Pain and Patient Expectations:
Using Motivational Interviewing to Promote Best Practices

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*Medical Officer, Health Systems Team*
*Division of Unintentional Injury Prevention*

American Dental Association Webinar
July 17, 2019
Agenda

- Background: the opioid overdose epidemic and opioid prescribing
- The CDC Guideline for Prescribing Opioids for Chronic Pain
- Opioid prescribing in dental practice
- Motivation interviewing: communicating with patients
- CDC resources to support providers in effective communication
Background: The Opioid Overdose Epidemic and Opioid Prescribing
Overdose Death Rates Involving Opioids, by Type, United States, 1999-2017

Overdose Death Rates by County, United States, 2000-2016

Estimated Age-adjusted Death Rate per 100,000:
- 0-2
- 2-4
- 4-6
- 6-8
- 8-10
- 10-12
- 12-14
- 14-16
- 16-18
- 18-20
- 20-22
- 22-24
- 24-30

SOURCE: NCHS Data Visualization Gallery
CDC’s Focus Areas for Opioid Overdose Prevention

- Conduct surveillance and research
- Empower consumers to make safe choices
- Build state, local, and tribal capacity
- Support providers, health systems, and payers
- Partner with public safety
CDC’s Focus Areas for Opioid Overdose Prevention

- Conduct surveillance and research
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Support providers, health systems, and payers

- Promote use of the *CDC Guideline for Prescribing Opioids for Chronic Pain*
- Train healthcare providers on implementation of *Guideline*
- Provide tools to help integrate recommendations into clinical practice
## Opioid prescribing by specialty and volume, July 1 2016 – June 30, 2017

### Table 1. Opioid Prescribing by Specialty and Volume, July 1, 2016–June 30, 2017

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Prescribers,  n (%)</th>
<th>Opioid prescriptions,  n (%)</th>
<th>Average per prescriber</th>
<th>Median (IQR)</th>
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</thead>
<tbody>
<tr>
<td>Total</td>
<td>970,902</td>
<td>209,498,112</td>
<td>215.8</td>
<td>42.7 (6.7, 185.5)</td>
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<tr>
<td>Internal medicine</td>
<td>159,183 (16.4)</td>
<td>32,964,516 (15.7)</td>
<td>207.1</td>
<td>31.6 (5.2, 167.5)</td>
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<tr>
<td>Dentist</td>
<td>153,647 (15.8)</td>
<td>18,091,864 (8.6)</td>
<td>117.7</td>
<td>33.8 (8.7, 111.5)</td>
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<tr>
<td>Nurse practitioner</td>
<td>119,599 (12.3)</td>
<td>20,773,394 (9.9)</td>
<td>173.7</td>
<td>29.6 (5.2, 126.6)</td>
</tr>
<tr>
<td>Family medicine</td>
<td>100,173 (10.3)</td>
<td>42,914,316 (20.5)</td>
<td>428.4</td>
<td>174.6 (39.5, 521.8)</td>
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<tr>
<td>Physician assistant</td>
<td>82,412 (8.5)</td>
<td>19,513,698 (9.3)</td>
<td>236.8</td>
<td>73.7 (14.8, 234.1)</td>
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<tr>
<td>Surgery</td>
<td>70,321 (7.2)</td>
<td>10,441,677 (5.0)</td>
<td>148.5</td>
<td>73.0 (13.1, 204.5)</td>
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<td>Emergency medicine</td>
<td>44,755 (4.6)</td>
<td>10,118,589 (4.8)</td>
<td>226.1</td>
<td>136.9 (35.2, 312.5)</td>
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<td>Obstetrics and gynecology</td>
<td>38,811 (4.0)</td>
<td>4,004,591 (1.9)</td>
<td>103.2</td>
<td>56.1 (12.3, 137.2)</td>
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<td>Pediatrics</td>
<td>31,670 (3.3)</td>
<td>442,151 (0.2)</td>
<td>14.0</td>
<td>3.0 (1.1, 7.2)</td>
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<td>Orthopedics</td>
<td>27,882 (2.9)</td>
<td>12,231,363 (5.8)</td>
<td>438.7</td>
<td>267.9 (55.6, 607.9)</td>
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<tr>
<td>Oncology</td>
<td>19,093 (2.0)</td>
<td>2,762,328 (1.3)</td>
<td>144.7</td>
<td>60.6 (14.7, 183.5)</td>
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<td>Psychiatry</td>
<td>17,280 (1.8)</td>
<td>469,718 (0.2)</td>
<td>27.2</td>
<td>3.1 (1.1, 10.9)</td>
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<td>Pain medicine</td>
<td>14,245 (1.5)</td>
<td>18,731,444 (8.9)</td>
<td>1,314.9</td>
<td>18.8 (2.0, 1,106.0)</td>
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<td>Neurology</td>
<td>10,896 (1.1)</td>
<td>2,482,777 (1.2)</td>
<td>227.9</td>
<td>26.7 (4.1, 135.3)</td>
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<td>Physical medicine and rehab</td>
<td>7,642 (0.8)</td>
<td>7,818,609 (3.7)</td>
<td>1,023.1</td>
<td>137.9 (18.4, 869.2)</td>
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<td>Radiology</td>
<td>7,524 (0.8)</td>
<td>175,945 (0.1)</td>
<td>23.4</td>
<td>3.2 (1.1, 10.7)</td>
</tr>
<tr>
<td>General practice</td>
<td>5,465 (0.6)</td>
<td>1,797,229 (0.9)</td>
<td>328.9</td>
<td>61.6 (8.4, 282.9)</td>
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<tr>
<td>Hospitalist</td>
<td>4,757 (0.5)</td>
<td>388,910 (0.2)</td>
<td>81.8</td>
<td>40.3 (15.8, 80.8)</td>
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<tr>
<td>Palliative care</td>
<td>852 (0.1)</td>
<td>185,210 (0.1)</td>
<td>217.4</td>
<td>45.4 (9.2, 201.5)</td>
</tr>
<tr>
<td>All others</td>
<td>54,695 (5.6)</td>
<td>3,189,806 (1.5)</td>
<td>58.3</td>
<td>9.0 (2.1, 46.2)</td>
</tr>
</tbody>
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U.S. Opioid Prescriptions: Still High Despite Recent Declines

