Opioid Stewardship Series, Season 1, Episode 9: Getting Patient Buy-In Through Education

Speaker 1 (00:03):

I want to introduce, um, Dr. Holly, Holly Geier from the Mayo Clinic here in Phoenix, Arizona. Um, Dr. Geier is a hospital internal medicine physician, with a sub-specialty in addiction medicine, and has been a leader throughout Mayo Clinic's opioid stewardship journey.

Speaker 2 (00:21):

It's a privilege to be with all of you today. You know, we're going to be talking about the end user of all of this, and at the end of the day, the patient is really what this is all about, right? Why wouldn't we educate them? Why wouldn't we get buy-in and how do we do it? It's not as simple as it sounded like when I first took over some responsibilities on this topic in 2016, and I've done a lot of learning along the way. So, I want to take you on my journey and give you some understanding that I've acquired. So, let's go over our objectives. We're going to start off with assessing how patient engagement and shared-decision making can really improve opioid safety and all of the stewardship efforts that go with it. We're going to look at how we can apply these educational strategies to inform patients, and importantly, their family members, their friends about the risks and the side effects of opioids.

Speaker 2 (01:09):

What we don't want are overdoses. We don't want opioid use disorder or OUD. And then we're going to analyze the, the resources that are available to patients when the community for harm reduction. We'll talk a little bit about California, a little bit about Arizona, and what might be out there. So, let's jump right in here. You know, do, do patients and providers see eye-to-eye on every topic? Anyway, I know we've got prescribers, providers, and other allied health staff in the mix here listening <laugh>, and if you said "yes" to this question, I'd like to join your practice. The reality is that there is this chasm between us, and I want to explore a little bit just what that comes from. So when, when we look at the alignment challenges, why there is this need to educate our patient population, it really comes down to our priorities.

Speaker 2 (01:59):

Patients have a different set of priorities when they're seeking medical care than we have when we're offering them medical care. As counterintuitive as it seems, when they come to us, they're, they're coming for you more often than not. These immediate needs, you know, what, what hurts? What symptom do they have? It's really a symptom-based regimen for the drivers into the healthcare field. What's worrisome, what scares them, how do we alleviate those fears? And then often what's, you know, kind of self-limited, common cold symptoms when we want to focus on diabetes. You know, ankle sprain when we know that, um, their thyroid level is way off and they're taking a homeopathic regimen, right? Providers see the world from a different vantage point. We look at it from the full scope of health, you know, not necessarily what's the short-term problem, but how will this impact the long term?

Speaker 2 (02:49):

What's the risk of future disease in whatever their condition is that they're presenting with? Or is there a short-term problem, not necessarily at high risk of deterioration, but something else that we see during that that visit is? Studies have suggested there's an alignment between a patient's reason for a visit and a physician's main concern at that visit, <laugh> less than 70% of the time. I thought that was a very generous number, to be perfectly honest. It's important to understand that of all the top health priorities that patients are gonna seek evaluation for, there was a nice submarine and study that was done as recent, that looked at 163 elderly patients. And I believe this made it into JAMA. They found pain, not surprisingly, to be that number one complaint. And as you can see here, there's a nice little list of complaints.

Speaker 2 (03:36):

That list went on for another two to three pages. There had to be 20, 30 of them. But at the top of that list: pain. Recognizing that pain is gonna be one of the biggest things that's discussed in office visits, in patient encounters, it's important that we have the right perspective when we approach that patient. And more often than not, patients are gonna be asking, what is your treatment going to be doing for me? How are you going to get me out of this pain? How are you going to give me better quality of life? Whereas in the opioid epidemic, providers have learned to ask, hold on, what will this treatment do to you? Right? And it's this unalignment between these two perspectives on opioids that has created the need for great education on this topic and the need for alignment when we address patient complaint of pain.

Speaker 2 (04:23):

The point of partnership has been well studied and there's been enough things that have been evaluated. I've got a list here of six items that I think best comprise the reasons why we should be partnering. But number one, improve compliance. Are they gonna stick to the regimen that we give them? You know, improved satisfaction. Patients are more likely to be pleased with the care if they become partners with the regimen that's offered to them. Help them, allow them to help design this care plan. And you can do that by augmenting non-opioid pharmacotherapy therapies. Opioid or non-pharmacologic therapies reduce readmissions. If patients don't have their symptoms well controlled, they will seek it from another source, albeit an emergency room or a direct admission elsewhere. Let's partner to make sure they have good expectations for what pain will look like in the outpatient regimen.

