Pain Management and the Opioid Epidemic: What You Need To Know

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Continuing Education Disclosures

• No commercial bias

• Paid consultant to provide pain management continuing education
The goal of this presentation is to increase knowledge and understanding of audiology professionals on the relationship between the opioid epidemic, hearing loss, and quality pain assessment and management.
Presentation Outcomes

• The learner will:
  – Discuss the impact of opioid overprescribing
  – Discuss the importance of preventing chronic pain
  – Use therapeutic communication skills when assessing pain
Opioid Misuse and Hearing Loss
Literature Review

• It is likely that opiate-associated hearing loss results from the interaction of ingested opioids with opioid receptors within the inner ear (Nguyen et al. 2014)

• Presence of opioids in the diet pills, as one of multiple opioids including methadone and heroin, have been implicated in acute hearing loss (MacDonald et al, 2015)

• Temporary hearing loss occurred after inhalation of oxymorphone (MacDonald et al 2015)

• In some individuals, opiate abuse can cause temporary or permanent hearing loss. It is possible, in fact, that after several episodes of temporary, unreported hearing loss, the loss may become permanent (Rawool, 2016)

• Patients with fibromyalgia had an increased likelihood to report subjective hearing loss (Stranden et al, 2016)

• Hearing loss is independently associated with prescription opioid use disorders among those aged 49 years and younger (McKee et al, 2019)
Other Issues

• Babies born addicted to opioids may have neurological problems including failed hearing screenings (Williams, 2018)

• Need audiology professionals committed to working with high risk mothers and their children (Williams, 2018)

• Limited studies exploring the link between opioid misuse and hearing loss (Campbell, 2018)
Believe me… I get it!

"Honestly? I preferred when we didn't talk about the elephant."
The Current State of the Opioid Crisis: How did we get here?
* Patients in the other listed conditions may contribute to the number of those living with chronic pain.
Pain Management Facts

• National economic cost about $560-635 billion/year
• Pain is a uniquely individual and subjective experience
• Influenced by a variety of biological, psychological, and social factors
• For many patients, treatment of pain is inadequate
  – Access and availability to effective treatments
  – Inadequate clinician knowledge about the best ways to manage pain
Over the last 15 years the labor force participation rate fell more in counties where more opioids were prescribed.


Nearly half of men aged 25-54 who are not in the labor force take pain medication daily. Two-thirds of these men are taking a prescription pain medication daily.

Michigan-Opioid Prescribing Engagement Network
(http://michigan-open.org/)
Opioid Prescribing after Procedures
Michigan Opioid Prescribing Engagement Network (OPEN)
http://michigan-open.org/

Opioids Prescribed After Surgery

Range of Prescribed Pills: 12-120 tablets

What’s the problem?

• Patients were overprescribed opioid medications after surgical procedures

• Too many ‘extra’ opioids in the community

• Prescribers need more education on how to assess and appropriately prescribe medications to treat pain
Have you ever had prescription opioid medication left over after a medical or dental procedure?
Recent National Headlines

• U.S. launches four-state study to find ways to reduce opioid overdose deaths
  – Kentucky, Massachusetts, New York and Ohio
• Two teen brothers, hockey players, dead on same day of opioids
• Ohio doctor charged with 25 counts of murder, accused of prescribing excessive doses of painkillers
• Florida's opioid lawsuit against CVS, Walgreens aims at distributors
• The Opioid Crisis Explained in Black and White

“With opioid deaths disproportionately high among whites (80% of opioid overdose deaths in 2017), drug addiction and overdose risks are no longer problems just for poor minorities. Perhaps, not coincidentally, the approach to addressing the problem has changed”

Relieving Pain in America (2011)

• Improving care for people with acute, or chronic pain, requires **broad improvements in education**, especially with regard to:
  – the multiple causes and effects of pain,
  – the range of treatments available to help people obtain relief, and
  – the need to consider chronic pain as a biopsychosocial disorder.
Government Mandated Changes
Three Key Points:

- Hospitals must have a process to address pain assessment when necessary.
- Hospitals must have a process, upon clinical determination, to either treat patient pain or refer patients for pain treatment including nonpharmacologic or pharmacologic approaches.
  - Note: **Treatment** should include a combination of approaches.
- Hospitals must have a process for the clinician to reassess and respond to a patient's pain based on reassessment criteria.
  - ‘Treat to stay ahead of the pain’
- Pain should be assessed during every patient encounter.
Michigan Facts

