Workshop for Communicating with Chronic Pain Patients

Minnesota Chapter-
American College of Physicians
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Patient-centered communication about opioids

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Why Doctors Prescribe Opioids to Known Opioid Abusers

Anna Lembke, M.D.

Patient Satisfaction, Prescription Drug Abuse, and Potential Unintended Consequences

Aleksandra Zgierska, MD, PhD
Michael Miller, MD
David Rabago, MD

Commentary

Patient-centered health care: are opioids a special case?

Jane C. Ballantyne, MD, FRCA*
Is there an inherent conflict?

- Patient-centered care is “respectful of and responsive to individual patient preferences, needs, and values”
  - Not a customer service activity
  - Not an alternative to evidence-based care
  - Not a reason to continue harmful or ineffective therapy

- Patient-centered pain care considers evidence of potential benefits and harms in context of patient goals and values

Balancing benefits and harms

Individual patient benefit

Societal harms
Balancing benefits and harms

Pain relief

Abuse/misuse

X
Balancing benefits and harms

**Anticipated Benefits**
- Social participation
- Pain relief
- Work
- Physical activity

**Mood**
- Sleep

**Tolerance**
- Depression

**Dependence**
- Addiction
- Injuries
- Fatigue
- Slow cognition
- Social withdrawal

**Common Harms**
- Respiratory depression
- Death
Police Officer, Deal-Maker, or Health Care Provider? Moving to a Patient-Centered Framework for Chronic Opioid Management

Christina Nicolaidis, MD, MPH

- Law enforcement framework: provider catches misusers, enforces rules, punishes/rewards behavior
- Positional bargaining framework: provider negotiates conditions for prescribing, compromises with patient
Case 1

- You return from vacation to an urgent message about one of your long-time patients...
- 51 year old man on morphine SR 15 mg at bedtime and oxycodone IR 5 mg Q6h PRN (up to 4/day) for chronic back pain
  - Called to request refill 5 days too early
  - Covering MD provided 7 day rx, but requested UDT first
  - Patient was verbally abusive to nurse
  - RN recalls a similar episode in the past
  - You have not been concerned about this patient’s opioid use
Case 1

- PDMP review: no outside rx
- UDT result
  - Cannabis positive
  - Opiate positive
  - Oxycodone negative

- What else do you want to know?
  - What is your differential diagnosis?
Case 1
## Case 1 follow-up

<table>
<thead>
<tr>
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<th>Initial approach (law enforcement/ bargaining framework)</th>
<th>“Redo” approach (patient-centered/ benefit-harm framework)</th>
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</thead>
</table>
| **Response to aberrant behavior** | Discussed violation of opioid contract  
Outlined conditions for continued prescribing | Assessed causes of behavior  
Reassessed benefits/harms of therapy |
| **Plan for opioids** | Continue as long as patient adheres to contract | Start tapering based on limited benefits & increased risk of harm. Add naloxone. |
| **Plan for follow-up** | Monthly UDS | Visit to share decision making about further opioid dose reduction, other pain treatment |

Approach to interviews with chronic pain patients

Charles Reznikoff, MD, FACP
Addiction medicine, internal medicine
Hennepin County Medical Center
“For the simplicity on this side of complexity, I wouldn’t give a fig. But for the simplicity on the other side of complexity, for that I would give you anything I have.”

Oliver Wendell Holmes
Overview

• Identify unhealthy pain talk
• Set physician expectations
• Identify intoxicated patients
• Structure the interview
• Screen for risks: nonjudgmental and casual
• Redirect, reassure and distract
• System issues managing pain patients
This is for patients with Chronic Pain Syndrome, on chronic opioids
Chronic Pain Syndrome, on chronic opioids

Pain which has a severity and duration that cannot be explained by tissue damage, complicated by chronic exposure to opioids
Chronic pain syndrome on chronic opioids

High health care utilization
High psychiatric comorbidities
High addiction comorbidities
High mortality from opioids
The pain interview with a chronic pain patient may take the entire visit!
Pain control is often of high importance to the patient
Define “Pain talk”

The patient dwells on the severity and nature of experienced pain in a way that does not convey useful diagnostic information.
“Pain talk” is not healthy

- Dwelling on pain amplifies it
- Disregulated pain (not undertreated pain)
- Unrealistic expectation about the doctor visit
- Distracts from meaningful assessments
  - Risk assessment, mental health and functional assessment
- Creates feelings of powerlessness in the doctor
- May prompt unneeded opioid escalation
More on pain talk...

• Rule out new tissue damage
  – Try not to overttest
  – This requires confidence!
• Patients can be distracted/redirected from pain talk
• Pain talk is a monologue, not a dialogue
• “Patient centered” interview, empathy, not helpful
Know when “pain talk” is becoming unhealthy for you and/or for the patient

See how long you can get them to talk without talking about their pain
Do not prescribe opioids to escape an uncomfortable patient encounter
Identify patients who are intoxicated or in withdrawal

- Opioid withdrawal
  - Anxious, focused on pain/opioids, fidgety
- Opioid intoxication
  - Nodding off, pinpoint pupils
- Benzos/alcohol intoxication
  - Rambling, emotionally labile, big pupils (bzds)
- Stimulant intoxication
  - Angry, paranoid, demanding, psychomotor agitation
“you seem drowsier than normal today”
or
“when was your last pain pill?”
or
“could there be any drugs in your system right now?”
Predictable timeline for opioid withdrawal

• Short acting
  – 12 hours anxiety, pain
  – 24 hours full withdrawal begins

• Long acting
  – 24 hours anxiety, pain
  – 2 days full withdrawal begins

• Methadone
  – 1-2 days anxiety, pain
  – 3 days full withdrawal begins
Keep negotiations simple when working with a patient intoxicated or in withdrawal...

