risk for Severe Harms

- 50 yo man on opioids for LBP x 5 years is prescribed fentanyl 75mcg/72 hours.
- Hospitalized for bowel obstruction.
- Hx of falls
- Hx of depression

Resource: Courtesy of Melissa Weimer, DO, MCR
Case: “Lost Generation” “Legitamate Pain, Compliant, w/ therapeutic alliance

• 68 yo female with rheumatoid arthritis pain. She is prescribed a total of 350mg MED for the last 5 years with no adverse events. She is moderately functional. Your clinic has developed a new opioid policy stating that patients prescribed doses >120mg MED need to attempt an opioid taper. She is concerned that she might develop serious harms from her opioids.

• **Taper plan:** Slow taper by 10% per month over a year to a safer dose. May elect to slow down the taper if she experiences periods of worsening pain and/or opioid withdrawal.

• If her disease continues to generate active nociceptive pain not controlled with DMARDs, she may well be a candidate for long-term opioids, but at a safer dose.

Resource: Courtesy of Melissa Weimer, DO, MCR
Case: “Lost Generation” with Hopelessness

- 63 yo man with history of low back pain and severe depression after a work injury in 1982.
- He has not worked since and spends most of his day being sedentary.
- He has been unwilling to engage in additional pain modalities despite multiple offers.
- He is prescribed oxycodone IR 30mg every 4 hours. You have tried other opioids but he has not had improvements.
- He refuses an opioid taper and states he will seek another provider if you start to taper his opioids.

Taper Plan: Offer buprenorphine, subacute detox program, OR a 1 month rapid opioid taper

Resource: Courtesy of Melissa Weimer, DO, MCR
Gripe and Treasure Hunt!
“Listening is Doing Something... The opium haze gradually draws back. It becomes less like an intervening barrier and more and more like an aura emanating from the patient.”

*Seeing the Patient Through an Opium Haze*

Balint Groups-2016

John Muench, MD, MPH

Dept of Family Medicine-OHSU
Difficult Conversations in Medicine?

- Antibiotics
- End of life-hospice
- Stimulants
- Hypnotics
- Benzodiazepines
- Opioid refusal for CNNP
- Opioid taper
- Opioid removal based on risk/aberrant behavior
What makes This Difficult?

- Being with **suffering** and feeling **helpless**
- Reduced Patient **satisfaction**
- Conversations take more **time**
- Not enough team **support**
- Not enough “effective” non-opioid tx options
- Pt won’t agree to non-opioid tx
- When you “buy” the science (I don’t believe it)
- Discomfort with expressed emotions/guilt/shame
- Disbelief that “my” patient is misusing/abusing

(The place where it hurts is the place where you care)
Are all Patients Resistant to Change?

- **Power of 1/3rds**-(Receptive, Ambivalent, Resistant)- M. Parchman-Group Health (2016) and anecdotal experience

- **1 in 4** patients receiving long-term opioid therapy in a primary care setting struggles with opioid- CDC

- **1 in 10** are deliberately using in a way that might result in harm- Kevin E. Vowles, U of NM
5 Step Navigation Process

Courtesy of Barry Egener, MD

1. Navigating the emotional landscape
2. Elicit the Patient’s Perspective
3. Present your perspective
4. Agree on common goals
5. Set Limits
Navigating the Emotional Landscape
Step 1 of 5

1. Awareness of Common Traps and Negotiation Strategies
2. Deal with Emotions (Model willingness, Reflect, Validate, Support,)
3. Drop Defensiveness
4. Share Control when Safety Allows
5. Focus on Function, not Pain
6. Agree to Disagree (identify the impasse, clarify boundaries, manage your reactions, learn to soothe self)
Traps and Levels of Negotiation

References: courtesy of Brad Anderson, MD Keiser-Portland
“Given all that I have been through...you just want me to suffer?”
(Compassion Trap)
"If you cut me off I will loose my job and become homeless!"

(All or Nothing Trap)
“Are you accusing me of being an addict?”

(Addiction Labeling/Guilt Trap)
“Don’t bother with any other meds, I’ll just kill myself.”

(Desperate/Threatening Trap)
Negotiation Strategies/Trap

- Trauma Drama-fast talking
- Intimidation
- Inconsolable crying
Navigating the Emotional Landscape
Step #1

Team Practice

Identifying Traps/Negotiations

Generate Examples of Traps from Own Practice

– Team A- Bobcats
– Team B- Tiger Cubs
– Team C- Wolfs
– Team D- Bears

Be Ready to Report out
Navigating the Emotional Landscape

Step #1

1. Deal With Emotions
2. Don’t Be Defensive
3. Share Control
4. Focus On Function, Not Pain
Navigating the Emotional Landscape - Step #1

Dealing With Emotions (yours and your Pt’s)

Willingness to feel uncomfortable

Support

Validation

Reflection
Navigating the Emotional Landscape - Step #1

Willingness to Feel Uncomfortable

Parallel Process

“Neither one of us could stand to be with the horrific emotional pain she lived with everyday!”
The Art and Science of Compassion

The parallel process of the patients and providers is....both brains take the “low road”

Resource: Courtesy of Kim Swanson, Ph.D.-St. Charles Health System, Bend, OR
Navigating the Emotional Landscape - Step #1

REFLECTION

“You seem upset by what I’ve said.”

“You seem pretty angry.”

“I notice you are tearing up”

“Your body language looks tense to me”
Navigating the Emotional Landscape

Step #1

Validation

“Anyone would be upset if they had to deal with pain 24 hrs a day.”