- Opioid-related overdose deaths reached an all-time high in 2017
- Michigan Department of Health and Human Services
  - Opioid Overdose Deaths
    - 2015 1,320
    - 2016 1,786
    - 2017 1,941/2,729 (all overdose deaths) = 71% Opioid Related
      https://www.michigan.gov/opioids

- Many people turn to heroin after first abusing prescription pain medications, either their own, or those belonging to a family member/friend
- Doctors are prescribing less medication; however, increasing access to treatment programs is important to stop/prevent overdose deaths
2015 Michigan Prescription Drug and Opioid Abuse Task Force

• Task force members varied greatly in their professional backgrounds to provide a solid cross-section of input

• 25 primary recommendations and seven contingent recommendations in the areas of prevention, treatment, regulation, policy and outcomes, and enforcement
  – Required registration and use of Michigan Automated Prescription System (MAPS) by those who are prescribing and dispensing prescription drugs.
  – Increase in licensing sanctions for health professionals who violate proper prescribing and dispensing practices.
  – Required additional training for professionals who prescribe controlled substances.
Department of Licensing and Regulatory Affairs (LARA)

• Effective June 1, 2018
  – obtain the patient’s informed consent on a form prescribed by the Michigan Department of Health and Human Services and must also provide information (education) on opioid dangers and precautions. HB 4408, PA 246 (2017)

• Effective June 1, 2018,
  – all licensed prescribers required to register, and query, the Michigan Automated Prescription System (MAPS) when prescribing controlled substances to any patient
  – MAPS platform had to be updated and replaced

• Beginning July 1, 2018
  – for acute pain, the prescriber shall not prescribe the patient more than a 7-day supply of an opioid within a 7-day period
    • before prescribing or dispensing to a patient a controlled substance in a quantity that exceeds a 3-day supply, a licensed prescriber shall obtain and review a MAPS report concerning that patient
    • Many providers are writing a 3-day supply given fewer requirements for prescribing this amount
Principles of Quality Pain Assessment
What are we dealing with?
Acute, Chronic or Acute on Chronic Pain
Acute Pain

• Is a symptom
• Signal of a disease process
• Is associated with tissue trauma
• Cause usually obvious
• Usually lasts <6 months
• Examples
  – Tooth extraction, appendectomy, hip replacement, etc.
Chronic/Persistent Pain

- Is a diagnosis
  - Diabetes, Hypertension, Hearing Loss and other illnesses
- No useful function served
- Cause is not always clear
- Usually lasts >6 months
- 100 Millions Americans are living with chronic pain
Acute on Chronic Pain

• Exactly what it sounds like
• Opioid and anti-inflammatory medication work well for the acute pain as a short-term solution
  – Ibuprofen, oxycodone, etc.
• Very challenging to treat acute pain needs when a patient is already on opioids
  - opioid hyperalgesia
  - tolerance
Are you, or someone you know, living with chronic pain?
Categories of Pain

• Nociceptive
  – injury, disease, or inflammation (sprain or strain) from trauma or surgery

• Neuropathic
  – damage to brain, spinal cord, or peripheral nerves
    • Stroke, diabetic neuropathy (sensitivity), peripheral vascular disease (vascular constriction), burn injuries, etc.

• Emotional
  – an unpleasant feeling, or suffering, of a psychological, non-physical, origin
# Common Words Describing Pain and Distress

<table>
<thead>
<tr>
<th>Emotional Distress</th>
<th>Neuropathic Pain</th>
<th>Nociceptive Pain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frightening</td>
<td>Burning</td>
<td>Tender</td>
</tr>
<tr>
<td>Punishing</td>
<td>Flashing</td>
<td>Sharp, cutting</td>
</tr>
<tr>
<td>Vicious</td>
<td>Shooting</td>
<td>Dull</td>
</tr>
<tr>
<td>Annoying</td>
<td>Stabbing</td>
<td>Cramping</td>
</tr>
<tr>
<td>Nagging</td>
<td>Tingling</td>
<td>Squeezing</td>
</tr>
<tr>
<td>Unbearable</td>
<td>Prickling</td>
<td>Throbbing</td>
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</tbody>
</table>