How are you getting home?
Identify mental health crises early in the interview

Do not negotiate opioid doses with a patient in mental health crisis
Structured Interview

• Open with casual life questions:
Structured Interview

• Open with casual life questions:
  – What do you do for fun?
Structured Interview

• Open with casual life questions:
  – What do you do for fun?
  – Tell me about your family.
Structured Interview

• Open with casual life questions:
  – What do you do for fun?
  – Tell me about your family.
  – How do you get around? Who shops for you?
Structured Interview

• Open with casual life questions:
  – What do you do for fun?
  – Tell me about your family.
  – How do you get around? Who shops for you?
  – What do you do for work? How are your finances?
Structured Interview

• Open with casual life questions:
  – What do you do for fun?
  – Tell me about your family.
  – How do you get around? Who shops for you?
  – What do you do for work? How are your finances?
  – Who cooks for you? Who cleans for you?
Structured Interview

• Open with casual life questions:
  – What do you do for fun?
  – Tell me about your family.
  – How do you get around? Who shops for you?
  – What do you do for work? How are your finances?
  – Who cooks for you? Who cleans for you?
  – Tell me about your social life.
Notice:
These are life questions that do not give ready openings for pain talk
What have you accomplished?

• Functional screening
• Built a connection with the patient
• Distract patient from their pain
• Assess mood and anhedonia
• Begun a safety screening
Structured Interview

• Open with casual life questions
• Progress to mental health questions:
Structured Interview

• Open with casual life questions
• Progress to mental health questions:
  – How are you sleeping?
Structured Interview

• Open with casual life questions
• Progress to mental health questions:
  – How are you sleeping?
  – How is your mood?
Structured Interview

• Open with casual life questions
• Progress to mental health questions:
  – How are you sleeping?
  – How is your mood?
  – What stresses you out? What worries you?
Structured Interview

• Open with casual life questions
• Progress to mental health questions:
  – How are you sleeping?
  – How is your mood?
  – What stresses you out? What worries you?
  – Do you have any bad memories you can’t shake off?
Structured Interview

• Open with casual life questions
• Progress to mental health questions:
  – How are you sleeping?
  – How is your mood?
  – What stresses you out? What worries you?
  – Do you have any bad memories you can’t shake off?
  – Do you have any mental health issues?
Respectfully respond to the mental health symptoms, but

Don’t get side tracked or mired,

Keep the interview moving.
What have you done here?

• Mental health is the commonest reason pain is not controlled
• More progress on your risk assessment
• Furthering the bond with the patient
• Testing the patient’s ability to distract from pain talk
Structured Interview

• Open with casual life questions
• Progress to mental health questions
• Next ask about drugs and alcohol:
Structured Interview

• Open with casual life questions
• Progress to mental health questions
• Next ask about drugs and alcohol:
  – Do you smoke cigarettes?
Structured Interview

• Open with casual life questions
• Progress to mental health questions
• Next ask about drugs and alcohol:
  – Do you smoke cigarettes?
  – Do you drink alcohol? How much?
Structured Interview

• Open with casual life questions
• Progress to mental health questions
• Next ask about drugs and alcohol:
  – Do you smoke cigarettes?
  – Do you drink alcohol? How much?
  – Do you smoke weed? (or “marijuana”)

Structured Interview

• Open with casual life questions
• Progress to mental health questions
• Next ask about drugs and alcohol:
  – Do you smoke cigarettes?
  – Do you drink alcohol? How much?
  – Do you smoke weed?
  – Have you ever used cocaine? Even once?
Structured Interview

• Open with casual life questions

• Progress to mental health questions

• Next ask about drugs and alcohol:
  – Do you smoke cigarettes?
  – Do you drink alcohol? How much?
  – Do you smoke weed?
  – Have you ever used cocaine? Even once?
  – Have you ever used heroin? Even once?
Structured Interview

• Open with casual life questions
• Progress to mental health questions
• Next ask about drugs and alcohol:

  – *These are routine questions I ask everyone!*
Don’t overreact to positive answers

don’t let the patient feel accused of being an addict or drug seeker (even if they are!)
Your risk assessment is nearly complete!

It has been “painless” so far!
Structured Interview

• Open with casual life questions
• Progress to mental health questions
• Next ask about drugs and alcohol
• Ask about pill related behaviors:
Structured Interview

• Open with casual life questions
• Progress to mental health questions
• Next ask about drugs and alcohol
• Ask about pill related behaviors:
  – Where do you store your pills?
Structured Interview

• Open with casual life questions
• Progress to mental health questions
• Next ask about drugs and alcohol
• Ask about pill related behaviors:
  – Where do you store your pills?
  – Do you ever forget to take them?
Structured Interview

• Open with casual life questions
• Progress to mental health questions
• Next ask about drugs and alcohol
• Ask about pill related behaviors:
  – Where do you store your pills?
  – Do you ever forget to take them?
  – How do you know when to take them?
Structured Interview

• Open with casual life questions
• Progress to mental health questions
• Next ask about drugs and alcohol
• Ask about pill related behaviors:
  – Where do you store your pills?
  – Do you ever forget to take them?
  – How do you know when to take them?
  – Has anyone asked to borrow a pill?
Is your pain ever so bad that you need to take extra medicine?
Is your pain ever so bad that you need to take extra medicine?

