



Barriers to Opioid Monitoring in Primary Care



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Trends in opioid use

US prescription opioid sales, 1997-2007

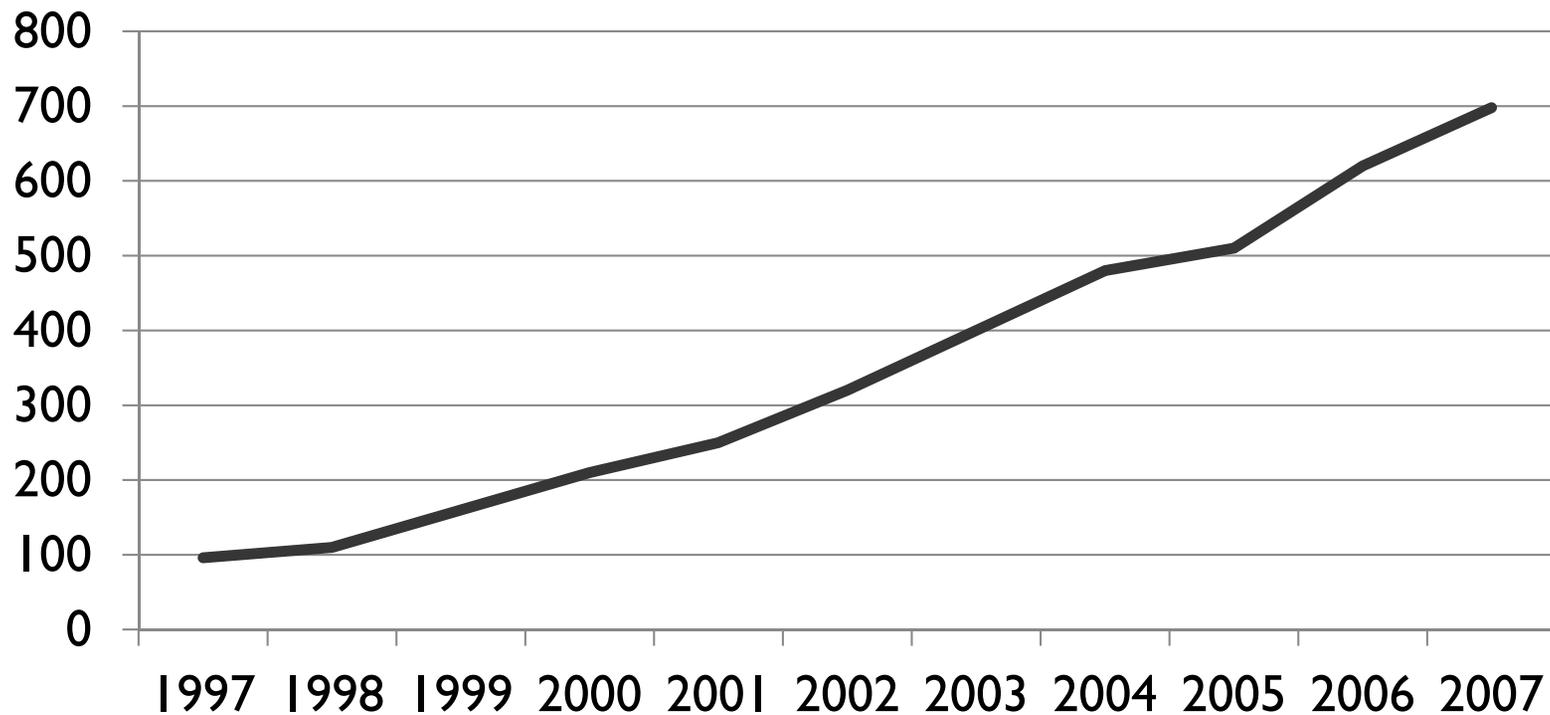
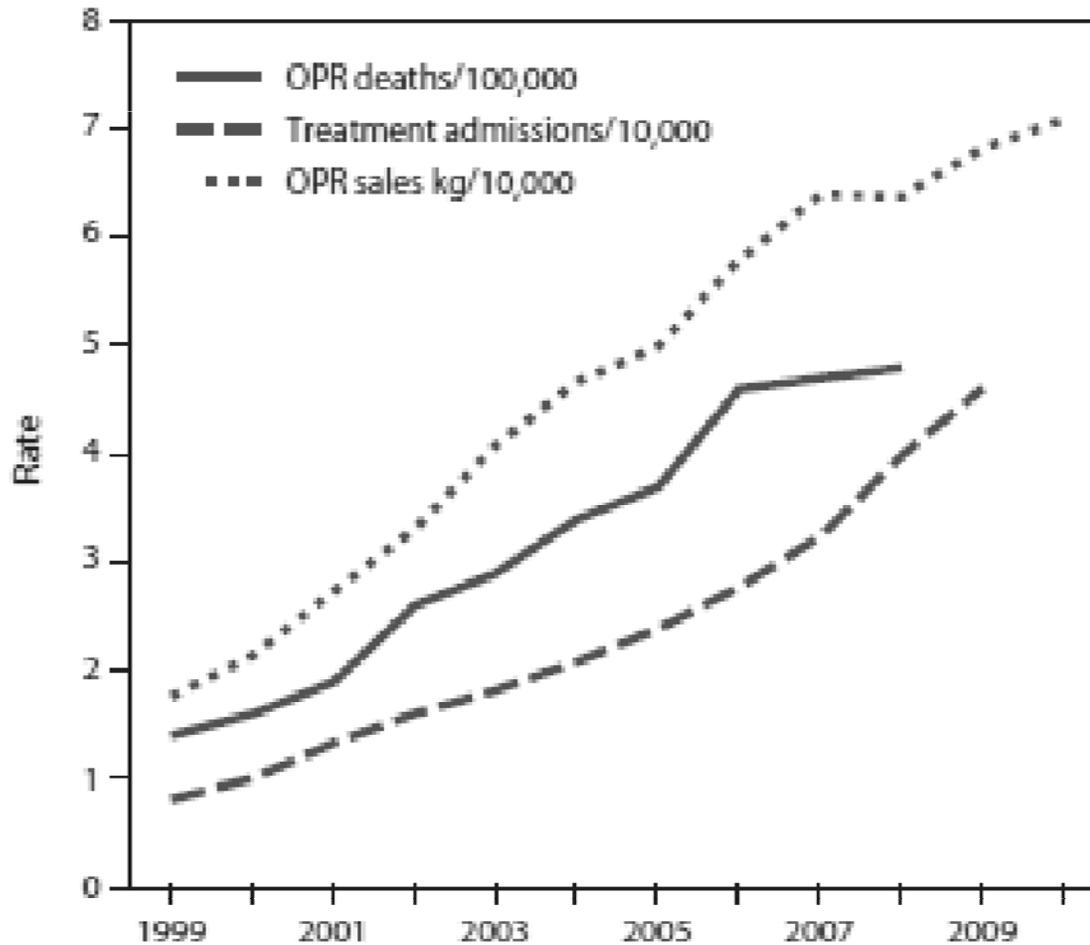