Too many opioid prescriptions for too many days at too high a dose.

**Too Many Days**
- Average prescription days supply increased 33% from 2006 to 2015.

**Too High a Dose**
- A dose of 50 MME or more per day doubles the risk of opioid overdose death, compared to 20 MME or less.

**Too Many Prescriptions**
- In 2015, there were enough prescriptions for every American to be medicated around the clock for three weeks.

(640 MME per person, which equals 5 mg of hydrocodone every 4 hours)

**Nationwide Inconsistencies**
- The total amount of opioids prescribed (per person for the year 2015) varied widely from county to county.

1,319 MME
Average of highest 25% of US counties in 2015

203 MME
Average of lowest 25% of US counties in 2015
Association of Opioid Prescriptions From Dental Clinicians for US Adolescents and Young Adults With Subsequent Opioid Use and Abuse

Alan R. Schroeder, MD; Melody Dehghan, BA; Thomas B. Newman, MD, MPH; Jason P. Bentley, PhD; K. T. Park, MD, MS

Key Points

**Question** Are opioid prescriptions from dental clinicians that are written for pain management of third molar extractions from adolescents and young adults associated with subsequent opioid use and abuse?

**Findings** In this cohort analysis of claims data, index opioid prescriptions in opioid-naive adolescents and young adults compared with age- and sex-matched controls were associated with a statistically significant 6.8% absolute risk increase in persistent opioid use and a 5.4% increase in the subsequent diagnosis of opioid abuse.

**Meaning** The findings suggest that dental opioid prescriptions, which may be driven by third molar extractions in this age group, may be associated with subsequent opioid use and opioid abuse.