What do you do when the pain is this bad?
How do you make up the difference when you take extra pills?

Do you run out early?

What happens when you run out of medications?

Have you ever needed to borrow or buy a pill from a friend?
What to avoid during the structured interview...

• Reacting judgmentally, offering assessments
• Making decisions about medicines
• Getting side tracked into “pain talk”
• Making it sound like you are checking boxes on a questionnaire
• Seeming rushed
After this is done, discuss pain and opioid dose
If the patient catastrophizes their pain, use the information you have gathered to redirect them
Be self aware of your emotions

• Doctors like to fix problems
• Doctors like to satisfy patients
• Doctors do not like grey areas
• Your training may not be adequate
  – (addiction & psychiatry)
• You may be busy or stressed on that day
• Your system may not support you
Do not accept these statements

• These pills aren’t doing anything for me
• I want my pain to be zero
• OK, I’ll just find more on the street
• You are the only doctor who can help me
• What are you going to do about my pain?
• I’m going to complain/sue/write a bad review of you
Being lied to

• The patient may not know they are lying
  – They may be confused and desperate
• Allow lies that only serve to save face
  – “I didn’t realize this was such a big deal”
• Try to correct lies that are unhealthy
  – “I can’t live with this level of pain”
• Dismiss or redirect from lies that are unhealthy and cannot be corrected
  – “Someone put cocaine in my orange juice”
Instead of trying to catch a patient in a lie,

Try to create an atmosphere where they don’t need to lie.
The opioid tolerant patient can't reliably discern their body's signals. *But they know opioids will help!*
“Have you noticed a relationship between work stress and your headaches?”

“So you’re telling me that whenever work is stressful, your headaches get worse?”
“I am not saying it is all in your head!”

“But when you are having a bad day, everything feels worse?”
“I am so sorry that happened to you.”

“You will never be pain free until you confront what happened to you in your past”
Some patients have lost confidence in their body.

They need reassurance that they will heal, that they are not in danger.
Some patients show up to hear “no”

They look to you to set limits for them.
Pain Flare-Medication Vicious Cycle

Baseline chronic pain → Pain flare

Misinterpretation as successful medication adjustment

Resolution → Pain flare

Medication increase

Misinterpretation as disease progression or tolerance to opioid
Some patients will respond better to limit setting if offered an early follow up.

They are anxious about future pain as much as in pain in this moment.
Try to strengthen your patient-doctor bond even if you aren’t willing to prescribe opioids
Make sure you are aligned with the patient first and foremost
Many docs lose confidence that the patient would return if not given opioids
It is ok to reflect back to them what you are observing and what you observe:

“It sounds like things are actually going ok for you.”

“You look relatively comfortable.”
I always tell patients seeking more opioids what I would want done for my sister or brother in a similar situation and why.
It is ok for you to explain the limits of your training, the clinic’s capacity, or your comfort zone
Summary

• First center yourself
• Screen the patient for withdrawal, mental health
• If appropriate conduct a structured interview
• Redirect from pain talk
• Ally yourself with the patient
• Build up your relationship with the patient
Medical home for pain patients

- Embedded addiction/buprenorphine doc
- Embedded pain psychologist
- Embedded psychiatrist
- Embedded pain specialist
- Nurses on board, excited for pain work
- Pharmacist on call
- Lab/toxicology on call, aware of your needs
Opioid prescription “dispensaries”

- Centralized clinic with nurse, pharmD
- All chronic opioid patients from all clinic providers pick up their scripts there
- Staff trained and interested in working with these patients
- Consistency with patient provider agreement
- Can identify red flags in patients (and providers!)
Weekly pain clinic debriefings

• A multidisciplinary team of providers to debrief on the most challenging patients
• Invite any prescriber in your system
• Trains the prescribers
• Improves consistency
• Helps triage referrals
• Appropriate venue to vent
System support

• Pain care a major source of burn out
• Pain control incentives are counterproductive
• Pain provider patient agreement needs to be up to date and carefully crafted
• Patient representative needs to understand these dynamics
• Someone should run the data on pain patients
• Your boss needs to support your (time etc)
Thank you!
Questions?
BOX 1. CDC recommendations for prescribing opioids for chronic pain outside of active cancer, palliative, and end-of-life care

Determining When to Initiate or Continue Opioids for Chronic Pain

1. Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate.

2. Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how therapy will be discontinued if benefits do not outweigh risks. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.

3. Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy.

Opioid Selection, Dosage, Duration, Follow-Up, and Discontinuation

4. When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids.

5. When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when increasing dosage to ≥50 morphine milligram equivalents (MME)/day, and should avoid increasing dosage to ≥90 MME/day or carefully justify a decision to titrate dosage to ≥90 MME/day.

6. Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed.

7. Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently. If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.

Assessing Risk and Addressing Harms of Opioid Use

8. Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (≥50 MME/day), or concurrent benzodiazepine use, are present.

9. Clinicians should review the patient’s history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months.

10. When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs.

11. Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.

12. Clinicians should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder.

* All recommendations are category A (apply to all patients outside of active cancer treatment, palliative care, and end-of-life care) except recommendation 10 (designated category B, with individual decision making required); see full guideline for evidence ratings.
Resources

• 2016 cdc guideline chronic opioid prescribing: www.cdc.gov/drugoverdose/prescribing/guideline.htm


• Free online cme and moc on opioid prescribing and addiction mnmed.org/advocacy/Key-Issues/prescription-opioids-lecture-series
Think Different: CARE PLANS
Consistent care across systems for patients on chronic opiates or drug abuse potential

Ankit Mehta, MD
Hospitalist, Regions Hospital/HealthPartners
Assistant Professor of Medicine, University of Minnesota Medical School
Think different

"Insanity is doing the same thing over & over again & expecting different results."