Figure adapted from CDC Grand Rounds, 2/17/11; data source DEA ARCOS

Unintended consequences

FIGURE 2. Rates^a of opioid pain reliever (OPR) overdose death, OPR treatment admissions, and kilograms of OPR sold — United States, 1999–2010



Definitions

- ▶ Opioid analgesics
 - ▶ Natural and synthetic relatives of morphine
 - ▶ Regulated by DEA as controlled substances
- ▶ Chronic pain
 - ▶ Pain that persists and interferes with function
 - ▶ Not acute pain
 - ▶ Not palliative care/pain associated with terminal illness
- ▶ Opioid monitoring
 - ▶ Ongoing assessment of effectiveness, harms, and adherence



Outline

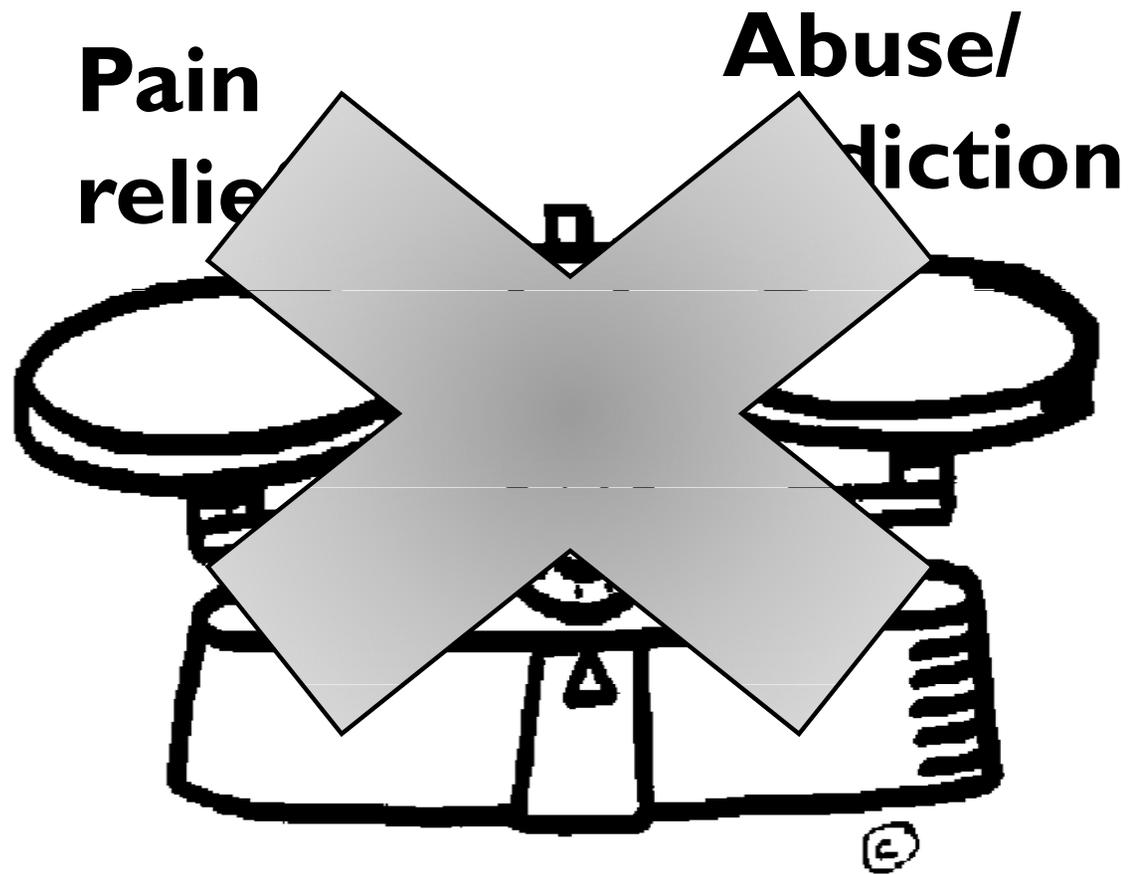
- ▶ Opioid monitoring goals and guidelines
- ▶ Primary care adherence to guidelines
- ▶ Study results—barriers to monitoring in primary care
- ▶ Implications



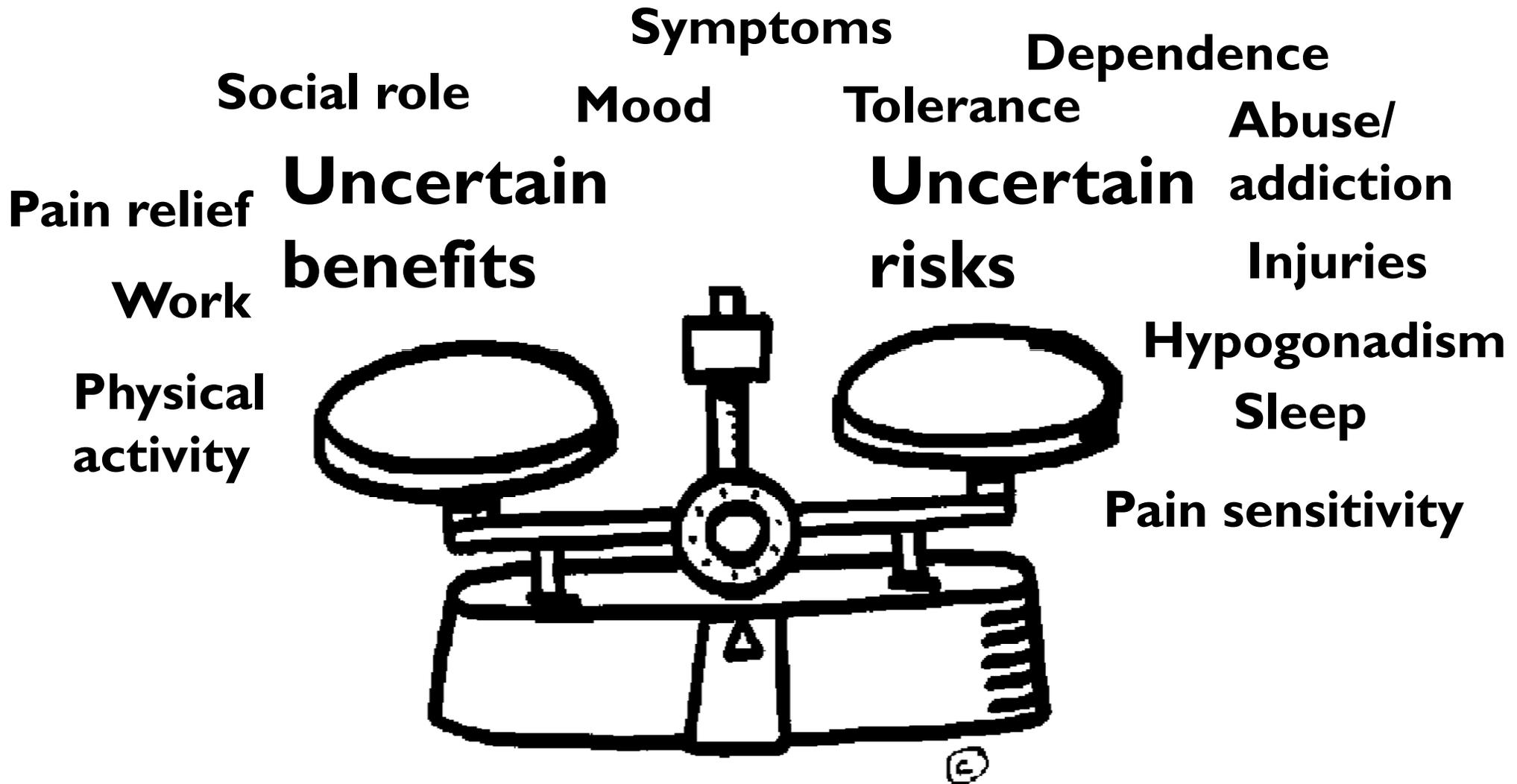
Goals of opioid monitoring

- ▶ Primary goal is patient centered: maximize benefit, minimize harm for individual patient
 - ▶ Evidence for benefits of opioids in chronic pain is limited
 - ▶ Evidence is weak overall
 - ▶ Available trials show modest or no benefit
 - ▶ *For most patients with chronic pain, harms may outweigh benefits*
- ▶ Secondary goal: minimize possibility of collateral harm
 - ▶ Most non-medical rx drug users get them from a friend or relative (70% total; 65% for free, 9% for money, 5% stolen)

Balancing benefits and harms



Balancing benefits and harms



Opioid monitoring

▶ Effectiveness

- ▶ More than reduction of pain intensity
- ▶ Improved overall function and quality of life
- ▶ Progress toward individual goals

▶ Harms

- ▶ Common symptoms (constipation, nausea, somnolence)
- ▶ Long-term harms (sleep disordered breathing, hypogonadism)
- ▶ Psychosocial harms (role interference, dependence concerns)
- ▶ Addiction

▶ Adherence

- ▶ Appropriate medication taking
- ▶ Safe storage and disposal
- ▶ No sharing, borrowing, or selling

VA/DoD opioid monitoring guidelines

	Recommended practice
Informed consent	Provide written and verbal education
	Discuss specific goals of treatment
	Review opioid agreement (consider signature)
	Obtain consent for UDT (can be verbal)
Visit frequency	Reassess at least every 1-6 months
Effectiveness	Discuss progress toward individualized treatment goals
	Assess pain intensity, pain-related function, satisfaction
Harms	Evaluate adverse effects and tolerability
Adherence	Discuss how and when patient is taking medication
	Perform UDT periodically
	Assess adherence to overall treatment plan

Who needs opioid monitoring?

