Protect Your Patients, Protect Your Practice: Universal Precautions in Prescribing Controlled Substances

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Objectives
At the completion of this presentation, the participant will be able to:

- Describe the principles of universal precautions used as standard of care in prescribing controlled substances.
- Assess patients for the risk of drug misuse, abuse, and addiction, and assign a level of risk to each patient.
- Discuss the current status of synthetic drug use in Eastern Tennessee and Southwest Virginia.
The Universal Challenge

- “Perfect Storm”
  - Pain control
  - Risk of misuse and abuse
- Increase in unintended overdose deaths
- Ethics drive providers to prescribe
- Fear of sanctions affects prescribing habits
- What happens?
The Universal Challenge

- Adequately control pain with a variety of etiologies
- Evidence-based medicine is lacking or conflicting
- Identifying and managing high-risk situations
- Treating addictions resulting from pain control efforts
- Scale balances
  - Public health priorities
  - Individual pain and suffering
The 4D’s of Prescriber Involvement

- **Deficient (Dated Practitioner)**
  - Too busy to keep up with CME
  - Unaware of controlled substance categories
  - Only aware of a few treatments for pain
  - Prescribes for family or friends without a record
  - Unaware of symptoms of addiction

- **Duped**
  - Always assumes the best about the patient
  - Leaves script pads lying around
  - Falls for the “water excuse”
  - Can’t say “no”
The 4D’s of Prescriber Involvement

- **Deliberate (Dealing)**
  - Selling medications for money, sex, other drugs
  - Pill mill
  - Prescribing for known addicts

- **Drug Dependent (Addict)**
  - Self-prescribing or from colleague
  - Asks staff to pick up prescriptions in their name
  - Using another prescriber’s DEA
  - Fictitious patients
Universal Precautions

- Apply an appropriate minimum level of precaution to ALL patients
- A good starting point for those treating conditions requiring chronic controlled substances
- Every patient, every time
  - Improve patient care
  - Reduce stigma
  - Contain overall risk
1. Diagnosis with Appropriate Differential

- Identify treatable causes for pain
- Check the labs, look at the x-rays and read the consultant reports
- In absence of objective findings, treat symptoms
- Address comorbid conditions
  - Substance use disorders
  - Psychiatric illness
2. Assessment of Risk of Addiction

- Past or current substance misuse
  - Personal
    - Tobacco use
    - Behaviors: legal problems, accidents, DUls, etc.
  - Family
    - Addiction is a GENETIC disease
- Sensitive and respectful
- Patient-centered urine drug testing
- If patient refuses assessment, consider unsuitable for controlled substances
Urine Drug Testing

- Protects the patient and YOU
- NOT to “catch” people doing bad things
- Provide a “teachable moment”
  - Risks of substance abuse
  - Diagnose addiction and refer to treatment

QUESTION: Would you prescribe warfarin without checking and INR? Would you prescribed insulin without checking a blood glucose level?

- DON’T prescribe controlled substances without doing a UDS
Safe Prescribing for Pain: Assessing for pain and the potential for opioid abuse - YouTube
<table>
<thead>
<tr>
<th>Screening Tool</th>
<th>Purpose</th>
<th>Patient Populations</th>
<th>Number of Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>NIDA Drug Use Screening Tool</td>
<td>Identify patient drug use, including the nonmedical use of prescription drug</td>
<td>All patients</td>
<td>Up to 8</td>
</tr>
<tr>
<td>Opioid Risk Tool (ORT)</td>
<td>Identify those at risk of prescription drug abuse prior to prescribing</td>
<td>Pain patients</td>
<td>5</td>
</tr>
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<td><a href="http://www.opioidrisk.com/node/2424">http://www.opioidrisk.com/node/2424</a></td>
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<td>Screener and Opioid Assessment for Patients with Pain (SOAPP)</td>
<td>Identify those at risk of prescription drug abuse prior to prescribing</td>
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<td>5-24</td>
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<tr>
<td>Current Opioid Misuse Measure (COMM)</td>
<td>Determine if patients on opioid therapy are abusing their prescriptions</td>
<td>Pain patients on opioid therapy</td>
<td>17</td>
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Patient Triage

- After assessment of risk, stratify patients into 3 basic groups
  - **Group 1 – Primary care patients**
    - No past or current history of substance use disorder
    - Noncontributory family history
    - No major or untreated mental illness
  - **Group 2 – Primary care patient with specialist support**
    - Past history of substance abuse or significant family history
    - Concurrent psychiatric disorder
    - NOT actively addicted but increased risk
Patient Triage

- Group 3 – Specialty Pain Management
  - Complex case
  - Active substance abuse
  - Major, untreated psychiatric illness
  - Significant risk to themselves and to provider

Reassess over time – patients may move from one group to another at any time
3. Informed Consent

- Discuss and answer questions about treatment plan
  - Anticipate benefits
  - Foreseeable risks
- Explore issues of addiction, dependence, and tolerance at patient level
- Include Prescription Drug Monitoring program
4. Treatment Agreement

- Expectations and obligations

- Part of an overall opioid management plan to set boundaries and guidelines for treatment
  - Schedule for office visits, prescription renewal policies
  - Monitoring processes (e.g., pill counts, random urine drug tests)
  - Safe use of opioid therapy (i.e., use only as directed, storage and disposal of opioids)
  - Prohibited behaviors and grounds for tapering/discontinuation of therapy
  - Obtaining opioids from one prescriber and filling prescriptions at one pharmacy
  - Reasons, methods for discontinuation of opioid therapy ("Exit Strategy")
  - Clarify boundary limits
5. Assessment of Function