Albert Einstein
Overview

• Opioid Epidemic:
  A flood of opioids, rising tide of deaths

• Opioid prescribing equation:
  Scope and downstream impact of prescribing in inpatient setting

• High utilizers

• Individualized Care plans
OPIOID EPIDEMIC

• A flood of opioids, rising tide of deaths
Perspective

A Flood of Opioids, a Rising Tide of Deaths

Susan Okie, M.D.

![Graph showing deaths from unintentional drug overdoses in the United States from 1999 to 2007.](image)
In 2007, Purdue Pharma pled guilty to misleading the public about the risk of addiction to the drug in a lawsuit brought by the U.S. Department of Justice, and it paid $634.5 million in fines.
Philip Seymour Hoffman's death ruled accidental

The actor died accidentally of a deadly mix of drugs, New York medical officials announce.

The office of New York’s chief medical examiner said that actor Philip Seymour Hoffman died from “acute mixed drug intoxication” from substances including heroin, cocaine, benzodiazepines and amphetamines. (Jay L. Clendenin / Los Angeles Times / January 19, 2014)
Prince died from accidental overdose of fentanyl

Medical examiner's report doesn't say whether the potent painkiller had been prescribed.

By David Chanen and Jeremy Olson Star Tribune staff writers | JUNE 3, 2016 — 10:02AM
National Overdose Deaths
Number of Deaths from Prescription Opioid Pain Relievers

Source: National Center for Health Statistics, CDC Wonder
The New Heroin Epidemic

Ten years ago, prescription painkiller dependence swept rural America. As the government cracked down on doctors and drug companies, people went searching for a cheaper, more accessible high. Now, many areas are struggling with an unprecedented heroin crisis.

By Olga Khazan
Illustrations by Lauren Giordano
OCTOBER 30, 2014

2010- 6% of MN 12th graders used narcotics, 1.4% heroin

Percent of admissions for addiction treatment (MN):
2010- 3% heroin
2011- 10% heroin
2014- 14.6% heroin
National Overdose Deaths
Number of Deaths from Heroin

Source: National Center for Health Statistics, CDC Wonder
“Skyrocketing female overdose death rates are closely tied to a boom in the overall use of prescribed painkillers”

“Studies suggest that women are more likely to have chronic pain, to be prescribed higher doses, and to use pain drugs longer than men”

“The report highlights the need for "a mindset change" by doctors, who have traditionally thought of drug abuse as a men's problem”

“One striking finding: The greatest increases in drug overdose deaths were in women ages 45 through 54, and 55 through 64. The rate for each of those groups more than tripled between 1999 and 2010.”

High Risk Mix: Opioids, Benzodiazepines, Sleepers, Antidepressants
OPIOID PRESCRIBING EQUATION IN HOSPITALS
Opioid prescribing equation in hospitals

- Half of hospitalized patients in US are exposed to opioid medications during their hospitalization*
- Among opioid naïve patients admitted to the hospital, one quarter go on to receive a script for an opioid in 72 hours after discharge**
- 4% have ongoing use 1 year after discharge**

Drivers of physician’s decision making?*

• Hospitalists find acute exacerbations of chronic pain challenging

• Negative prior experiences related to opioid prescribing strongly inform future prescribing

• Opioids are often used as a tool to facilitate discharges and prevent admissions

HIGH UTILIZERS
High utilizers?

• Less than 1% of patients account for 21% of national healthcare spending, and hospital costs are the largest category of national healthcare expenditures\(^1,2\)

• Many patients who disproportionately contribute to high healthcare costs also have high hospital admission rates\(^3,4\)

9 patients made nearly 2,700 ER visits in Texas

AUSTIN, Texas — Just nine people accounted for nearly 2,700 of the emergency room visits in the Austin area during the past six years at a cost of $3 million to taxpayers and others, according to a report. The patients went to hospital emergency rooms 2,678 times from 2003 through 2008, said the report from the nonprofit Integrated Care Collaboration, a group of health care providers who care for low-income and uninsured patients.
CARE PLANS
Care Plans: Purpose

• To see whether the use of specialized care plans for high risk patients could reduce the rate of medically unnecessary hospital admissions and ED visits.
Prior Literature---Mostly ED-based

Individual care plans can reduce hospital admission rate for patients who frequently attend the emergency department, Newton JA, et al, Emerg Med J (UK), 2010, Jun 1

Case management of patients who frequently present to a Scottish emergency department, Skinner et al, Emerg Med J 2009;26

Effectiveness of Electronic Medical Record Care Plans at Decreasing Emergency Department Recidivism and Narcotic Prescribing
Annals of Emergency Medicine, page S256, October 2011
R. Kapur*, J. Siff, C. Emerman
MetroHealth Medical Center, Cleveland, OH
High and Low Frequency Emergency Department Users: A Comparative Analysis of Morbidity, Diagnostic Testing, and Health Care Costs
Annals of Emergency Medicine, October 2011 J. Oostema*, J. Troost, K. Schurr, R. Waller, Michigan State University College of Human Medicine

Results
A total of 1969 individuals visited the ED 10 or more times per year during the study period. When compared to infrequent users, these individuals had lower admission rates (11.1% vs. 17.9%, p<0.001), and lower mortality (1.5% vs. 0.7%, p=0.002). Mortality in the high frequency cohort was limited to patients with chronic alcoholism and sickle cell disease. Although frequent users were less likely to receive CT scans on a given ED visit (0.16 vs. 0.23, p<0.001), this effect was not observed for ultrasounds or lab tests. The annual number of CT scans received was higher among frequent users (2292 vs. 851, p<0.001). Most frequent ED users were insured, typically through Medicaid (50%) or Medicare (25%). Charges per visit were lower among frequent users ($2891 vs. $5294, p<0.001), but total charges rose steadily with increasing ED use. Eighty patients with >29 visits/year had the lowest triage acuity (86% low acuity), lowest admission rate (4.5%), and lowest ICU admission rate (0.5%), while receiving the highest number of annual CT scans (3.7 scans/year). This sub-cohort incurred over $4,800,000 in charges per year. These results were all significantly different than infrequent users (p<0.001).