Therapeutic Communication Skills
Characteristics of Therapeutic Communication Skills

• Respecting the client's personal values and beliefs
• Allowing time to communicate with the client
• Using communication techniques to provide client support
  – Active listening, silence, proper body language, etc.
• Encouraging the client to verbalize feelings (e.g. fear, discomfort)

https://www.registerednursing.org/nclex/therapeutic-communication/
Therapeutic Communication Skills Checklist: Opioid Misusers

• Accept patients for who they are… Not who you want them to be
• Empathy
  – Sensing a client's emotions and reacting to them as if they were your own
• Authenticity
  – Exhibiting genuine thoughts and emotions in the therapeutic approach
• Unconditional Positive Regard
  – show your patient that no matter what they do, your respect for him/her remains the same
Principles of Patient and Family Centered Care (PFCC)

• Information Sharing: Healthcare providers and patients / families **share complete and unbiased information** with each other.

• Participation: Patients/families build strength with experiences that enhance control and independence.

• Collaboration: Includes policy and program development as well as the delivery of care.

• Dignity and Respect: All people are treated with respect and dignity.

  • Source: IFCC  [http://www.ipfcc.org](http://www.ipfcc.org)
PFCC and Pain Management

• Information Sharing
  – Past medical history should not influence pain management options

• Participation
  – Allow patients/families to play an integral role in building their care experience

• Collaboration
  – Main focus of pain management plans should be safety and prevention of transition to chronic pain

• Dignity and Respect/Therapeutic Communication
  – Sharing of information should occur from both sides; transparency and honesty is key
Core Principles of Quality Pain Management: Important Pieces to the puzzle

• “Quality” Assessment

• Acceptance

• Action

Pasero and McCaffery (2011)
Pain Assessment

- W-Words
- I-Intensity
- L-Location
- D-Duration
- A-Alleviating/Aggravating Factors
Assessing Medication Side Effects

• Four types of opioid receptors
  – Mu, Kappa, Delta and Nociceptin
• Mu receptors are located throughout the body
  – Opioid medication binds to these receptors
• Side effects are based on Mu receptor location/function
Mu Receptor Location and Side Effect/s

- Respiratory System $\rightarrow$ decreased respiratory rate
- GI System $\rightarrow$ nausea, vomiting, constipation
- Cardiovascular System $\rightarrow$ slow heart rate
- Central Nervous System $\rightarrow$ dizziness, euphoria
- Central and Peripheral Auditory System $\rightarrow$ sensorineural hearing loss

(Nguyen et al, 2014)
Pain Assessment: Best Evidence

• Use best words for screening: discomfort vs. pain

• Know the words that describe pain* (emotional, neuropathic, nociceptive)

• Sensitivity to cultural and gender differences
Vital signs are always reliable indicators of the intensity of a patient's pain. 
True or False
Who has more pain?

vs.
Acceptance

• “The clinician must accept the patient’s report of pain” (American Pain Society, 2003)
• Self-report is the gold standard
• Rely less on vital-sign assessment and more on observing behaviors
• Ask, “why is it so difficult for me to believe this person is in pain?”
Action

• Primary goal is preventing transition to persistent/chronic pain
  – If persistent pain exists, assess separately from the acute issue
• Review pain related orders and documentation
• Try pharmacologic and non-pharmacologic interventions
• Remember… SAFETY FIRST!
Functional Analgesia

• Three Components
  – Pain at rest vs. pain with activity → Assessment
  – How ‘comfortable’ are you’? How can I help? → Acceptance
  – Is what we are doing making a difference? → Action

• Patient Centered Goals
  – ADLs= “I want to take care of myself”
  – Physical Therapy= “ I want to be an active participant in my care”
  – Return to work= “I want to provide for myself and my family”
Sleep and Pain
Patients may sleep in spite of severe pain. True or False
Sleep and Pain

- Studies are now linking chronic sleep loss and pain
- Excessive sleepiness
  - Diagnosed and Undiagnosed Obstructive Sleep Apnea (OSA)
  - Sedating CNS-Acting medications
- Recent studies have consistently linked sleep deprivation to increased pain sensitivity
Snoring is a Warning Sign. . .

- Snoring ≠ restful sleep
- May indicate airway obstruction
- Must be attended to promptly
- May require a Respiratory Therapy consultation and/or a sleep study
Summary of the Research

• The relation between pain and sleep is reciprocal
• Reduction, or fragmentation, of sleep enhances pain sensitivity
• Management of insomnia may contribute to more effective management of pain, and provide patients with greater relief
• Results suggest the importance of adequate sleep in various chronic pain conditions or in preparation for elective surgical procedures

Content courtesy of Timothy Roehrs, Ph.D.
Factors Influencing Pain Perception

• How one interprets pain messages and tolerates pain can be affected by:
  – age
  – gender
  – culture
  – family and social support emotional and psychological state
  – memories of past pain experiences
Reducing Anxiety Increases Comfort*

- Assess anxiety and impact on pain
- Assess and communicate about pain routinely with families and patients
- Create an individualized plan with input from the child/parents/families
- Ask patients and families about pain and comfort
- Educate patients and families about pain management practices and option
- Pain and anti-anxiety medications may have serious side effects
Opioid/Benzodiazepine Related Deaths

• Additive and synergistic effects
  – More analgesia
  – Increased sedation
  – Slower respirations
  – Increased CO2
  – Less tidal exchange
  – Decreased response to CO2

• Outcome → Death
What can we do now…
Inpatient Survey Results:
What can we do to improve your pain control?

| "Why should I have to deal with pain when I come to the hospital? They treat me as a drug seeker. I have pain outside the hospital I deal with everyday. I shouldn't have to deal with it when I come to the hospital" | I don't know, they gave me a heating pad and everything. I've tried it all. |
| "dosage is fine, just need more frequency" | |
| "you could give me a pain pump for control. Sometimes when you hit the button it takes a while for a nurse to get here." | Get me home! |
| "Keep an eye on the clock and give me my meds when I need it" but when you get behind it takes a day to catch up | Quieter would be nice. Magic (n=2) |
| Having something stronger available | Make my pain go away |
| Keep door shut to reduce noise level in room, keep schedule per pain meds, MD to be easier to talk to, change in MD to be better to work with. | |
| Make sure the doctor's get their orders straightened out so I don't have to suffer. | The doctor has a problem, nothing personal. I question how well the doctor is listening. I'm touched too roughly, I'm not a horse or shoe leather. Don't scrub so hard when cleaning me up, be more gentle |
| They're working on it, it's a work in progress. | Not much, I've been getting hot and cold packs, too, which is helpful. |
| I don't know if there can be anything else done. | I don't know yet. |
| more warm blankets | Get me up and moving |
| I want people to pray for me. I know it sounds silly, but there's not much else I can do for the pain. | Hearing Related |
More medication does not increase patient satisfaction… hearing and listening does!
Most Important: Set Realistic Expectations!!

Slide used by permission of Paul Hilliard, MD, MS
Patient Expectations

• Understand past experience is a powerful contributor

• Use empathetic communication and practical explanations

• Most importantly… Listen to me!!!

Jayasankar, 2009
Health Care Professional Expectations

• ‘Do what I ‘tell’ you to do, because I know what’s best for you’
  – This approach does not work!!
• Traditionally known as “compliance”, now called “adherence”
• Improving adherence is based on the following:
  – ensuring that patients have the right information and know how to adhere
  – helping patients believe in their treatment and become motivated to commit to it
  – assisting patients to overcome practical barriers to treatment adherence and develop a workable strategy for long-term disease management

What are realistic expectations?

- Injuries are painful
- Anxiety can increase perception of pain
- Must maintain a balance between safety and comfort
- Response to medication varies based on the individual
- Reduction of pain by 30-50% is more achievable than eliminating it
- Continually assess pain management/control vs. functional improvement

An ounce of Prevention is worth a pound of Cure

- Ben Franklin
Review of Prevention Principles

• Primary Prevention
  – Improving the overall health of the population by intervening before health effects occur

• Secondary Prevention
  – Screening to identify diseases in the earliest stages

• Tertiary Prevention
  – Managing disease post diagnosis to slow or stop progression

Apply Prevention Principles to Improve Pain Management
Primary Prevention

• Primary Prevention
  – Educate the general public on the dangers of opioids
  – Increase/Improve education of healthcare professionals on the importance of comprehensive pain management with, and without, opioids
Secondary Pain Prevention

• Proper pain assessment
  – Pain vs. Comfort
  – What words are being used to describe the pain?