Prescription opioids and risk of adverse outcomes

- **Increasing dose** of prescription opioids is associated with increased risk of overdose death*
- Most opioid overdose deaths are associated with **multiple sources and/or high dosages****
- **Longer duration and higher dosages** of opioid treatment are associated with opioid use disorder***
- **Short-term opioid exposure** in opioid-naïve patients is associated with long-term use****

CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016

Primary care
- Patients > 18 Years with chronic pain
- Outpatient settings
- Outside of active cancer, palliative, and end of life care

www.cdc.gov/drugoverdose/prescribing/guideline.html
The *Guideline* contains 12 recommendations, grouped into 3 conceptual areas.

https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm
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- Determining when to initiate or continue opioids for chronic pain
- Opioid selection, dosage, duration, follow-up, and discontinuation

https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm
The Guideline contains 12 recommendations, grouped into 3 conceptual areas:

- Determining when to initiate or continue opioids for chronic pain
- Opioid selection, dosage, duration, follow-up, and discontinuation
- Assessing risk and addressing harms of opioid use

https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm
Recommendation examples*

- When opioids are used for acute pain, prescribe no more than needed (Recommendation 5)

- Check Prescription Drug Monitoring Program (PDMP) data (Recommendation 9)

- Avoid concurrent benzodiazepines and opioids whenever possible (Recommendation 11)

- Arrange medication-assisted treatment for opioid use disorder (Recommendation 12)

*Some of the recommendations might be relevant for acute care settings or other specialists, such as emergency room physicians or dentists, but use in these settings or by other specialists is not the focus of the Guideline. Refer to other sources for specific settings; for example: Pennsylvania Guidelines on the use of Opioids in Dental Practices, Indian Health Service’s Recommendations for Management of Acute Dental Pain.
American Dental Association
Statement on the Use of Opioids in the Treatment of Dental Pain

1. When considering prescribing opioids, dentists should conduct a medical and dental history to determine current medications, potential drug interactions and history of substance abuse.
2. Dentists should follow and continually review Centers for Disease Control and state licensing board recommendations for safe opioid prescribing.
3. Dentists should register with and utilize prescription drug monitoring programs (PDMP) to promote the appropriate use of controlled substances for legitimate medical purposes, while deterring the misuse, abuse and diversion of these substances.
4. Dentists should have a discussion with patients regarding their responsibilities for preventing misuse, abuse, storage and disposal of prescription opioids.
5. Dentists should consider treatment options that utilize best practices to prevent exacerbation of or relapse of opioid misuse.
6. Dentists should consider nonsteroidal anti-inflammatory analgesics as the first-line therapy for acute pain management.
7. Dentists should recognize multimodal pain strategies for management for acute postoperative pain as a means for sparing the need for opioid analgesics.
8. Dentists should consider coordination with other treating doctors, including pain specialists when prescribing opioids for management of chronic orofacial pain.
9. Dentists who are practicing in good faith and who use professional judgment regarding the prescription of opioids for the treatment of pain should not be held responsible for the willful and deceptive behavior of patients who successfully obtain opioids for non-dental purposes.
10. Dental students, residents and practicing dentists are encouraged to seek continuing education in addictive disease and pain management as related to opioid prescribing.

American Dental Association
October 2016

(2005:328; 2012:139; 2016:286)

ADA Policy on Opioid Prescribing (October 2018)

Resolved, that the ADA supports mandatory continuing education (CE) in prescribing opioids and other controlled substances, with an emphasis on preventing drug overdoses, chemical dependency, and diversion. Any such mandatory CE requirements should:

1. Provide for continuing education credit that will be acceptable for both DEA registration and state dental board requirements,
2. Provide for coursework tailored to the specific needs of dentists and dental practice,
3. Include a phase-in period to allow affected dentists a reasonable period of time to reach compliance,

and be it further

Resolved, that the ADA supports statutory limits on opioid dosage and duration of no more than seven days for the treatment of acute pain, consistent with Centers for Disease Control and Prevention (CDC) evidence-based guidelines, and be it further

Resolved, that the ADA supports improving the quality, integrity, and interoperability of state prescription drug monitoring programs.

American Dental Association
October 2018

Communicating with patients about opioid therapy
Two basic principles for effective communication

• Approach patients with compassion

• Use relationship-building skills, including
  • Reflective listening
  • Empathic statements
What is motivational interviewing?