- ▶ Everyone! Goals apply to all patients
- ▶ Monitor more intensely if needed based on...
 - ▶ Recent dose increase or medication change
 - ▶ Aberrant behaviors
 - ▶ Lost/stolen meds, early refill requests
 - ▶ Borrowing, sharing medications
 - ▶ Obtaining medications from other providers
 - ▶ Risk for misuse/abuse/addiction

Risk for misuse/abuse/addiction

Risk level	Patient characteristic
Low	No history of substance or MH disorder
	Good social situation
	Good adherence to other treatments
Moderate	History of substance use or MH disorder
	Any positive UDT or legal problems
	Young age
High**	Unstable or untreated substance/MH
	Repeated/persistent aberrant behavior

** High risk patients should be managed in structured specialty setting or co-managed

Limitations of opioid monitoring

- ▶ Doesn't address appropriateness issues
 - ▶ Prescribing when benefit unlikely (e.g., back pain, headache)
 - ▶ Prescribing for chronic pain in urgent settings
 - ▶ Prescribing for minor ailments
- ▶ Doesn't address underlying deficiencies in pain management training and services
- ▶ Limited evidence for improved outcomes
 - ▶ Systematic review: (2010) “weak” support for UDT and opioid agreements
 - ▶ Some practices well supported by indirect evidence
- ▶ Not widely implemented in primary care

