SAFE PRESCRIBING: THE PHYSICIAN’S CHALLENGE

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OBJECTIVES

• Assess the risk of opioid abuse in patients to whom you are considering or already prescribing opioids
• Establish monitoring strategies that are commensurate with risk assessment
• Learn the role of SBIRT in addressing the spectrum of substance use
• Define and identify substance use disorder
• Identify the drug-seeking patient
• Learn ways to locate local addiction treatment resources
PRESCRIPTION DRUG ABUSE

A national problem

- 17,000 deaths from painkiller ODs annually
- More deaths from Rx Drug OD than MVAs

A Colorado problem

- 300 deaths in CO each year from Painkiller ODs
- CO 12th in self-reported nonmedical use of opioid
- Annual deaths from painkillers more than tripled from 2000 to 2013

http://takemedsseriously.org/
THE PHYSICIAN’S CHALLENGE

To adequately address patients’ acute and chronic pain...

...while following safe prescribing principles.
BUT I DON’T TREAT CHRONIC PAIN!

Every chronic pain patient was first an acute pain patient

   The transformation is not always clear

Every pill that your patients don’t use can be diverted

   ▪ Colorado teens: Rx drugs “easier to get than beer”
   ▪ Street value of oxycodone: about $1 per mg

Prescriptions for acute sports injuries may put adolescents at risk for misuse

http://takemedsseriously.org/

The Poor Doctor & the Rich Patient.

"you are very ill!"
THE PATIENT EVALUATION: CHRONIC PAINFUL CONDITIONS

Thorough evaluation (S/O) of:

1) The painful condition – including function
2) Risk – including SUD

Formulate an Assessment

1) The painful condition
2) Risk

Formulate a Plan

1) The painful condition
2) Risk
PATIENT EVALUATION

Subjective

Objective
S/O: THE PAINFUL CONDITION

Subjective:
CC/HP, including prior work-up and treatment
Reported level of function and functional limitations

Objective:
Examination
Imaging
Electrodiagnostics, other testing
Observed level of function and functional limitations
Review of old records for verification
Subjective:

- Personal and family substance use history (include history of overdose)
  → SBIRT if positive
- Psychiatric history
- History of trauma/abuse
- Also consider: Comorbidities and medications that ↑ risk of respiratory depression (COPD, OSA; benzos, other opioids, etc.)

Objective:

- Urine drug testing & PDMP review - before you prescribe
- Consider screening for anxiety and depression
- ?Nocturnal oximetry? If at risk
A: THE PAINFUL CONDITION

What is the pain generator? What is the diagnosis?

What type of pain is it?

• Nociceptive: somatic (DJD); visceral (IBS, endometriosis)
• Neuropathic: e.g., diabetic neuropathy, PHN, radiculopathy
• Mixed: migraine

• Opioid-related: hyperalgesia, tolerance (Pain: Assessment, Non-Opioid Treatment Approaches and Opioid Management. ICSI Guideline).
A: RISK

- Risk for abuse/addiction
- Comorbidities
- Concurrent medications

- Use a tool to help you quantify the risk of opioid abuse
ASSESSING RISK - TOOLS

- High sensitivity and specificity for those at risk (Webster and Webster 2005)
- Quick and easy to score – 5 items
  - Low Risk 0-3
  - Moderate Risk 4-7
  - High Risk 8+
- High score: increased likelihood of future abusive drug-related behavior

[Table]

Questionnaire developed by Lynn R. Webster, MD to assess risk of opioid addiction.