• Identify the correct type of pain
  – Acute, chronic, or acute on chronic
  – Nociceptive, neuropathic, and/or emotional

• Improve treatment of acute pain to prevent transition to chronic pain

• Offer drug and non-drug pain management options
Tertiary Pain Prevention

• Listen to your client/patient
• When pain exists, treat is with a comprehensive pain management plan
  – Opioid and non-opioids based on medical history
  – Introduce non-drug therapies at diagnosis
• Create a relationship with your client/patient using honesty and respect to build trust
Utilize a Comprehensive Treatment Plan: Pharmacological and Non-Pharmacological Therapy
Factors to Consider

- Age
- Type(s) of Pain
- Pain Intensity
- Respiratory & Sedation Status
- Underlying Pathology
- Opioid Tolerance
- Organ Function
- Persistent (Chronic) Pain
- Kinetics of Analgesic
- Anesthesia & Other Meds

Individualized Therapy

Used by Permission- C. Pasero, MS, RN-BC, FAAN (2013)
Summary of Michigan O-PEN Acute Care Pain Treatment and Prescribing Recommendations

- Discuss **expectations** regarding recovery and pain management goals
- Consider **non-opioid** medications when appropriate
- **Oral** opioids are preferred over IV (more anesthesia options)
- **Non-pharmacological** therapies should be encouraged [e.g. cold or heat, compression, physical therapy, yoga, music, distraction (i.e. Lamaze)]
- Refer and provide **treatment** resources for patients who have, or are suspected to have, a substance use disorder.

[https://www.michigan.gov/documents/lara/Acute_Care_Opioid_Treatment_and_Prescribing_Recommendations_Surgical_-_FINAL_620739_7.PDF](https://www.michigan.gov/documents/lara/Acute_Care_Opioid_Treatment_and_Prescribing_Recommendations_Surgical_-_FINAL_620739_7.PDF)

Michigan-OPEN  http://michigan-open.org/
How to Achieve Pain Control…

• Regular and systematic evaluation (Acute Care setting…reassessment, or pain relief score)

• Constant drug levels as required by the patient (i.e. scheduled/around the clock dosing)

• Preemptive analgesia → treat in anticipation of painful activities (e.g. prior to Physical therapy)

• Use of multimodal regimens

Cogan (2013)
Multimodal Pain Management Therapy
Definition

• Addition of a non-opioid medication, such as an ibuprofen, which often lessens adverse effects by allowing the opioid dose to be reduced
• Combination therapy is often more effective then using one method
• Choice of medication, dose, route, and duration of therapy should be individualized
• Approaches that utilize physical methods such as heat or cold, and psychological methods such as relaxation and cognitive-behavioral therapy with pharmacotherapy permit opioid dose reduction and improve patient outcomes (American Pain Society)
Multimodal Pain Management Therapy II

• Additive or synergistic analgesic effects many minimize adverse drug effects by allowing doses of opioids to be decreased

• Options*
  – local anesthetics, NSAIDs, gabapentinoids, and acetaminophen, as well as alpha-2 agonists, ketamine, esmolol, cannabinoids, and nonpharmacologic approaches

Skinner, 2004; Cogan, 2010; Elvir-Lazo & White, 2010
Cannabinoids in Pain Treatment*
Overview I

• Terms marijuana and cannabis are used interchangeably

• Cannabinoid Receptors
  – CB1 (Central Nervous System: brain, brain stem and spinal cord)
    • Regulate the cannabinoid neurotransmitter effects
  – CB2 (Periphery: stem cells, spleen, and other immune cells)
    • Regulate interactions protecting neurons from pathogens
    • Interfere with inflammatory mediators that increase sensitivity
    • Respond to peripheral nerve injury

• Available in multiple routes

Overview II

• Regulations
  – Controlled Substance Act of 1970: Schedule 1 (High potential for abuse)
  – States are legalizing for medical and recreational use
  – Federal law supersedes individual state laws
  – Use restricted in research and clinical practice
• American Medical Association (2009) and American Nurses Association (2016) calling for much needed research
• Evaluate evidence without bias and dispassionately prepare for discussions with patients and colleagues
Non-Pharmacological Strategies

