The Challenges of Opioid Prescribing in Family Practice

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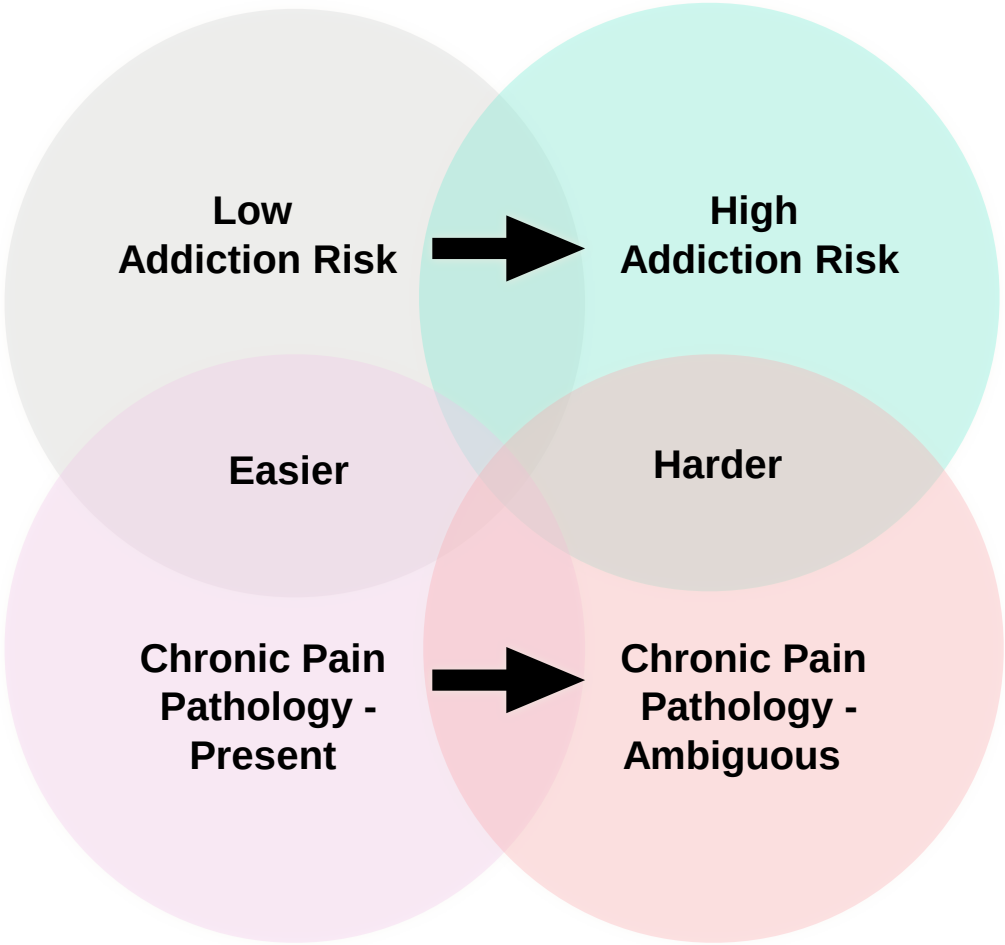
Know your patients



How we feel

- “I have to give them something…”
- “Nobody else will look after them…”
- “I have a very complex practice…”
- “I inherited all these patients…”
- “I don’t know what else to do…”

“Addiction Often Starts in Hospital” Vancouver Sun, August 2009

- “Since 2005, the rate of new prescription-drug addicts has outpaced the number of people getting hooked on marijuana.”
- “…most commonly abused …opioids and benzodiazepines…”
- “…starts with the physician who doesn’t do a thorough substance use and abuse assessment…because the system isn’t set up for that…”

THE VANCOUVER SUN

- Gary Franklin, FME: there have been occasions where short-term post-surgical or dental prescriptions have led to desire for long-term opioid use (and subsequent misuse)

Historic challenges

- Chronic pain has no home in the medical community
- Family physicians by default
- Few chronic pain programs
- Few guidelines
- Poor education on chronic pain and addiction
- Addiction also marginalized in our system

Current challenges

- Implementation of new College Standard
- Still no home for chronic pain
- College has expectations
- Still few programs for patients, but improving
- Education for physicians improving, but still limited
- Still the family physician’s problem
- Increasing public awareness re prescription opioid addiction
- Fentanyl overdose crisis

What do you need?