Validated (Butler 2008)
- 24 questions, 5 min est
- Harder to deceive, but less sens/spec than original version
- Easy to Score
  Positive: ≥ 18
- High score: increased likelihood of drug abuse
RECOGNIZING SUBSTANCE USE DISORDER

Abstinence → Occasional Use → Regular Use → Problematic Use → Abuse → Dependence
DIAGNOSING SUBSTANCE USE DISORDER
DSM 5 DIAGNOSTIC CRITERIA

DSM IV: abuse, dependence

DSM 5: substance use disorder with three severities

11 criteria: severity based on number of positive criteria

2-3 Mild
4-5 Moderate
6 or more Severe
DIAGNOSING SUBSTANCE USE DISORDER

DSM 5 DIAGNOSTIC CRITERIA

1. Taking the substance in larger amounts and for longer than intended
2. Wanting to cut down or quit but not being able to do it
3. Spending a lot of time obtaining the substance
4. Craving or a strong desire to use
5. Repeatedly unable to carry out major obligations at work, school, or home due to use

http://www.buppractice.com/node/12351
DIAGNOSING SUBSTANCE USE DISORDER

DSM 5 DIAGNOSTIC CRITERIA

6. Continued use despite persistent or recurring social or interpersonal problems caused or made worse by use

7. Stopping or reducing important social, occupational, or recreational activities due to use

8. Recurrent use in physically hazardous situations

9. Consistent use despite acknowledgment of persistent or recurrent physical or psychological difficulties from using

http://www.buppractice.com/node/12351
10. Tolerance as defined by either a need for markedly increased amounts to achieve intoxication or desired effect or markedly diminished effect with continued use of the same amount. (Does not apply when used appropriately under medical supervision)

11. Withdrawal manifesting as either characteristic syndrome or the substance is used to avoid withdrawal (Does not apply when used appropriately under medical supervision)
RECOGNIZING THE DRUG SEEKING PATIENT

Recognize “red flags”

- Demand to be seen right away, often at the end of the day
- New to town, passing through, doctor unavailable
- Call after hours
- Unusual and assertive behavior
- At extremes of being over- or under-dressed
- Lack of impulse control, mood instability, emotionally labile
- Overly complementary (“You are the only one who understands…”)

https://www.deadiversion.usdoj.gov/pubs/brochures/drugabuser.htm
RECOGNIZING THE DRUG SEEKING PATIENT

Recognize “red flags” (continued)

- “Textbook” history, or evasive and vague
- Demonstrates unusual degree of knowledge of drugs
- Lack of interest in a diagnosis
- Asks for specific drugs
- Track marks and scars

https://www.deadiversion.usdoj.gov/pubs/brochures/drugabuser.htm
THE DRUG SEEKING PATIENT

Differential diagnosis:
- Diversion: a legal matter
- Addiction: a disorder that needs treatment
- Pseudoaddiction: a response to inadequate pain control
P: TREATING THE CONDITION/PAIN

- Evidence-based treatments for the condition and type of pain being treated
- Therapy of underlying disorder (e.g., diabetes)
- Establish treatment goals:
  - Patient specific functional treatment goals
  - Realistic goals for pain reduction (not realistic to expect elimination of pain)
Psychologic/psychotherapy: CBT
Complementary and integrative: acupuncture, yoga
Physical/rehabilitation modalities: massage therapy, manipulation therapy, trigger point injection, PRP injection
Interventional treatment: Facet blocks, ESI, others
Referrals
Pharmacologic

<https://www.icsi.org/guidelines__more/catalog_guidelines_and_more/catalog_guidelines/catalog_neurological_guidelines/pain/>.
P: TREATING THE CONDITION/PAIN (CONTINUED)

- Pharmacologic Therapy
  - Non-opioid medications
    - Acetaminophen, NSAIDs/COX-2 inhibitors, steroids, muscle relaxants, calcium channel modulators and other anti-seizure medications, antidepressants (TCAs, SNRIs)
  - Topical medications
- Opioid medications
  - Only when indicated, other treatments inadequate
  - Informed consent
  - Start with low dose IR formulations, not ER/LA preparation
Pharmacologic treatment targeting the pathophysiology

- Nociceptive
  - Topical agents
  - Acetaminophen, NSAIDs/COX-2, steroids, muscle relaxants, antidepressants

- Neuropathic
  - Antidepressants (TCAs and SNRIs) and calcium channel modulators
P: MONITORING AND MITIGATING RISK