• Complementary Therapies
  – Use in addition to the traditional approach aka medication
  – Limited evidence, but can be used on a case-by-case basis
  – Relaxation response
    • Slowed HR, reduced BP, improved digestion, enhanced immune activity, etc.
  – Practitioner concerns that prevent use
    • Time, tools, knowledge, and confidence
  – Most do not require a prescription/provider order

Kris Kwekkenboom, PhD, RN- University of Wisconsin: 2014 Conference Lecture
Non-Pharmacological Therapies

- Positioning (e.g. physical therapy, Pilates, Yoga, etc.)
- Controlled/Deep breathing (e.g. Lamaze=psychological and physical preparation)
- Distraction (music, comfort measures*, reading, etc.)
- Touch (e.g. M-Technique is process that involves stroking in cycles of 3, Healing touch, etc.)
- Massage
- Reflexology
- TENS (transcutaneous electrical stimulation)
- **Noise control** (i.e. acute care patient satisfaction data)
- Chiropractic manipulation
- RICE Method
  - Rest Ice Compression Elevation
Your comfort and pain control are a priority to your healthcare team on 6B. Please let your doctor or nursing staff know if any of these available options can help you in reaching your recovery goals.

### 6B COMFORT & PAIN CONTROL CHOICES

<table>
<thead>
<tr>
<th>COMFORT ITEMS</th>
<th>ACTIONS TO PROMOTE COMFORT</th>
<th>PERSONAL HYGIENE ITEMS</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Extra pillow</td>
<td>- Re-positioning</td>
<td>- Toothbrush</td>
</tr>
<tr>
<td>- Warm blanket</td>
<td>- Stretch</td>
<td>- Toothpaste</td>
</tr>
<tr>
<td>- Heat/ice pack</td>
<td>- Range of motion</td>
<td>- Soap</td>
</tr>
<tr>
<td>- Pajama bottoms</td>
<td>- Go for a walk</td>
<td>- Shampoo</td>
</tr>
<tr>
<td>- Extra gown</td>
<td>- Dim or shut off the lights</td>
<td>- Deodorant</td>
</tr>
<tr>
<td>- Socks</td>
<td>- Open or close the window blinds</td>
<td>- Lotion</td>
</tr>
<tr>
<td>- Fan</td>
<td></td>
<td>- Comb</td>
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<tr>
<td>- Spiritual/Religious Resources</td>
<td></td>
<td>- Mouth swabs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Vaseline</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Razors</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>WAYS TO RELAX</th>
<th>BORED? THINGS TO DO</th>
<th>NOTHING WORKING?</th>
</tr>
</thead>
<tbody>
<tr>
<td>- In-room TV has music, relaxing sounds, and white noise channel options</td>
<td>- Bedside Art Program</td>
<td>- Please do not hesitate to let your doctor or nursing staff know if your pain is not relieved.</td>
</tr>
<tr>
<td>- Spiritual Care</td>
<td>- Use your personal laptop, free WiFi available</td>
<td>- Please let us know what comfort and pain control options have worked in the past.</td>
</tr>
<tr>
<td>- Bedside Music Program</td>
<td>- Use your personal MP3 or music player</td>
<td></td>
</tr>
<tr>
<td>- Pet Therapy*</td>
<td>- Coloring books, crayons, puzzles, and reading materials</td>
<td></td>
</tr>
<tr>
<td>- Art Cart*</td>
<td>- TV/DVD player available if not in use</td>
<td></td>
</tr>
<tr>
<td>- Massage Therapy*</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Pet Therapy, Art Cart, Bedside Music Program, and Bedside Art Program availability varies. Bedside massage therapy requires scheduled appointment and fees are charged at the time of service. Brochure for massage therapy is available upon request to nursing staff.
Things to remember…

• Set realistic expectations
• The opioid epidemic is multifaceted
• When treating pain, the goal is to assess and treat pain appropriately
• Therapeutic communication skills are an important part of building trusting relationships with our patients
• Introduce a comprehensive pain management early in the treatment plan to prevent opioid misuse and prevent the transition to chronic pain
Reference List Available Upon Request