Speaker 2 (05:14):

And let's design a care plan that allows them to get the help they need if the pain isn't well controlled. This is gonna help drive down costs in the big picture. We all know that, and it's gonna reduce unnecessary waste, including patients seeking alternative treatments from other providers to have their symptoms addressed. And then ultimately, we know it's going to improve their long-term health. Opioid use disorder and addiction are well-recognized complications along with cases of overdose when we don't screen appropriately. So, bringing them in as partners, making them engaged in their care are key. What is this partnership going to prevent? Well, we talked about a couple of these. Opioid use disorder, other things. Death, right? Associated with overdoses, non-fatal overdoses. There's a number of those that take place oftentimes before the ultimate overdose. Diversion, side effects, worsening of chronic pain, that hyperalgesia syndrome is real and ultimately, misuse.

Speaker 2 (06:13):

We know that prescribing opioids comes with inherent risks. You know, I think I see this even amongst my own colleagues, this concept that if opioids are used in legitimate pain situations, the individuals using them are low-risk for complications. And the reality is the data just doesn't support that. The data supports that opioids are safe if used in the right patient for the right indication, with the right drug, for the right dose, for the right length of treatment. When we've got the cosmos aligned, shall we say, with that, you're probably going to have a very good outcome for that patient. And things that complicate how to do this well is that chronic pain is a big driver in America. We see 50% to 80% of people that are dying from opioid overdoses had a history of chronic pain. That's a really common reason we're giving opioids as opposed to them getting it from the streets, right?

Speaker 2 (07:05):

On polypharmacy, we know that overdose is high in populations who use opioids with benzodiazepines, muscle relaxants or other sedatives, and that's in up to 20% of all people who developed dependency. We need to work on that. And the misuse trends, you know, for an individuals that ultimately work their way to heroin, four out of five, 80% of them started off with prescription opioids. So, there is a high level of responsibility on our part to get this right and to educate from the beginning. First thing we're going to do is talk about the importance of changing the mindset of pain itself. Historically, patients have come over the last 20 years with the understanding that the point of providing any type of pain medication is to get them out of pain. That's not our reality. We need to move from a mindset of elimination of pain with any pharmacotherapy to functionality with pain.

Speaker 2 (07:54):

Pain, especially when acute is there for a purpose, it limits and it helps us heal. Patients need to understand that. So, this brings us to our first concept of education. In the acute prescribing world, this is what patients need to know. Acute pain is expected. It's helpful, it helps with healing. And we use a combination of pharmacological and non-pharmacological strategies along with mental coping to get through it. If we do provide opioids, it's key during acute prescribing that we are educating them on safe opioid use. So, taking only as prescribed, don't use up that pill bottle when you're out of pain, get rid of it. Use with non-opioid approaches, conjunctively, and then try and mitigate side effects. You know, based on bowel regimens, nausea, things like that. Opioid storage is key. Please educate on them. Make sure that they're keeping these opioids in a safe, stored, locked place.

Speaker 2 (08:49):

And then destroy all leftovers immediately. And then educate on complications. What does addiction look like in its early phases? What are overdose risks? And how can we mitigate those? And that should say naloxone there, but how do we provide that therapy in appropriate circumstances such as those that are receiving more than 90 morphine milli-equivalence a day or those who have baseline cardiopulmonary risk factors for overdose. Those also receiving other medications, such as sedatives, opioid storage, and disposal. These are some of the kind of the hot tips that we educate our patients on. But essentially, giving instructions at a handout form. Every time that opioids are provided, tell them to stop taking when symptoms are controlled. They do not need to finish the bottle. Let 'em know that diverting medications to friends or family is illegal and can lead to death.

Speaker 2 (09:39):

Get the drugs out of the house when done. And there's different ways to dispose of these. You can mix them with palatable or unpalatable substances. Kitty litter, coffee grounds. You can drop 'em off at many pharmacies now that have disposal locations. Per the FDA, you can legally flush them, as counterintuitive as it seems, because many of the byproducts that we produce during opioid intake and ultimately metabolism are just as potent, if not sometimes more potent than the original product. And we pee those out <laugh>. So it's making it into water supply anyway, per the FDA. Chronic opioid prescribing, this is also key. So, many of the same things that we talked about from an education for acute prescribing are applicable here. Watch for disease. Let them know that it in itself as chronic pain is a disease and it's CNS- or central nervous system-sourced, there is a lot of brain rewiring that takes place.