- Patient-centered
- Collaborative
- Guiding
- Enhances a patient’s intrinsic motivation to change
- Explores and helps the patient resolve contradicting feelings or ideas

Principles of motivational interviewing

- Express empathy through reflective listening
- Develop discrepancy between clients’ goals or values and their current behavior
- Avoid argument and direct confrontation
- Adjust to client resistance rather than opposing it directly
- Support self-efficacy and optimism

Principles of motivational interviewing

- **Express empathy through reflective listening**
- Develop discrepancy between clients’ goals or values and their current behavior
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Express empathy through reflective listening

- Ask open-ended questions
- Listen
- Reflect
- Express appropriate empathy
Principles of motivational interviewing

- Express empathy through reflective listening
- **Develop discrepancy between clients’ goals or values and their current behavior**
- Avoid argument and direct confrontation
- Adjust to client resistance rather than opposing it directly
- Support self-efficacy and optimism

Develop discrepancy between clients’ goals or values and their current behavior

- Reflect back content from patient

- Elicit ambivalent statements with nonjudgmental, reflective listening

- Ask about goals and how opioids help or don’t help

- Reflect ambivalence back to the patient
Principles of motivational interviewing

- Express empathy through reflective listening
- Develop discrepancy between clients’ goals or values and their current behavior
- Avoid argument and direct confrontation
- Adjust to client resistance rather than opposing it directly
- Support self-efficacy and optimism

Avoid argument or direct confrontation

- Argument and direct confrontation can reinforce a defensive, oppositional stance

- Recognize patient resistance as a signal
  - Listen more carefully
  - Change direction
Principles of motivational interviewing

- Express empathy through reflective listening
- Develop discrepancy between clients’ goals or values and their current behavior
- Avoid argument and direct confrontation
- Adjust to client resistance rather than opposing it directly
- Support self-efficacy and optimism

Adjust to client resistance rather than opposing it directly

- Adjust to resistance – “rolling with resistance”
- Reflect what the patient said in a neutral way
- Reframe the conversation
Principles of motivational interviewing

- Express empathy through reflective listening
- Develop discrepancy between clients’ goals or values and their current behavior
- Avoid argument and direct confrontation
- Adjust to client resistance rather than opposing it directly
- **Support self-efficacy and optimism**

Support self-efficacy and optimism

- Reinforce signals that the patient is considering something different
- Provide credible, clear, actionable information
Remaining patient-centered when there is a conflict

1. Understand the patient’s concerns and expectations
2. Validate concerns, emotions – use empathy, normalization
3. Inform about reassuring features of the history and exam
4. Explain your recommendation given risk and benefits
   (go back to 2 if needed)
5. Flexibly negotiate alternatives
6. Explore for residual concerns

Challenges exist – but they can be overcome

- Limited Time
- Lacks of specific training for providers on motivational interviewing or treatment of pain
- Limited strategies for influencing motivation
- Discrepancies between patient and provider goals
- Lack of understanding of a patient’s perspective and current situation
CDC Resources for Communication
Clinician Outreach and Communication Activity (COCA) Webinar Series

1. Overview of Guideline
2. Non-opioid Treatments for Chronic Pain
3. Assessing Benefits and Harms of Opioid Therapy
4. Dosing and Titration of Opioids
5. Opioid Use Disorder—Assessment and Referral
6. Risk Mitigation Strategies
7. Effective Communication with Patients

https://emergency.cdc.gov/coca/calls/2016/index.asp
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https://emergency.cdc.gov/coca/calls/2016/index.asp
Interactive Online Training Series

https://www.cdc.gov/drugoverdose/training/online-training.html
You would be right to say, "We know more about the risks of opioids now than we used to, and we now know that a high dosage of opioid medication poses significant risk, especially for the long term. Let's work together to find a safer pain management plan for you that involves less opioids." However, this is where conflict often begins.

Melissa pleads, "Please, please refill my opioid medications; if I didn't have them I surely couldn't manage my job and my family!"

Confronting Melissa directly by refusing to continue her current opioid prescription will only heighten the conflict. Instead, acknowledge the patient's concerns and work to understand her perspective. Ask open-ended questions if you need clarification. Then, reiterate what you heard to ensure understanding.

"How is the medication helping you? Do you have any side effects?"
"I agree that stopping your prescription abruptly would not be a good idea. Given that, what do we need to do going forward?"