Conclusion
As frequency of ED use increases, acuity of disease decreases while intensity of diagnostic workup and healthcare costs increase. Further study should elucidate the motivations of patients with very high ED use and examine strategies to curb overuse.
High vs Low Frequency ED patients

Compared to Low Frequency Patients, High Utilizers had:

--Lower admission rates 11.1 vs 17.9%  p<0.001
--Lower mortality 0.7 vs 1.5%  p<0.002
--More annual CT scans 2992 vs 851  p<0.001

Notes:

--Mortality in HF users limited to alcohol and sickle cell disease
--Highest utilizers (>29 visits/yr) had:
  *lowest triage acuity, admission rate (4.5%)
Care Plan Mantra

EASY TO CREATE

EASY TO FIND

EASY TO USE

OH YEAH, AND IF EVERYONE HAS ONE, NO ONE HAS ONE
Hospital Care Plan Committee

Leaders from:
Hospital Medicine
Nursing
Quality
Care Management
Risk Management
Emergency Medicine
Primary Care
EMR specialists
Types of Care Plan Templates

1) Narcotic restriction
2) Behavioral
3) Common Presentation
4) Mixed
Easy to Create (Templates)

- Our goal at Regions Hospital is to provide high quality, safe care to all our patients. Out of concern for your well-being, your doctors and nurses referred your case to the Regions Care Plan Committee for review. **The committee made the following recommendations** to help coordinate your care, and to make sure you continue to receive the safest care possible.
Easy to Create (Templates)

Here are the guidelines we use to provide you with safe and effective care. We want to help our patients avoid problems with narcotics.

We will not give IV narcotics (drugs given in the vein) in the Emergency Room (ED) unless you have an acute medical condition not related to chronic pain.

The best place to get routine medical care or care for ongoing pain is from your clinic care team. The ED is not the right place for this care. We will help you set up visits with your clinic providers.

We do not fill prescriptions for narcotics taken by mouth when you are discharged from the hospital or ED.

For ongoing pain, follow your clinic doctor’s care plan.

We do not use IV Benadryl or IV Benzodiazepines (Valium, Ativan) for pain control.

We will let you know about treatment programs for substance abuse if they seem right for you.

We will not do repeated imaging studies (such as CT scans) unless there is a good reason. These imaging studies can put you at risk for radiation exposure. We will only do them when an exam or lab tests suggests that you may have new medical problem.

Don’t try to get narcotic prescriptions from other hospitals or clinics, unless it is your usual primary clinic or provider. We are part of a community program that keeps track of narcotics prescriptions.
EASY TO FIND (HM/ED/CLINIC)

ED/Hospital Compliance Careplan exists - See Careplan in Chart Review
Outcomes: 114 Care Plans

Overall Actual ED Visits and Hospital Admissions
11/24/10-10/21/13

- Overall ED visits have decreased by 45.92%
- Overall Admissions have decreased by 67.27%
### Care Plan Survey Results

6. In your opinion, which of the following is most likely to prevent care plans from improving coordination of care for high-risk patients?

<table>
<thead>
<tr>
<th>Option</th>
<th>Response Percent</th>
<th>Response Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient buy-in (e.g. patients will use other systems)</td>
<td>10.0%</td>
<td>1</td>
</tr>
<tr>
<td>Provider buy-in (e.g. providers will not consistently implement/abide by established care plans)</td>
<td>10.0%</td>
<td>1</td>
</tr>
<tr>
<td>System implementation (e.g. EMR limitations)</td>
<td>10.0%</td>
<td>1</td>
</tr>
<tr>
<td>Inadequate coordination between ED-Inpatient-Clinic</td>
<td>50.0%</td>
<td>5</td>
</tr>
<tr>
<td>Other (please specify)</td>
<td>20.0%</td>
<td>2</td>
</tr>
</tbody>
</table>
What do patients think?

ANALYSIS OF HIGH-UTILIZERS' EXPERIENCE WITH SPECIALIZED CARE PLANS

Ian Melander, MD, Tyler Winkelman, MD and Richard Hilger, MD
SFHM, HealthPartners - Regions Hospital, St. Paul, MN, 2013

--Attempted to contact 64 patients on care plans (phone calls, mail)
--47 patients unreachable (phone disconnected, address change, etc..)

