Safe Prescribing Practices and Resources

Comprehensive approach to high-quality management of non-cancer chronic pain

- *Empathize, partner with the patient*
- *Perform a complete history and physical, including biopsychosocial assessment*
- *Set functional goals*
- *Utilize shared decision-making*
- *Employ multi-modal treatment plan (pharmacotherapy, behavioral therapies, physical activation)*
- *Employ careful polypharmacy*

Select appropriate patients

Optimal: Already engaged in multi-modal treatment plan but not achieving functional goals, no history of addiction, no history of prescription drug misuse

Higher risk patients will need increased monitoring and support until they are stabilized

Discuss potential benefit/harm of treatment

Potential benefits:

- Improved pain
- Improved functional status
- Improved quality of life

Potential harms:

- Adverse/side effects
- Physiologic dependence
- Addiction

Also: "If we have to stop the medication because of safety problems, we will not try them again."

Use a treatment agreement

Including: informed consent for opioid therapy, bilateral agreement for bundled treatment plan (multimodal, monitoring, follow up) and rules of the practice

Talking points: *"This is so you know what to expect from us and what we expect from you."*

Understand opioid pharmacology

Understand the relative potency of different opioids, and duration of action

Relative Potency	
Oral Dose (MG)	Medication
30	Morphine
7.5	Hydromorphone (Dilaudid ®)
20	Oxycodone
30	Hydrocodone

Assess and re-assess the 5 As

- **Analgesia**: 0-10 Numeric Rating Scale
- **Activities of daily living** (functional goals): "*Your goal was to walk 20-30 minutes daily. How is it going?"*
- **Adverse effects**: detailed questions
- **Addiction/misuse**: Is the patient running out early? Does the urine drug test show unprescribed meds/drugs? Does the prescription monitoring program patient report suggest Dr. Shopping, diversion, or abuse?
- **Adherence** to the treatment agreement: Is the patient no-showing appointments? Pill counts

Frame and respond to problems in terms of harm vs. benefit

- Explain how patient's behavior or the outcome of the treatment is not in line with the treatment agreement
- Firm but empathic -- you will still work with pt on pain treatment and primary care
- Patient is not bad; treatment is not effective, not safe, not appropriate
- Benefits no longer outweighing harms. *"Cannot responsibly continue prescribing opioids as I feel it would cause you more harm than good."*

Document

- Indication for treatment
- Discussion of potential harm and benefit
- Informed consent and treatment plan
- Results of 5 As assessment and reassessment with each visit
- Response to problems

Discontinue when necessary using an appropriate plan

See the back of this page for recommendations

Duration of Action:

Immediate release (4-6 hrs) << <controlled release (8-12 hrs) <<< methadone/fentanyl (24-72 hrs)

Adapted from Dr. Will Becker, Yale School of Medicine

TOOLS/RESOURCES

Circumstance	*Next steps*	*Recommendation*
Opioids ineffective	Attempt to reach consensus with patient re: ineffectiveness	10-20 week taper off
Intolerable side effects	Usually have consensus with patient	Taper off as rapidly as tolerable
Addicted to opioids	Referral to treatment Give Patient Overdose Prevention Education handout Consider naloxone co-prescription	-Suggested taper schedule with remaining opioid supply -Consider supportive withdrawal meds (NSAIDs, clonidine, reglan) -No further opioid prescription
Addicted to other substance		
Doctor shopping	Consider addiction diagnosis Referral to treatment Give Patient Overdose Prevention Education handout Consider naloxone co-prescription	No further opioid prescription
Diversion	→	

Adapted from N. Katz

Access the prescription monitoring program

www.ctpmp.com

Electronic log of every scheduled medication filled in any CT pharmacy

Sortable by patient

1-2 week lag time from fill to record

Goals of treatment: SMART

Developed by Christina Nicolaidis

Specific

Measurable

Action-oriented

Realistic

Time-bound

Urine drug testing

- Confirms use of prescribed medication: Adherence Testing
- Tests for use of non-prescribed medications and illicit drugs
- Performs better than physician impression

Which test to order?

- Immunoassay is screen
- Gas chromotography/mass spectroscopy for confirmation – recommend doing this any time you get an *unexpected result*
- Always ask and document recent intake before sending test

Common errors:

- Standard Utox8 does not include oxycodone, fentanyl or buprenorphine: you *must* include tests of medications patient is prescribed
- In most cases, oxycodone will *NOT* cause opiate assay to be positive; however, it *can* in high doses. Therefore, you MUST do confirmatory testing
- Hydrocodone metabolizes to hydromorphone so pt who takes hydrocodone may frequently have + hydromorphone on opiate GC/MS

(Katz, Fanciullo. Clin J Pain, 2002)

0-10 Numeric Rating Scale to assess Analgesia: