Prophylaxis of Medical–Legal Complications in Chronic Opioid Therapy

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Objectives

- Scope of the problem: COT use increasing
- “Double edged sword” of care for patients COT
- Approaches for new patients on COT
- Tools for providers
- Pain Contracts, Pain assessments, PDMP
Deaths Double From Prescription Drugs
CO Doctor Arrested for running “Pill Mill”
In CO, 84 Doctors have had “actions” against them in last 3 yrs by DEA
The Pendulum Swings Left...

1980’s National recognition that pain was often undertreated

Fear of addiction, fear of reprisals against practitioners, lack of experience with high dose narcotics reasons most cited by PCPs


1999 JCAHO adopts the “5th Vital Sign” policies

Patients’ rights to pain control, Screen for pain Assessment, Document/re-assessment/ follow-up
Set standards, Educate providers about pain/policies, Educate patients. Include patient needs in discharge planning
Collect data to monitor the effectiveness and appropriateness of pain management.
Colorado Guidelines For Prescribing Controlled Substances For Intractable Pain 5/16/96

- Hx/Px documenting why, where, “Psychological function,” “Substance Abuse Hx”
- Tx Objectives (intensity, function, relationships)
- Informed Consent
- Periodic Review (monitoring for dose escalation)
- Consultation
- Records
- Compliance with Controlled Substances Laws
- Addiction vs. Physical Dependence
A New Epidemic: Prescription Opioid Abuse

First time initiates to non-prescribed opioids:
1990 to 2001: 600,000 → 2,000,000

ED visits involving opioids OD’s
1994 to 2002: 41,687 → 90,232 (Up 117%)

1990 → 2000 Admission for detox up 155%

10% of girls 12–17 and 7% of boys admit to Prescription medication abuse
Overdose in prescribed opioids

- Cohort study of 10,000 patients
  - Followed for 42 months average
  - 61% with full follow up
- Risk of overdose and death increased with higher dose of opiates:

<table>
<thead>
<tr>
<th>Opiate Dose/day</th>
<th>Annual Overdose Risk</th>
<th>RR</th>
</tr>
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<tbody>
<tr>
<td>1–20 mg</td>
<td>0.2%</td>
<td>1</td>
</tr>
<tr>
<td>50–99 mg</td>
<td>0.7%</td>
<td>3.7</td>
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<tr>
<td>&gt;100 mg</td>
<td>1.8%</td>
<td>8.9</td>
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Prescribed opioids and overdose risk

- Overdose risk increased in patients with:
  - Substance abuse
  - Depression
  - Concomitant sedative–hypnotic use
- Risk for events greatest after initiation of therapy or refill
Growing Role of patients on C.O.T.

- Growth of patients on C.O.T.: 25% per year
- Growth of patients at DH: 5–10%
Addiction, Dependence, Tolerance and Pseudoaddiction

**Addiction**: Primary, chronic neurobiologic dz c/ genetic, psycho-social and environmental factors
- Impaired control over drug use
- Compulsive use
- Continued use despite harm and craving

**Dependence**: State of adaptation where withdrawal symptoms can be created

**Tolerance**: State of adaptation where exposure to drug causes it to lose effect over time

**Pseudoaddiction**: appearance of drug-seeking behavior when pain isn’t adequately treated

*Consensus panel American Pain Society (APS), American Academy of Pain Medicine (AAPM) and American Society of Addiction Medicine (ASAM)*
Goals of Therapy with Opioids

- Treat Pain (very subjective, from MD POV)
- Prevent Addiction/Diversion
- Prevent Side Effects
- Compliance (charts/DEA/hospital)
- Improve Quality of Life:
  - Decrease Pain!
  - Mood, social relationships
  - ? Function (paucity evidence that opiates affect function)

> 50% of providers thought patients should be weaned off opiates if there was no improvement in functional status. Survey Denver Health, Fischer 1/2007
Great Expectations; How Much Do Opiates Help?

- Opiates can be expected to work in about 40% of patients
- Opiates may lower pain by about 30–35%
- 40–50% of patients will drop out on their own
- If no response after 3 months, further treatment unlikely to be helpful
Selection of patients

- The Difficulties of treating patients on COT
- Do we pick them or they pick us?
- Majority PCP’s rarely initiate COT
Approach to new (or new to us) opiate initiates

- Pain Assessment
  - Opioid Consent/Contract
    - Assess for Abuse/Psych
      - Trial of Opioids
        - Reassessment

Alternatives to Opioids
- Stable/adjust Dose
- Adjuvant meds
- Psychiatric Consult
- Other Consults
- Assess sub abuse
- Assess addiction
- Exit Strategy
Tools To Predict Opiate Abuse

- SOAPP and SOAPP–R
  - Positive likelihood ratio: 2.50 (1.93–3.24)
  - Negative LR: 0.29 (0.18–0.46)

- Opioid Risk Tool (ORT)
  - Positive LR: 14.3 (5.35–38.4)
  - Negative LR: 0.08 (0.01–0.62)

Judgment, Previous records, PDMP
Triaging Risk of Abuse

- **Low Risk Patients (<10 Soapp–24r)**
  - Annual UTox
  - ≤6 month reassessment

- **Medium Risk (10–21)**
  - Periodic UTox
  - If “calm” period, less freq monitoring
  - If 2+ “red flags”, consult specialist / psych

- **High Risk (22+)**
  - UTox every visit initially, then less
  - Violations result in more monitoring or referral
  - Less abusable opioid formulations
Screening for ongoing abuse

- COMM
  - 17-item, self-administered
  - Score >9 detected opioid misuse with
    - -LR of 0.08
    - +LR of 3.48
    - Sensitivity 77%, Specificity 66%

- ABC
  - 20-item, yes/no questionnaire, staff-administered
    - Sensitivity 88%, Specificity 86%
Pain Assessment and Documentation Tool (PADT)

Areas covered:
- Analgesia
- Activities of daily living (turn over)
- Adverse events
- Aberrant drug-related behavior
- DH adds:
  - Pain contract? Last Utox? Last PDMP?
  - Is patient benefiting from Opioid Tx?
  - Continue, decrease, add, refer on…
The Case for Urine Toxicology

- Can aid in monitoring for substance abuse, other Rx abuse, and opioid misuse
- 122 CPP followed 3 years
  - 43% “yellow flags”
  - Behavior 22%  29% +UTox
  - 14%  8%  21%
    (21% illicits, 14% nonRx)

Behaviors: Freq calls, lost/stolen Rx, excessive consumption, visits s/ appt

Recommendations for urine toxicology testing

- APS–AAPM Guidelines
  - 5.2: In patients on COT who are at high risk or who have engaged in aberrant drug–related behaviors, clinicians should periodically obtain urine drug screens or other information to confirm adherence to the COT plan of care (strong recommendation, low–quality evidence)
  - 5.3: In patients...not at high risk...clinicians should consider periodically obtaining urine drug screens or other information to confirm adherence to the COT plan of care (weak recommendation, low quality evidence)

Data Requester registration is now available. For detailed instructions on registering with the Colorado Prescription Drug Monitoring Program, please download and read the Data Requester Registration Manual. For Technical questions about registration, please contact the CO PDMP Technical Helpdesk at 1-877-324-4878 or copdmphelpdesk@ghsinc.com. For Program or Policy questions, please contact the Colorado State Board of Pharmacy’s PDMP Helpdesk at 303-894-5957 or pdmpinr@dora.state.co.us.

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Password: 
Summary

- COT is increasing in every way
- We have a responsibility to treat our patients, but can do it responsibly (and document it)
- Reasonable expectations, and an exit plan
- Surveillance for addiction, substance abuse...