Take Home Message: high risk patients need better coordination of care/ discharge phone calls likely don’t add benefit for this patient population.
Lessons Learned

- Start small with 5-10 of your highest risk patients
- Involve clinic team whenever possible before creating CP!!
  **consistent message across system**
- Creating a committee leads to better coordination
  **recruit social work, care management staff**
- Need buy in from ED providers and leadership
- Don’t expect perfection. Don’t get disappointed when a care plan doesn’t work.
  **Change your culture over time**
  **Less hospitalists being fired by patients**
“If you build it, they will come”
Next Steps

- Case Manager to oversee program
- Care plan order placed in EPIC, routed to the correct committee for review
- Disease specific care plans (Dialysis)
- How do we create a more coordinated system within the community for high risk patients?
  **Community resources**
  **HIPAA**
  **Patient Privacy policy changes needed for the 1%**
- **Two pronged approach:**
  1. Prevent new narcotic addictions
  2. Proper treatment for those already addicted
THANKS

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Prepare for Pain: A Rounding Framework to Ease Uncertainty in the Hospital

Paul Kleinschmidt, MD
Internal Medicine, Hospitalist
University of Minnesota
Uncertainty
Objectives

• Approach chronic pain flares in hospitalized patients as one would any other illness with a systematic approach
• Recognize patient concerns, and how to guide the conversation to goal setting and risk/benefit discussion
• Recognize empathy as an invaluable skill
• Consider whether the CDC recommendations for care of persons with chronic pain can help guide inpatient decision-making
Congestive Heart Failure

• Admitting a patient with CHF:
  – Confirm: Is this really a CHF exacerbation? Symptoms? Weight Gain? Physical findings (CVP, LE edema, rales) Tests: Xray, BNP
  – Etiology: Medication review and ask patient about changes; salt intake; arrythmias; ischemia
  – Rounding: I/O; weight; medications given – extra doses overnight? Symptom/Function improvement
  – Expectations? Patient may not voice unless asked
    • Shared decision making if reasonable
Preparedness: Mental Model and Checklist for Admission of Chronic Pain Flare

• Verify Diagnosis: Cognitive bias--Anchoring is there a different etiology to pain this time?

• Implicit bias: Towards a patient population? Racial?

• Emotional Check: How Am I feeling? Empathy Time-Out---this patient does not want to be in this position

• Pre-Visit Framework
**Ethnicity as a Risk Factor for Inadequate Emergency Department Analgesia**

Knox H. Todd, MD; Nigel Samaroo; Jerome R. Hoffman, MD

*JAMA.* 1993;269:1537-1539

ED: isolated long-bone fracture: Hispanics were twice as likely to receive no analgesia as White pts

**Ethnicity and Analgesic Practice**


ED long-bone Fx: 74% of white pts received analgesia, versus 57%, RR 1.66
For pain related visits 1993-2005, white patients were more likely to receive opioids (31%) than black patients (23%) or hispanic patients (24%).
Pre-Visit Framework
What do you want to know?

• 90 seconds: Please write down which pieces of information from the chart review, or emergency room physician, or otherwise that you want before you meet the patient

• 2 minutes: Now share with the person next to you your list: circle the matches, and take turns sharing the items that you don’t’ have

• I will share our ‘checklist’ and solicit a few more ideas that are missing
Checklist for Chronic Pain Flare

- Verify and Confirm Dx
- Review Notes
- Notes and Care Plans
- Talk to ED +/- PCP / Pain
- PMP Query: MME/day
  - Last Refill
  - Benzodiazepines
- Mental Health Co-morbidities
- Addiction History
- Drug Screens
- Medical Risk: OSA, age
- Tissue Damage or Acute on chronic injury
- Nurse Observations
- PROVIDER GOALS
  - IV or no IV?
  - Escalate dose?
  - Discharge higher dose?
Pre-Admission Framework

• Confirm Dx: What is chronic pain diagnosis or syndrome?
  – E.g. Verified chronic pancreatitis, chronic abdominal pain, low back pain. How long-standing is the diagnosis, ie. Adequate workup?

• Notes and Care Plans: from PCP, pain specialist
  – Care plan: Pain Contract? ED care plan? Recent visits and DC summaries?
  – Nursing Notes and observations: over-sedated? vomiting? Diarrhea? Vital signs

• Discussion with ED physician +/- primary care
  – +/- Pain Specialist
Pre-Admission Framework

- PMP query, and current Medication List (CDC #9).
- Total Morphine Milligram Equivalents per day
  - Greater than 50 MME/day risky (CDC #5)
  - Over 90 MME/day dangerous, avoid higher (CDC #5)
    - Last refill: this is key! 31 days ago on 30 day refill
- Mental health co-morbidities and medications
  - Especially Benzodiazepines! (CDC #11)
- Tissue Damage? Evidence or possibility of organic disease?: e.g. Lipase up?
- Urine Drug Screen: any previous in system? (CDC #10)
Differential Diagnosis for Chronic Pain Flare

• Different acute process
• Worsening of chronic pain for various reasons
  – Mental illness or psychosocial
    • Anxiety is treated by opioids
    • Psychosocial stress; Depression
  – Physical-Medical contribution:
    – Unclear
• Withdrawal: Ran out of Pills Early: when was last refill?
• Opioid Use Disorder: tolerance, addiction, etc.
• Diversion: many prescribers, drug screen neg
Pre-admission Framework

• Talk to Nurse: how is Mr. R doing? (avoid biased question)
  – Observed vomiting? Anxiety? Withdrawal sx?
• Physician goals -- Your game plan: What are your goals as physician? CDC #2
  – IV seems reasonable, but set for X hours as expectation
    IV not reasonable, because….. (risks/benefits)
  – Will you send them home on higher dose oral opiates? How long? Who will follow-up?
    • 3 days or less for acute pain CDC #6, rarely more than 7
Approach to the Visit

• Empathy: Validate the patient’s pain as real, frustrating

• Guide conversation to Function and Goals
  • Who are they as a person? “Tell me about yourself.”
  • Baseline Function: “What do you like to do on a good day?”
  • Psychosocial: “Is home relaxing for you?”
  • Ideas: “What do you think is causing this pain?”