- Monitoring for harms of non-opioid medications (e.g. acetaminophen, NSAIDs, others)
  - Renal and liver function, GI bleeding, sedation
- Monitoring for harms of opioid medications
  - Controlled substance agreement
  - Plan consistent with the level of risk

Establish plan for and frequency of patient monitoring
(see next slide)
P: MONITORING AND MITIGATING RISK

• Urine drug testing – when starting and AT LEAST annually (CDC)
• Review of PDMP – when starting and AT LEAST every 3 months (CDC)
• Carefully assess/reassess if doses reach 50, 90, 120 MED/MME
• Avoid prescribing opioids and benzodiazepines concurrently (CDC) (FDA warning)
• Periodic reevaluation
  5 A’s: Analgesia, Activity, Adverse events, Affect, Aberrancy (Based on Passik & Weinreb, 1998)
• Periodic reassessment with risk tools (COMM)
• Referrals, as indicated (psych, addiction, pain management)
**ADDICTION**

SBIRT
Motivational interviewing
Referral to addiction treatment resources

https://findtreatment.samhsa.gov

ABERRANCY MANAGEMENT

- Aberrancy: Deviation from controlled substance agreement
- Investigate the reason
  - Inadvertent: Loss Theft Memory problems
  - Medical: Self-directed pain management
  - Non-medical: Diversion Personal non-medical use
- Seen in 5-80% of pain population on opioids
  1-3
- Response to aberrancy: depends on severity


Steven Wright, MD. Basics of Chronic Pain Management. CPEP
OPIOID-RELATED ABERRANCIES
LOW LEVEL

• Early refill once
• Self-directed dose ↑ once
• Missed / late for appointment
• Low dose alcohol for special occasion only
• Not informing prescriber of mild adverse reactions
• Non-notification of other opioid prescriber for good reason x1
• Occasional problem-solving phone calls rather than office visits
• Non-participation in non-medication pain approaches for economic reasons
OPIOID-RELATED ABERRANCIES
INTERMEDIATE LEVEL

- Early refill >1
- Consider self addicted
- Lost / stolen prescription
- Unauthorized overuse >1
- Focused on specific opioid
- Unauthorized cannabis use
- Limited interest in non-opioid approaches
- Multiple phone calls rather than office visits
- Not informing prescriber of significant adverse reactions
- Non-opioid substance addiction slip → return to abstinence
- Non-participation in non-medication approaches for noneconomic reasons
OPIOID-RELATED ABERRANCIES
HIGH LEVEL

• Forged prescription
• Cocaine / Stimulant use
• Involvement in DUI / MVA
• > 3 lower level aberrancies
• Non-pain related opioid use
• IV or IN route of administration
• Aggressive demands for opioids
• Active non-opioid substance relapse
• Refusal of non-medication approaches for pain
• Intoxication / Oversedation: reported or observed
• Multi-sourcing: other prescribers / street / internet
• Stealing opioids / Obtaining from nonmedical sources
• Reliance on problem-solving phone calls rather than office visits
Table. Elements of Initial Work-up for Opioid Prescribing

Required Elements for Documentation

- Medical history and physical exam
- Diagnostic, therapeutic, and laboratory results
- Evaluations and consultations
- Treatment objectives
- Informed consent and agreement for treatment
- Discussion of risks and benefits
- Treatments
- Medications (including date, type, dosage, and quantity prescribed)
- Instructions
- Periodic reviews
- Urine drug screen results

Recommended Additional Areas To Document

- Old records, especially those relevant to the presenting problem
- Pain intensity level on each visit
- Levels of functioning and quality of life on each visit
- Patient’s subjective complaints and provider’s observations
- Patient’s explanations for any drug-related aberrant behaviors, requests for early refills, etc.
- Description of provider’s thinking process when making changes in medications, evaluation of lab and imaging results, recommendations for other treatments, and evaluation of urine drug tests and aberrant behaviors