- Knowledge regarding chronic pain treatment
- Knowledge regarding addiction medicine
- Knowledge regarding depression, anxiety, and PTSD
- Advanced communications skills
- Awareness of community resources
- Willingness to change
- A plan for your practice
- Individual plans for each patient

Tools that help

- Addiction risk tools
- Depression/anxiety questionnaires
- Pain/disability assessment tools
- Opioid manager
- Individualized treatment agreements
- Urine drug screening
- Random pill counts
- PharmaNet

Change your approach

- Patients with recent onset pain (at risk for chronic pain)
- Patients with worsening chronic pain not on opioids
- **Addiction risk assessment**
- Non-opioid options and modalities
- Opioid “Trial” of treatment
- Universal precautions
- **No benzodiazepines**
- Pain BC websites – www.liveplanbe.ca www.painbc.ca
- Self-Management BC – www.selfmanagementbc.ca

Change your approach

- “Legacy” patients
- **Meet them where they are**
- Treatment agreements, UDS, etc.
- Pain questionnaire packages
- Pain BC websites – www.liveplanbe.ca and www.painbc.ca
- Self-Management BC – www.selfmanagementbc.ca
- Slowly reduce opioid dosage to comply with new standard
- Slowly reduce benzodiazepines, then D/C
- Will need help for some

Change your approach

- Smaller refills, more frequent dispensing
- Partner with pharmacy for monitoring of patient compliance and medication reviews
- Inform pharmacies in area of policies such as early refills and lost/stolen medication

Continuing education

- Addiction medicine courses
- Chronic pain courses
- Mental health (depression /anxiety/PTSD)
- **GPSC PSP Chronic Pain Module**
- Motivational interviewing
- CBT for pain, anxiety, depression

A major challenge

- A major issue in treating patients with chronic pain is to recognize that some patients are at high risk for addiction, or are already suffering from addiction
- Treating chronic pain in a patient with active addiction, past addiction, or high risk for addiction is very difficult
- Probably not best done in family physician's office

Chronic pain and addiction

- Addiction is a biopsychosocial condition characterized by certain behaviours
- Chronic pain is also a biopsychosocial condition, but is easier to manage in patients with low addiction risk

Guiding principles

- Patients with chronic pain deserve good medical care
- Patients with the disease of addiction deserve good medical care
- The treatments are different, both are challenging
- Both often complicated by mental health problems
- Both marginalized in our health-care system

Medical record

- Keep good clinical notes
- Document treatment plans
- Document your reasoning
- Carefully document prescriptions
- Document discussion of non-prescription medication use
- Document PharmaNet use
- Document UDT results and actions based on outcome

I don’t have time

- Mental health care plan fee code 14043
- Most patients with chronic pain have depression or anxiety
- Addiction is a DSM-IV diagnosis
- Chronic disease management model
- Get help – mental health, addictions, & methadone programs
- Chronic pain programs (limited)
- ICD-9 Code 338.4 for chronic pain

42-year-old tradesman

- 2008 – Oxycontin 40 mg TID
- Gabapentin 2,400 mg/day
- Zopiclone 15 mg HS
- Effexor XR 225 mg OD
- Ativan 1 mg prn/2-3 per day
- Chlorpromazine 125 mg HS
- Seen by psychiatry and chronic pain physicians
- By Feb 2009 – OxyContin 320 mg/day

42-year-old tradesman

- Fracture C-spine (fell off roof)
- Failed shoulder surgery x 3, chronic pain
- Chronic rectal pain/failed surgery
- Past hx childhood sexual abuse
- Private disability insurance
- Married, children
- Past hx alcohol abuse (young adult)

42-year-old tradesman

- March 2009 Start slow wean off Oxy
- Used OxyContin and OxyIR
- Daily pick up local pharmacy
- “Severe withdrawal” each reduction
- Brief psych admission May 2009
- October 2009 oxycodone 160 mg/day
- October 2009 methadone program
- Opioid free July 2010

42-year-old tradesman

- Nov 2016 – No opioids since 2010
- Still has chronic pain but copes with it
- No benzodiazepines
- Depression and anxiety under control
- Daily exercise, relaxation, meditation
- Dealing with mental health was key
- Patient self-management also key
- Long journey, still not over

One final message

- Avoid benzodiazepines in combination with LTOT and/or other benzodiazepines or Z-drugs
- Reserve for short-term use, if at all

Benzodiazepines

Get to know your patients