• Patient Expectations and Goal Setting:
  • Risks and Benefits Discussion
Empathy: Acknowledge the Pain as Real

Original Article

Contrasting Tensions Between Patients and PCPs in Chronic Pain Management: A Qualitative Study

Alicia A. Bergman PhD, Marianne S. Matthias PhD, Jessica M. Coffing MPH,
Erin E. Krebs MD, MPH

First published: 19 July 2013  Full publication history
Patient Expectations

• “I can see that you have really been struggling in recent days with the pain worsening, and not being able to do what you usually do, and not sleeping. What are your goals during this hospital stay and after you go home from the hospital?

• What do you think we can accomplish during this hospital stay?

• Benefits of eliciting patient goals?

• Dangers of eliciting patient goals?
  – “What would better pain control allow you to do?”
Shared Decision Making: Goal Setting and Physician Expectations

• Setting Goals and Expectations upfront: patients in chronic pain have little control, and last minute surprises usually derail the therapeutic relationship.

• CDC recommendation #2: Before starting opioid treatment for chronic noncancer pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and how it will be discontinued if benefits do NOT outweigh risks.
  
  – Function: what is something you were able to do 2 weeks ago before things got worse, that you want to do again? Social goals, emotional goals.
  
  – PEG scale?? CDC #2 Dr. Erin Krebs.
PEG: Outpatient, longitudinal scale

1. What number best describes your pain on average in the past week:
   - 0: No pain
   - 10: 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: Does not interfere
   - 10: Completely interferes

3. What number best describes how, during the past week, pain has interfered with your general activity:
   - 0: Does not interfere
   - 10: Completely interferes

BRIEF REPORT

Development and Initial Validation of the PEG, a Three-item Scale Assessing Pain Intensity and Interference

Elin E. Krebs, MD, MPH, Karl A. Lorenz, MD, MSHS, Matthew J. Bair, MD, MS, Teresa M. Damush, PhD, Jingwei Wu, MS, Jason M. Sutherland, PhD, Steven M. Asch, MD, MPH, and Kurt Kroenke, MD
Susan W, 70-90 MME/day chronic abdominal pain, Multiple previous abdominal surgeries

• “Let me see if I have this right, and let’s come up with a plan together: several weeks ago you were able to get groceries, meet your knitting group, and walk the dog, but the last week things have gotten much worse and you haven’t been able to leave home. You said you just want this pain to be gone, and live your life. I can see how anyone would feel that way. While I don’t think we can get rid of the pain, we can work on a plan to control the pain so you can walk a little bit more in the hospital before going home, with the goal eventually to get back to knitting and walking your dog. What do you think?”

• CDC recommendation #2 –setting goals
Shared Decision Making: Risk and Benefit discussion, and clinician responsibility to patient

- **CDC recommendation #3**: Before starting opioids and then intermittently during treatment, clinicians should discuss known risks and realistic benefits of opioid therapy, and clinician responsibilities in managing opioid therapy
  - Be explicit and realistic about expected benefits of opioids
  - Accidental overdose and death, car accidents, addiction (opioid use disorder)
There is a direct relationship between daily MME/day and overdose death.

The relationship strengthens statistically and grows in magnitude as the MME increases.
Many studies, similar results
ICSI 2016:
Keep doses under 100 MME
If addict or on benzos <50 MME

CDC 2016:
Keep doses under 90 MME
ideally <50MME
Susan W continued

• “Doc, I need something to control my pain. I need more pain meds. Yeah, I want to get home and walk my dog too, but how can I even think about walking the dog with how much pain I’m in? Can’t you see I’m in horrible pain? The pain meds are the only thing that help at this point. It’s not that I want to be on more pain meds.”

• One of you is Susan, and the other the provider: practice responding with empathy, risks and realistic benefits, and if needed clinician responsibility to not do harm: 5 min
Susan W, 80 MME/day

- Empathy Statements: “I can see you are really hurting, I have no doubt that the pain is real. I can’t imagine how difficult this is.”
- P Partnership “Let’s work on a plan together”
- E Empathy/Emotions “You sound discouraged”
- A Apology/Appreciation “I can see you’ve…”
- R Respect “I respect your courage”
- L Legitimation “Anyone is your position…”
- S Support autonomy “I’d like to support your decisions”

- American Academy of Communication in Healthcare
Susan W: CDC #3: Be explicit and realistic about expected benefits

• “It sounds like you think you need higher doses of pain meds. Let’s first talk about the risks, and the chances of it helping you. We know more and more about the risks of opiate narcotic pain meds. For any surgery or medication we consider, we always think about the benefits and the risks. We know there are real risks of overdose and death from these meds, and becoming dependent on these pills--having them hijack your life—and you are already at a high dose that puts you at risk. If we go higher on the dose, it would put you in the highest risk of dying from accidental overdose. The few studies we have suggest that increases in dose in narcotic pain meds only help temporarily perhaps, don’t decrease pain that much, and certainly not over the long hall....”
Why won’t you give me more IV pain meds, doc?

• “You have told me that you want IV dilaudid as that is the only thing that has helped so far. I can see you are in a lot of pain and struggling. We docs always prefer pain medications that are oral, or pills, for long-standing illnesses and when people can swallow safely, because IV has some additional risks. I’m comfortable prescribing IV dilaudid overnight and then we will transition to pills only in the morning. How does that sound?”
  --- CDC #2

• “I’m wondering if you can describe how your experience with the IV is different?”  -- Explore
IV versus Oral Opiates

Journal of Anesthesia

A randomised trial of oral versus intravenous opioids for treatment of pain after cardiac surgery

Authors

Kurt Ruetzler, Constance J. Blome, Sabine Nabecker, Natalya Makarova, Henrik Fischer, Harald Rinoesl, Georg Goliasch, Daniel I. Sessler, Herbert Koinig
Unrealistic Expectations

• “You have told me that you wish the pain would just completely go away, and that your goal is no pain. I can’t imagine how hard it has been to be dealing with pain for this many years. I wish it was possible to take the pain away completely.” Pause....

• “Based on what you told me and your experience, I’m worried that it won’t be possible to take away the pain, and so we should look at how to live with it”
Conclusions: Living with Uncertainty

• A systematic approach may help decrease ambiguity, increase confidence, and hopefully lead to safer care for patient
  – e.g. CHF: Walk into meeting prepared, your goals
• Prepare and Frame the discussion with patient
  – Empathy; set realistic, safe goals; risk/benefit discussion
• Extrapolated from CDC guidelines of the use of opiates in chronic pain to inpatient chronic pain flares
• Take care of ourselves as we take care of patients with chronic pain
  – Build and preserve Relationship: pt not always happy
  – Increase skills; debrief with each other
Shared-decision making about opioid tapering

Erin E. Krebs, MD, MPH
Minneapolis VA Health Care System
University of Minnesota
Shared decision-making

- Involves both patient and physician sharing information and expressing preferences
- Does not require physician to give up prescribing decision authority

Degree of decision sharing

Patient alone

Severe opioid-induced nausea & constipation

Shared equally

No clear benefit, low-risk regimen

No clear benefit, high-risk regimen

UDT positive for cocaine & negative for prescribed opioid

Doctor alone

Figure adapted from Makoul and Clayman. Patient Educ Couns. 2006;60(3):301-12.
Case 2

- 55 yo woman on opioids for chronic LBP >15 years
- PTSD, insomnia, obesity, OSA, pre-diabetes, recurrent nephrolithiasis (s/p unilateral nephrectomy)
- Smokes 1 pack/day, no alcohol, no history of SUD
- Married with adult children & many grandchildren
- Self-identified “crafter,” used to love traveling
- Uses scooter for mobility outside

Morphine SR 60 mg TID
Hydrocodone/APAP 5/325, 2 tabs Q6h
Diazepam 2 mg QHS and 2 mg BID prn
Zolpidem 10 mg QHS
Sertraline 200 mg Q day

How would you assess her risk for opioid harm?
## Risk factors for death and OUD

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<tr>
<th>Risk Factor</th>
<th>Death</th>
<th>Opioid use disorder</th>
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<tbody>
<tr>
<td>Opioid dose &gt; 50 ME mg/day*</td>
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<td>X</td>
</tr>
<tr>
<td>Concurrent sedative-hypnotic*</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Substance use disorder (past or now)</td>
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<td>Depression or anxiety disorder</td>
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<td>X</td>
</tr>
<tr>
<td>Smoking</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>High pain severity or impairment</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Younger age</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Family hx of substance use disorder</td>
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Case 2 Assessment

- Chronic back pain on long-term opioid therapy
  - Risk factors for serious harm
    - High-dose (220 ME mg/day) therapy
    - Concurrent benzodiazepines & other sedatives
    - PTSD
    - Smoking
  - She is adherent to prescribed opioid therapy
Case 2

- 55 yo woman on opioids for chronic LBP >15 years
  - PTSD, insomnia, obesity, OSA, pre-diabetes, recurrent nephrolithiasis (s/p unilateral nephrectomy)
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Zolpidem 10 mg QHS
Sertraline 200 mg Q day

How would you assess opioid benefits?
Questions to ask

- Asking about activities & limitations
  - *Tell me about a typical day for you*
  - *Compared to five years ago, how is your life now?*
  - *How would your life be different if your pain didn’t interfere?*

- Clarifying specific opioid effects
  - *Do you take them by the clock or based on something else?*
  - *What do you mean when you say... [they take the edge off]?*
Monitoring tools: PEG

**P**ain on average

**E**njoyment of life

**G**eneral activity

What number best describes your pain on average in the past week? (from 0=no pain to 10=pain as bad as you can imagine)

What number best describes how, during the past week, pain has interfered with your enjoyment of life? (from 0=does not interfere to 10=completely interferes)

What number best describes how, during the past week, pain has interfered with your general activity? (from 0=does not interfere to 10=completely interferes)
Case 2 Assessment

- Chronic back pain on long-term opioid therapy
  - Risk factors for serious harm
    - High-dose (220 ME mg/day) therapy
    - Concurrent benzodiazepines & other sedatives
    - PTSD
    - Smoking
  - She is adherent to prescribed opioid therapy
  - No demonstrable benefit from opioid therapy
    - Pain is severe and interferes with family and home responsibilities, hobbies, social life, sleep, and walking
Case 2 exercise
Discuss overdose risk
Discuss opioid dose reduction
Develop plan for initial taper
Report out to group
Case 2 follow-up

- **Opioid taper**
  - Tapered off morphine SR over 18 months
  - Continues hydrocodone 5/325 mg TID PRN

- **Dramatically improved physical function**
  - No longer using scooter
  - Resumed hobbies, travel, care of grandchildren

- **Relapse in PTSD symptoms → mental health**
  - No change in benzodiazepines

- “I was angry with you in the beginning, but I have to admit you were right.”