EDITORIAL AND COMMENT

“Clues” That Patients May Be Willing to Consider Opioid Reductions

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As the US opioid crisis continues¹ and the limited role for long-term opioid therapy (LTOT) in chronic pain becomes ever more apparent, patient-centered, safe tapering of risky LTOT regimens has emerged as one of the most complex and challenging skills required of the general internist. However, while the Centers for Disease Control and Prevention (CDC),² the Veterans Health Administration,³ and other stakeholder organizations implore generalist prescribers to engage patients in discussions about tapers and implement them when benefits of LTOT no longer outweigh harms, guidance on how to have these conversations and implement tapers is scant. Furthermore, generalists report difficulty engaging patients about opioid safety, fearing the potential for fraught interactions that may strain the patient-provider relationship. Henry et al.'s study⁴ offers useful insights into a technique that may help prescribers increase patients' motivation for opioid tapering: listening for clues that a patient already may be considering a change. Furthermore, the study revealed that generalists may be missing opportunities to follow-up with patients about potentially indicated LTOT reductions nearly half of the time.

In their cross-sectional study, Henry et al. audio-taped 86 patient-provider encounters where the subject of LTOT could reasonably be expected to be discussed; all encounters included patients currently prescribed LTOT reporting at least moderate pain intensity (≥ 4 on an 11-point numeric rating scale) who indicated they were likely to discuss pain management during a scheduled clinic visit. While patients could only participate in one session, physicians could participate in visits with more than one patient. Using the transcribed patient encounters, the study team created a coding schema where they searched for “opioid assessments”: patient statements that explicitly expressed a positive, negative, or ambivalent stance about the LTOT regimen. They then assigned the opioid assessments to topics (pain relief, function, safety, side effects) and determined whether or not they counted as “clues.” Clues were meant to indicate a potential willingness to discuss dose lowering as they expressed either (a) negative or ambivalent opinions about opioids' clinical benefits, (b) concerns or fears

about harms, risks, or side effects from opioids, (c) positive attitude towards a lower opioid dose, or (d) resistance or ambivalence to a higher dose. Finally, if an assessment was coded as a clue, the team coded physicians' immediate response into one of three mutually exclusive categories: no/minimal response, supportive/empathetic statement, or explore/expand on assessment.

Several of the study's findings were noteworthy. First, on average, patients made 3.2 opioid assessments per visit with the most common assessment topics being LTOT's effect on pain relief (51%) and function (21%), followed by assessments related to opioid safety (14%), a category into which the authors included concerns related to overdose. Over half (58%) of patients endorsed at least one opioid-related side effect and 10% endorsed three or more side effects. Consistent with other studies, the most commonly endorsed side effects were constipation (15% of patients), sedation (15%), withdrawal symptoms (13%), and nausea (12%). Of note, the content of these assessments—addressing benefit and harm—is precisely the target for LTOT evaluation recommended by the CDC and others. Of the assessments, almost half (47%) were classified as clues, meaning a potential willingness to consider dose lowering. The clues were also widely prevalent: at least one appeared in 53% of visits while 21% of visits contained at least three clues. In terms of physician response to the clues, there was no or minimal response 43% of the time and sympathetic or empathetic statements 14% of the time. With fewer than half of the clues (43%), the physician pursued the issue with further discussion.

This study points to clear opportunities for next steps, one of which Henry et al. identified: developing and training providers in motivational interviewing-based approaches for conducting opioid tapering discussions. Motivational interviewing is a patient-centered counseling approach where the interviewer guides the patient into behavior change by helping them identify and resolve ambivalence; its successful application in smoking cessation⁵ and reducing alcohol consumption⁶ makes it a compelling choice for use in LTOT tapering. However, there is an important distinction between behavior change in substance use and LTOT that would need to be addressed in developing a prescriber training: prescribers have a duty to assess safety and to make necessary changes when safety is seriously compromised. For example, in the

case of a patient who develops opioid use disorder (OUD) from LTOT, in alignment with the standard of care, the prescriber needs to discontinue LTOT and initiate medication for OUD. While the patient's buy-in is critical for success and prescribers need to employ patient-centered counseling to facilitate the transition, LTOT discontinuation should occur even if the patient remains ambivalent about a change.

The study's results also support deployment of standardized patient-reported instruments among patients on LTOT to identify issues related to safety and efficacy. As the authors correctly point out, the prevalence of opioid-related issues is likely higher than their study identified because patient participants may not have spontaneously raised opioid-related issue(s) and providers may not have asked about them. While training and encouraging providers to ask detailed questions is one potential method to improve identification of safety/efficacy issues, competing demands on provider time and the typically rushed primary care visit argue for systems-based approaches to enhancing the process. Asking patients to complete brief self-administered assessments—for example, the Prescribed Opioids Difficulties Scale⁷ or the Patient-Reported Indications for Opioid Reassessment⁸ tool—before a visit that providers can review and discuss with a patient may provide a more efficient and effective path to raising the issue of opioid safety/efficacy and identifying related problems deserving of further discussion.

In summary, in their cross-sectional observational study, Henry et al. identified a high prevalence of clues that patients may be willing to discuss opioid dose reduction but a relatively low prevalence of provider follow-up on those clues. This work sets the stage for development of interventions and use

of tools that will help generalists improve recognition and management of opioid safety- and efficacy-related issues.

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