“All pain is real”

“I can understand that you might be angry with me for not prescribing narcotics when that’s the main reason you came in today.”

“I’m sure it’s been difficult to keep going to the doctor and to repeatedly have these tugs of war about a prescription.”

YOU DON’T HAVE TO AGREE TO EXPRESS UNDERSTANDING!
Navigating the Emotional Landscape
Step #1

SUPPORT

“I will have my MA call you tomorrow just to check in”

“I won’t abandon you as your provider”

“We are here for you”

“I care about you”

Or, for example, instead of speaking, hand a crying patient a tissue.
Navigating the Emotional Landscape - Step #1

Triad Practice: Tools = Willingness to feel uncomfortable, Reflection, validation, and Support

- Divide into groups of three
- Person A = Patient - uses traps/negotiations in an attempt to get needs met
- Person B = Provider - uses tools above
- Person C = Scribe - keep time, jot down observations, provide feedback

But 1st - let's see it in action!
Navigating the Emotional Landscape
Step #1

1. Deal With Emotions
2. Don’t Be Defensive
3. Share Control
4. Focus On Function, Not Pain
Navigating the Emotional Landscape - Step #1

**Don’t Be Defensive**

- Defensiveness Escalates Emotion

- Instead, make a statement about the patient’s experience
  
  “I am sorry for your loss”
Navigating the Emotional Landscape - Step #1

Share Control

(when it is safe)

- Models Collaboration
- Avoids Backing Patient into Corner
- Empowers the Patient to Make Changes
- Higher risk lower shared decision making (M. Weimer chart)
Navigating the Emotional Landscape

Step #1

Focus on Function

- Permits progress despite ongoing pain

- What can the patient do?
  What do the symptoms prevent?
Navigating the Emotional Landscape - Step #1

Triad Practice: Tools= Non-Defensiveness, Sharing Control, and Focus on Function

• Divide into groups of three
• Person A=Patient-uses traps/negotiations in an attempt to get needs met
• Person B-Provider-uses tools above
• Person C-Scribe-keep time, jot down observations, provide feedback

But 1st-let's see it in action!
Navigating the Emotional Landscape
Step #1

Agreeing to Disagree
(When Provider and Patient Can’t Agree)

- Identify the impasse
- Clarify boundaries
- Manage your reactions
- Learn to Soothe yourself
Navigating the Emotional Landscape
Step #1

Identify the Impasse

“It seems like we have reached an impasse.”

“You and I have very different views on how best to manage your pain.”
Clarify Boundaries

- **What you will do:**
  “I’d like to be your doctor and continue to help you with your help, despite our disagreement.”

- **What you will not do:**
  “Prescribing more of this medicine is something that is not in your best long-term interest. It is something that I feel uncomfortable with and cannot do.”
Navigating the Emotional Landscape

Step #1

Manage Your Reactions

- When you say “No”
  - What do you feel?
  - What thoughts do you have?
Learn to Soothe Yourself

- Breathe
- Create a Mantra-”I can do this with compassion and grace”
- Self-talk:
  “I’m being a helpful doctor.”
  “I can get through this.”
Navigating the Emotional Landscape

Step #1

Triad Practice: Tools= Agreeing to Disagree: Identify the Impasse, Clarify Boundaries, Manage your Reactions, Learn to Soothe Self

• Divide into groups of three
• Person A=Patient-uses traps/negotiations in an attempt to get needs met
• Person B-Provider-uses tools above
• Person C-Scribe-keep time, jot down observations, provide feedback

But 1st-let's see it in action!
Navigating the Emotional Landscape - Step #1

**Team Practice**

**Responding** to Traps/Negotiations

Generate Example Responses based on tools from Step 1:

- Team A- **Bobcats**
- Team B- **Tiger Cubs**
- Team C- **Wolfs**
- Team D- **Bears**

Be Ready to Report out
Navigating the Emotional Landscape - Step #1

Triad Practice: Tool= All of them

- Divide into groups of three
- Person A=Patient-Goal: to get provider to give them the “key”
- Person B-Provider-Goal: Compassionately Refuse to Give up the “Key”
- Person C-Scribe-keep time, jot down observations, provide feedback
Elicit the Patient’s Perspective
Step 2

Help the patient describe:

– The nature of the problem and how the problem has affected him/her
– Beliefs about causation
– Concerns about consequences of pain/ the future
– Expectations: Exactly what help the patient wants

DON’T ASSUME YOU KNOW!
Present Your Perspective
- Step #3

- Create an Empathic Bridge
- Present Your Perspective
- Conflict resolution in the face of anger:
  - Assent
  - Consolation
  - Apology
- 2 Min. Elevator Speech (ask what pt heard)
Start the conversation the right way. Your **1 minute** elevator speech:

- "Recent research has demonstrated that the use of opioids is proving to be less effective and less safe than we were once led to believe. In fact, there are some potentially dangerous side effects. I would like to take a few minutes to share how these new safety guidelines relate specifically to your medical treatment."

References: Courtesy of Laura Heesacker, LCSW, Jackson Care Connect
Agree on Common Goals
Step #4

- Allows Collaboration Despite Disagreement

- First agree on goals, then methods

- Positions vs Interests
Set Limits

Step #5

- Frame limits professionally, not personally
- Concentrate on what you are willing to do, rather than on what you refuse to do
Thank You
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7th Annual Pain Conference in Ashland on May 4, 5, and 6, 2017 - Oregonpainguidence.org