"Well, it does make me drowsy, and I am constantly constipated. Sometimes I completely forget things I am supposed to be doing."
"But, it is helping me deal with the pain, and that's why I can't imagine not having it."
"You're not just going to take away my pain pills, are you?"

Next, you want to validate her concerns and emotions while sharing how her situation isn't unique or troubling. Be empathetic and help to normalize her situation.
Clinical Tools

- Mobile App
- Training videos (communication)
- Checklist
- Pocket Guides
- Posters
- Fact sheets
Patient Education Resources

- Graphics
- Fact sheets
- Posters
- Podcasts
- Videos
- Infographics
CDC Resource Links

CDC Guideline for Prescribing Opioids for Chronic Pain:  
https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm

Resources for patients:  https://www.cdc.gov/drugoverdose/patients/index.html

Resources for providers:  https://www.cdc.gov/drugoverdose/providers/index.html

COCA Calls:  https://emergency.cdc.gov/coca/calls/2016/index.asp

Online Training Series for Healthcare Providers:  
https://www.cdc.gov/drugoverdose/training/index.html

CDC Publications:  https://www.cdc.gov/drugoverdose/pubs/index.html
Learn about the risks of prescription opioids
www.cdc.gov/drugoverdose
Dentists are likely the first health care professional that these people see.
Many studies have shown that a brief intervention from a health care worker is effective.
Patient Intervention

If suspicious of using/relapse behavior
- Private consultation
- Ask candidly about sobriety

- Dentists can be educated on interventions
  - Not accusatory
  - From a caring perspective

At very least….We can plant a seed.
Have you ever had one of these questions/situations in your practice?
I have a patient who I’m sure is drug-seeking.

- What am I obliged to do?
- What can I say to her?
I need to do some major procedures on a patient who tells me he’s a recovering alcoholic. He doesn’t want me to give him any narcotics for pain, but he’s going to be hurting.

He wants me to talk with his physician about what I prescribe. I don’t see why I should have to do that.
A teenage boy told my hygienist he smokes pot everyday.

Can I tell his parents?

Should I tell his parents?
One of my patients, a banker in town, came in this afternoon for a regular appointment with alcohol on his breath. It’s not the first time.

Should I treat him?

Should I say something to him?
Sure, I know some of my patients drink a lot. But that’s not my business—I’m just their dentist!
I am suspicious that my patient has “Meth Mouth.” How do I approach him/her?

What if I am wrong? I don’t want to offend her.

What if she says that she was on meth but it is under control?
What if she says yes, that she has a problem?
PCSS Mentoring Program

- PCSS Mentor Program is designed to offer general information to clinicians about evidence-based clinical practices in prescribing medications for opioid addiction.

- PCSS Mentors are a national network of providers with expertise in addictions, pain, evidence-based treatment including medication-assisted treatment.

- 3-tiered approach allows every mentor/mentee relationship to be unique and catered to the specific needs of the mentee.

- No cost.

For more information visit: [https://pcssNOW.org/mentoring/](https://pcssNOW.org/mentoring/)
PCSS Discussion Forum

Have a clinical question?

Ask a Colleague

A simple and direct way to receive an answer related to medication-assisted treatment. Designed to provide a prompt response to simple practice-related questions.

Ask Now

http://pcss.invisionzone.com/register
**PCSS** is a collaborative effort led by the American Academy of Addiction Psychiatry (AAAP) in partnership with:

<table>
<thead>
<tr>
<th>American Academy of Family Physicians</th>
<th>American Psychiatric Association</th>
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<td>American Academy of Neurology</td>
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<td>Addiction Technology Transfer Center</td>
<td>American Society of Pain Management Nursing</td>
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<td>American Academy of Pain Medicine</td>
<td>Association for Medical Education and Research in Substance Abuse</td>
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<td>International Nurses Society on Addictions</td>
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<td>National Association of Drug Court Professionals</td>
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Webinar Evaluations (Post and 30-Day)

- Each partner organization is asked to distribute a post and 30-day evaluation to participants for their completion.

- Participants in today’s webinar will be emailed the link to complete their evaluations.

- Thank you for your feedback!
ADA Contact Information

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