Also … PDMP findings
TOOL BOX

• Screening tool for substance use/abuse: NIDA, CAGE-AID, AUDIT, DAST, NIDA Modified Assist
• Screening tool for opioid risk – initial: ORT, DIRE, SOAPP-R
• Screening tool for ongoing monitoring of opioid risk and misuse: COMM, ABC
• Screening tool for depression and anxiety: HAM-D, PHQ 9, GAD 7, PHQ 4
• Pain assessment tool: Numeric Intensity Rating Scale, Brief Pain Inventory
• Function assessment tool: Brief Pain Inventory, Rolland Morris Disability Questionnaire
• Controlled substance Agreement: NIDA, AAPM
ADDITIONAL RESOURCES

General

• FSMB Model Policy on the Use of Opioid Analgesics in the Treatment of Chronic Pain

• DEA Practitioner’s Manual (2006 last pub)
ADDITIONAL RESOURCES

General

• CDC Checklist for Prescribing Opioids for Chronic Pain

ADDITIONAL RESOURCES

Motivational Interviewing


• Motivational Interviewing for Healthcare Professionals - Online Education http://www.ucdenver.edu/academics/colleges/nursing/programs-admissions/CE-PD/Pages/Motivational-Interviewing-for-Healthcare-Professionals.aspx
ADDITIONAL RESOURCES

SBIRT

• FACT SHEET Substance (Other Than Tobacco) Abuse Structured Assessment and Brief Intervention (SBIRT) Services

• SBIRT: Screening, Brief Intervention, and Referral to Treatment
  http://www.integration.samhsa.gov/clinical-practice/sbirt
ADDITIONAL RESOURCES

Tapering

- CDC Pocket Guide: Tapering Opioids for Chronic Pain
  DEA Practitioner’s Manual (2006 last pub)

- Tapering Long-term Opioid Therapy in Chronic Noncancer Pain
  http://www.mayoclinicproceedings.org/article/S0025-6196(15)00303-1/fulltext

- Helping Patients Taper from Benzodiazepines

- Benzodiazepines: How They Work and How To Withdraw (Ashton Manual)
  http://www.benzo.org.uk/manual/
ADDITIONAL RESOURCES

Urine Drug Testing


• Urine Drug Testing
PRACTICE RESOURCES

Policy for Prescribing and Dispensing Opioids

Colorado Dental Board, Colorado Medical Board, State Board of Nursing, and State Board of Pharmacy

In collaboration with the Nurse-Physician Advisory Task Force for Colorado Healthcare


PRACTICE RESOURCES

CDC

- Caution with any opioid dose
- For acute pain: Only 3-7 days of opioids
- For chronic pain:
  - Reevaluate 1-4 weeks after initiation, dose escalation
  - ≥50 MED Reassess risk / benefit
  - ≥90 MED Avoid or carefully justify

Colorado Department of Regulatory Agencies

- Use lowest effective opioid dose
- >120 MED Add safeguards, consult specialist
- >90 days Reevaluate opioid use
- TD, ER/LA Use clinical judgment

1 CDC Opioid Prescribing Guideline for Chronic Pain. 2016. Accessed 4/12/16
2 Colorado Opioid Prescribing, Dispensing Quad-Regulator Policy. 2014. Accessed 12/7/16
PRACTICE RESOURCES

https://www.colorado.gov/pacific/dora/PDMP
The Washington State Agency Medical Director’s Group (AMDG)
PATIENT EVALUATION

Summary
SAFE PRESCRIBING:  
THE PHYSICIAN’S CHALLENGE

Thorough evaluation of pain, function, and risk initially and on an ongoing basis
Use objective tools to assess risk and use in treatment planning
Know the guidelines and document your clinical rationale carefully, especially if practicing outside the guidelines
Do not practice beyond your scope of practice/capabilities: refer to Pain Management, Addiction, Psychology, and Psychiatry
Learn MI skills
Become familiar with treatment resources in your area
BEWARE OF COMMON PITFALLS

• Failure to recognize misuse, addiction, or the drug seeking patient
• Failure to identify individuals at higher risk
• Discomfort declining patient requests and demands
• Not sure how to manage aberrant behavior or how to help the addicted patient
• Failure to document clinical rationale
• Failure to refer when over our heads
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