Speaker 2 (10:33):

In general, these conditions are less likely to heal than acute conditions. So, you're going to wanna focus on non-pharmacologic options as first-line therapy. Opioids in general are not recommended for most cases of chronic pain. Be providing handouts for this. Send them to referral sources that can help provide additional education, such as valid websites. The CDC has some good ones. Safe opioid use. Again, take only as prescribed. Know that they're going to be screened and monitored through their course of treatment and use a controlled substance agreement to help facilitate this. Keep in mind, let your patients know that this is only a trial to improve functionality. If after about a month, if they're not provided a whole lot of relief with opioid therapy or if they're requiring increased doses, statistically they're not going to be good responders to opioid therapy. In most cases, consider deescalating opioids and trialing other therapies.

Speaker 2 (11:29):

Standardized messaging. There's a lot of ways to get your messages across. Here's just a couple of suggestions. Consider putting this information in your admission packet to the hospital. Handouts on both patient behaviors, what's expected of them during this stay for pain management, as well as what to expect for acute pain while inpatient. We developed similar documents for the outpatient environment as well, and those are handed out when, when opioids are provided. Consider developing some videos on this topic. Mayo Clinic ended up making more than 20 of them related to pain management, mind body management with chronic pain, things of that nature. Be sure to build these concepts for patient education into existing workflows. So, when, how, why by whom opioids are going to be prescribed. Let the patients know that. And then, of course, the management of complications.

Speaker 2 (12:19):

You're going to want referral processes for opioid use disorder, for naloxone provision, and then, how and when to discontinue prescribing when appropriate, including situations where there's clear diversion or opioid use disorder. We developed a handout database and I want to say 20 documents that we created internally. Here are some of the top ones, but they focused on opioid use and safety. Another handout for disposal, some on our prescribing guidelines and why patients may not be receiving what they've historically received in other situations for pain management. Just because we've recognized now all of the complications associated with chronic prescribing. Handouts for naloxone, for tapering, for mindfulness, or mind-body therapy. And then, a nice overview for chronic pain management and acute pain management. Once patients start understanding the why, they understand the how, and the how is what you'll be implementing. They'll be buying in much more easy if you've partnered with them on the "why." Community resources.

Speaker 2 (13:20):

So it, you know, as you go through this process and as complications are recognized, the community becomes a good location to send patients back to if your institution isn't necessarily able to help address these internally. So, I would say first off, leverage your social work and case management specialists to help build these relationships, community treatment programs, both for-profit and non-profit lists, as well as, counseling and substance use disorder providers. Having these handy in, you know, a handout format to give to patients can be a great resource. We did develop those internally. And then, you know, we can also instruct patients on county and state resources. Harm reduction is a big topic out there. Needle exchange programs, Naloxone access, and even safe injection sites are all increasingly recognized as great opportunities to actually get people into treatment.

Speaker 2 (14:17):

As paradoxical as it sounds, none of us in the physician world would ever endorse the patient using an illicit substance, right? It's not healthy. It's not safe. And so, there's always been this stigma from our perspective to allowing patients to, to go to a needle injection site. These have been well studied and the data actually shows paradoxically that when they're going there, they're getting counseling, they're being evaluated for secondary consequences of their drug use disorder. We're catching cases of endocarditis and infections. We're getting people into treatment and the treatment they need for medical problems. So, start checking into these because every state, including California, is increasingly recognizing their validity. And then, of course, naloxone access. I'm a big fan of a Naloxone prescription every time an opioid is written and teaching friends and family how to use it. The patient is rarely any better to their own treatment plan when they're experiencing an overdose.

Speaker 2 (15:11):

So, the more we can get it out there, the more helpful it is. And then of course, I've got a list here of federal resources. If patients have questions, where to take back their drugs, there's a disposal location website through the DEA. The SAMSHA Mental Health Services website gives a very nice listing of treatment resources for opioid use disorder by state and by county. There's also a SAMSHA National Helpline. Offer your patients that, and the people on the other end of the line can help guide them to treatment. Same thing for an HHS Opioid Treatment program website, which specifically deals more so with methadone as opposed to buprenorphine in the office setting. But for those that are interested in that treatment: great website.

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