- Documented assessment of pre-intervention pain scores and level of function
- Ongoing assessment and documentation of meeting clinical goals required to support continuation of therapy
- Failure to meet goals necessitates reevaluation and possible change in treatment plan
Safe Prescribing for Pain: Evaluating opioid effectiveness - YouTube
6. Appropriate Trial of Therapy

- Opioid (adjunctive medication)
- Time limited
- No problematic behavior
- Improved functioning
- Prescribe the fewest number of pills possible with the lowest abuse potential
7. Reassessment of Pain Score and Function

- Regular reassessment required
- Corroborative support from family or other third party
- Document rationale to continue or modify the current therapy
- Set SMART goals
  - Specific
  - Measurable
  - Action-oriented
  - Realistic
  - Time-dependent
8. Assessment of the 4 A’s of Pain Medicine

- Analgesia
- Activity
- Adverse effects
- Aberrant behavior
- (Affect)

Pain Assessment and Documentation Tool (PADT)
Action: Aberrant Behavior

Safe Prescribing for Pain: Red flags in the opioid using pain patient - YouTube
9. Review Pain Diagnosis and Comorbidities

- Underlying illnesses evolve over time
- Diagnostic tests change with time
- Patient may move from pain to addiction or addiction to pain
- Treatment focus may change over time (coordinate care)
10. Documentation

- Evaluate and document
  - Pain intensity, onset, location, duration, and quality
- Pain-related disabilities and other comorbidities
- Prior treatments (pharmacologic and nonpharmacologic)
- Current medications/allergies
- Medical, psychiatric, social history
- Substance abuse history
- Risk level for aberrant drug-related behavior
FUNCTIONING

- IF YOU ARE TREATING PAIN, FUNCTIONING GETS BETTER
- IF YOU ARE FEEDING AN ADDICTION, FUNCTIONING GETS WORSE
Conclusion

- Adopting a universal precautions approach to prescribing controlled substances
  - Reduces stigma
  - Improves patient care
  - Contains overall risk
- Applying the approach
  - Assists in identifying and interpreting aberrant behavior
  - Helps identify addiction and modify treatment plan
- Standard of care
UNIVERSAL PRECAUTIONS FOR PRESCRIBING CONTROLLED SUBSTANCES[i]: EVERY PATIENT, EVERY TIME

- IDENTIFY: Ask for picture identification. Confirm the diagnosis
- Try the less risky interventions for pain first: PT, NSAIDS, etc. TREATING PAIN WITH NON-NARCOTIC INTERVENTIONS IS TREATING PAIN.
- Get informed consent: Controlled Substance Agreement. This should always include notification that you use the Tennessee or Virginia Prescription Monitoring Program.
- Do a UDS. This protects the patient AND YOU.
- Assess Risk Factors for Substance Misuse Disorders
  - Family History (Addiction is a GENETIC disease)
  - Current Addictions (This includes smoking)
  - Behaviors symptomatic of a Substance Misuse Disorders (Legal problems, MVAs, DUs, etc)
- Assess Functioning
- Do a Time limited Trial (Expectations: No problematic behavior, IMPROVED FUNCTIONING)
- Have an Exit Strategy (know how to wean what you start; know where to refer patients with substance misuse problems)
- Periodic Reassessment
- Give the fewest number of pills possible with the lowest abuse potential
- DOCUMENT, DOCUMENT, DOCUMENT

THE BOTTOM LINE:
FUNCTIONING
IF YOU ARE TREATING PAIN, FUNCTIONING GETS BETTER
IF YOU ARE FEEDING AN ADDICTION, FUNCTIONING GETS WORSE

[i] Adapted from Gourlay
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SYNTHETIC DRUGS IN OUR REGION
Data from police, drug treatment centers and hospitals shows an apparent decline in synthetic drugs in Tennessee and Virginia after a law was passed banning most of the substances.

Cases are still being reported in emergency rooms across the state, but the number this year has dropped substantially.

Tennessee legislation bans the substances and allows local authorities to shut down businesses selling the packets.
K2 Spice and Bath Salts

- Synthetic cannabanoids (K2, Spice)
- Substituted cathinones (Bath Salts)

Amped: Ladybug Attractant
Snowman Glass Cleaner
Go Fast Carpet Deodorizer
2C-I “Smiles”

- **SC-1 in Florida**

Effects like combining LSD and ecstasy

Short acting synthetic psychedelic
2C-I Smiles

- Phenethylamine somewhat similar in effects to 2C-B
- Available primarily in powder form or pressed tablets
- Generally taken orally in combination with candy
- Sold at $300-500 per gram retail, and $50-200 USD per gram wholesale (2011)
- Oral 2C-I takes between 45-75 minutes to take effect
- Primary effects of 2C-I last approximately 5-8 hours when taken orally
- Schedule I in the US
Krokodil (desomorphine)

- Roughly the same effect as heroin but is at least three times cheaper and extremely easy to make
- Active component is codeine
- Addicts mix it with gasoline, paint thinner, hydrochloric acid, iodine and red phosphorous
- Currently an epidemic in Russia – DEA and law enforcement watching and waiting in US
- At the injection site, the addict's skin becomes greenish and scaly, like a crocodile's, as blood vessels burst and the surrounding tissue dies
Krokodil – Devastating Consequences

Consequences of krokodil use

http://www.buzzfeed.com/gavon/seriously-dont-use-krokodil

http://www.independent.co.uk/voices/iv-drip/krokodil-the-drug-which-gives-you-a-oneyear-life-expectancy-8167370.html

Select References