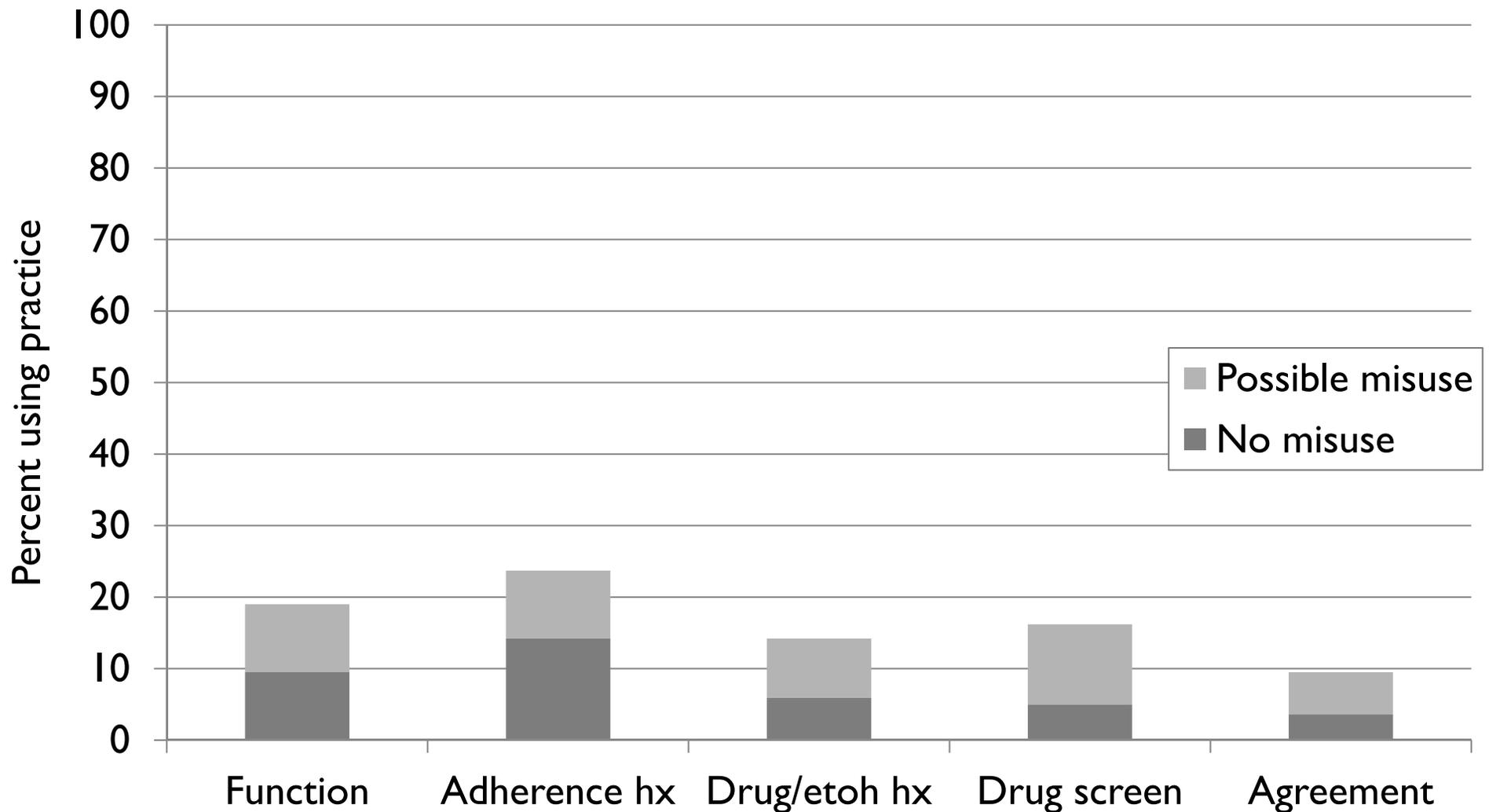


Primary care adherence to guidelines

Adherence to guidelines—VA primary care

- ▶ Record review at Indianapolis VAMC
 - ▶ Patients who filled >6 opioid rx in 12 months (n=1772)
 - ▶ Reviewed random sample of those treated in PC (n=169)
 - ▶ Assessed for recommended practices & evidence of misuse (aberrant behavior or substance use)
- ▶ Patient characteristics
 - ▶ 70% short-acting, 57% long-acting; mean dose=97 MEq mg/d
 - ▶ Indication for opioids: back pain 53%, arthritis/joint pain 13%, no identifiable indication 19%, cancer-related pain <1%
- ▶ Results
 - ▶ Evidence of misuse in 33%
 - ▶ Use of monitoring practices low and associated with misuse

Use of recommended practices



Adherence to guidelines—primary care

- ▶ Retrospective cohort; administrative data from 8 University-affiliated PC clinics
 - ▶ Non-cancer pain diagnosis, ≥ 3 opioid rx in 6 months
 - ▶ Assessed 5 risk factors for misuse: drug disorder, alcohol disorder, smoking, mental health diagnosis, age <45 years
- ▶ Results
 - ▶ UDT (ever): 8%
 - ▶ Regular visits (Q6 mo and within 1 mo of dose change): 50%
 - ▶ Restricted early refills (≤ 1 in 12 mos): 77%

Risk associated with UDT, early refills

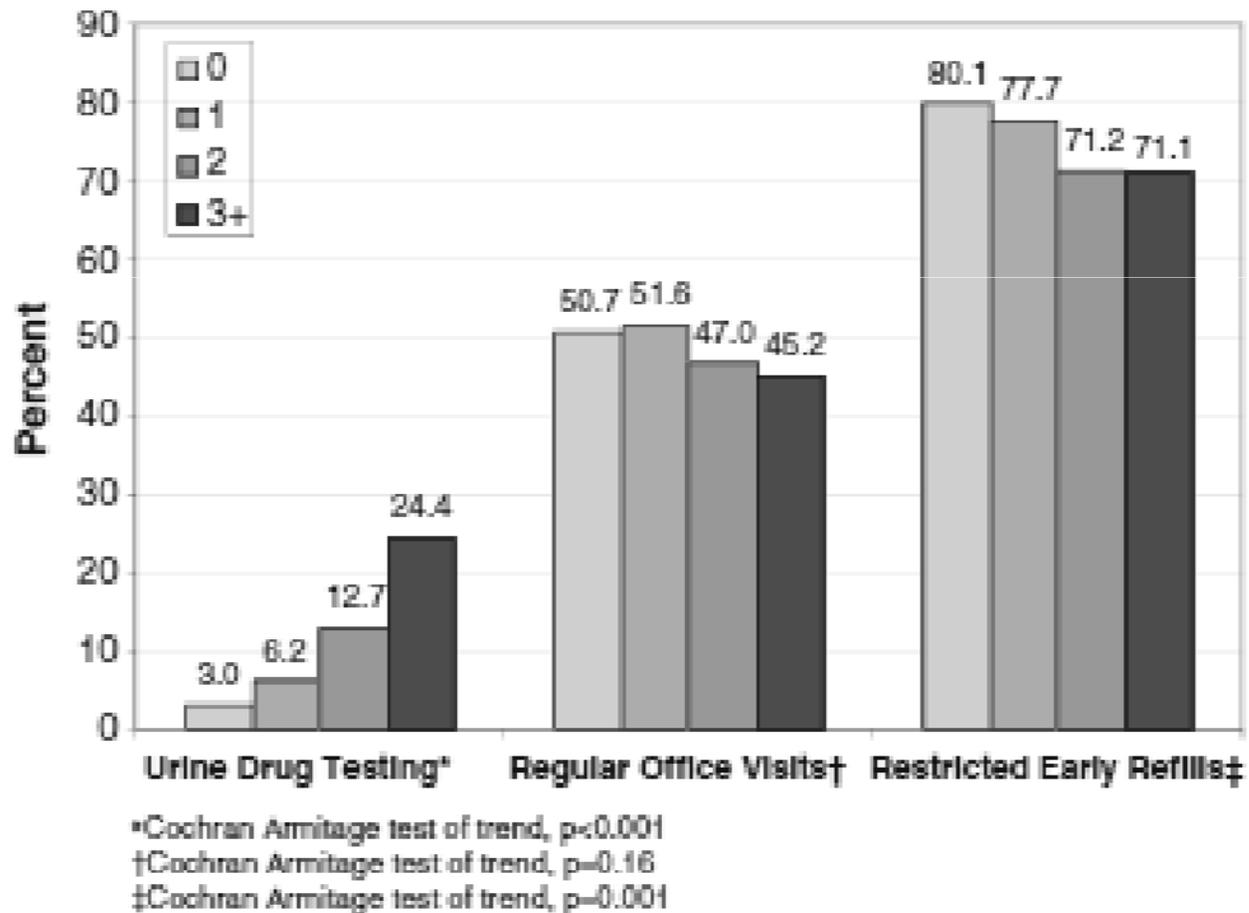


Figure 2. Receipt of recommended opioid risk management practices, by number of patient risk factors for opioid misuse.

Adherence to guidelines—VA

- ▶ Retrospective cohort; VISN-20 clinical database
 - ▶ Non-cancer chronic pain and ≥ 90 days opioid rx (n=5814)
 - ▶ Compared services over 12 months for 1136 patients with a SUD diagnosis vs. those without SUD
- ▶ Patients with SUD were more likely to receive...
 - ▶ UDT: 47% vs. 18%
 - ▶ Mental health visit (among those w/ diagnosis): 30% vs. 17%
 - ▶ Concurrent benzodiazepine: 27% vs. 23%
- ▶ No difference in number of primary care or physical therapy visits

Adherence to guidelines—summary

- ▶ Low use of opioid monitoring practices overall
- ▶ Some recommended practices more common among high risk patients: drug testing, mental health visits, documentation of adherence assessment
- ▶ Some high risk practices more common among high risk patients: providing early refills, prescribing concurrent benzodiazepines





Study results—barriers to monitoring in primary care

VA HSR&D CDA-2, “Improving the Safety and Quality of Opioid
Prescribing in Primary Care”

Project rationale

- ▶ Primary care providers...
 - ▶ Prescribe most long-term opioid therapy
 - ▶ Are concerned about harms of opioid therapy
 - ▶ Yet rarely follow guideline recommendations for monitoring of opioid effectiveness, harms, and adherence



Project overview

▶ Aims

- ▶ Identify barriers & facilitators to opioid monitoring
- ▶ Understand primary care physician and patient perspectives

▶ Methods

- ▶ Semi-structured depth interviews
 - ▶ General questions about opioid management
 - ▶ Specific topics: assessing effectiveness, decision to change therapy, taking a substance use history, drug screening, opioid agreements and ground rules
- ▶ Analysis informed by grounded theory



Setting and participants

- ▶ Six primary care clinics affiliated with one VAMC
- ▶ Primary care physicians (n=14)
 - ▶ Maximum variation sampling
 - ▶ Mean age 47 years (range 32-57)
 - ▶ 50% female
 - ▶ Mean time in VA 10 years (range 1-24)
- ▶ Patients (n=26)
 - ▶ At least six opioid prescriptions filled within the year
 - ▶ Randomly selected from participating physicians' panels





Institutional barriers: lack of system support for monitoring

Not enough time

- ▶ **Physician:** “Typically these are complex people with multiple problems... You need to really sit down, and go through a person’s record, and really try to make a more rational decision... I take it very seriously. It’s serious business. What if you do create an opiate problem for somebody? ...because you’re not being careful enough about it?”



Limited follow-up

- ▶ **Physician:** “In an inpatient setting if somebody has pain you can give something and the nurse can go back and assess the pain... In an outpatient setting, they’re gone. Unless they call back, we don’t have a system in place where my nurse can call and say, ‘how are you doing? Is it working?’ ... We just hope they don’t call back and be happy with what they got. You know it’s not a good system.”



Limited follow-up

- ▶ **Patient:** “I feel that if I’m explaining to my doctor that this medication is really not helping my pain, then they should be willing to try something else or just say, ‘okay, we’re gonna prescribe you this for 30 days and come back and see me and let me know if this medication is working for you,’ instead of saying, ‘Well that’s all I’m gonna do.’”



Inadequate support

- ▶ **Physician:** “...[E]specially people who live like two hours away...it’s really hard to bring them in for just a urine drug screen when they won’t even go for a stress test or this and that.”
- ▶ **Physician:** “Sometimes I wonder if they have somebody else’s urine.”





Attitudes and beliefs

Beliefs about patient selection

- ▶ **Physician:** “I do not at all routinely check patients...but I probably have a pretty good hit rate when I do because you just kind of get a sense as to them not being honest with you.”



Beliefs about patient selection

- ▶ **Physician:** “For those patients that have a legitimate reason for wanting to take it and if I can trust them—that they are not selling, they’re not abusing—and most of these are older patients of mine, I don’t have them sign a contract because they never request early refills, they don’t go to the ER in between visits to get them, and so there's no need for me to do periodic drug screenings and so forth.”



Beliefs about patient selection

- ▶ **Contrasting view—Physician:**
“There’s no way you can judge who is going to be a problem and who’s not. You just treat everybody fairly.”



Legalistic/law enforcement perspective

- ▶ **Physician:** “I think [drug screening] is destructive to a basic patient-doctor relationship. You’re there to help them and they can tell you their deepest, darkest secrets, but yet you’re policing them.”



Legalistic/law enforcement perspective

- ▶ **Physician:** “One patient I had on a narcotic contract... came to me and he was like, ‘Why am I on this? Why am I being singled out? I've never had any problems with abuse?’ ... It made me think that unless you’re going to do it consistently, unless you have a reason other than just looking at the person and thinking, ‘oh, maybe I should put him on a contract,’ maybe it’s not fair to do that.”



Legalistic/law enforcement perspective

- ▶ **Patient:** “I don’t see the purpose of [the opioid agreement]. It’s like signing a legal agreement with a doctor... it’s clearing him of responsibility...”



Legalistic/law enforcement perspective

- ▶ **Patient:** “My initial reaction to [the opioid agreement] is that we’re living in a police state... you have no recourse or something...It tells you exactly what you have to do and it’s hard to follow that. I mean, I could sign that and if you followed me around every minute you could get something on me.”



Contrasting views on opioid agreements

- ▶ **Physician:** “It’s a tool – it’s one tool to help educate the patient what proper pain management is and what their role is as the patient.”
- ▶ **Patient:** “The doctor has only a few moments, is trying to tell you everything that he could think of and the hospital can think of in areas to kind of protect, not just themselves, but you also.”



Physicians do not listen enough

- ▶ **Patient:** “He could have more of a sympathetic ear toward how I feel... I’ll tell him what is wrong with me and he’ll go and say, ‘well, I want you to go give a urine sample’.”



Physicians do not listen enough

- ▶ **Patient:** “I won’t take them like they want me to. They want me to take like five or six of them a day and I don’t want to take that many ‘cause I can’t function... I mentioned it to [the doctor] what I don’t like, and he said ‘you need them in your system. It goes along with the other medicine. They will help you.’”



Physicians do not listen enough

- ▶ **Patient:** “[Dr. X], I don’t know what his deal was, he said in the appointment you need to go to a higher level of medication. Well, in my world, staying at the same level to me is critical to my lifestyle, because, since I’ve finally accepted the fact there is no cure, my opinion is it’s gonna come to, I’ll be at a point where I can take too many drugs and not have a life.”





Implications for practice

Implications for practice—system-level

- ▶ Complex barriers call for multifaceted solutions
- ▶ Support is needed for high-quality monitoring
 - ▶ Systems for regular follow up
 - ▶ Frequent visits
 - ▶ Phone visits
 - ▶ PACT team involvement
 - ▶ Clinic and facility-level protocols
 - ▶ Education for patients, training for entire care team



Implications for practice—provider-level

- ▶ Maintain focus on balance of benefits and harms of medication, rather than trustworthiness of patient
 - ▶ Avoid law enforcement role
 - ▶ Share decision making about goals of therapy
 - ▶ Consider a broad differential diagnosis when faced with aberrant behaviors
- ▶ Time spent listening may be a good investment

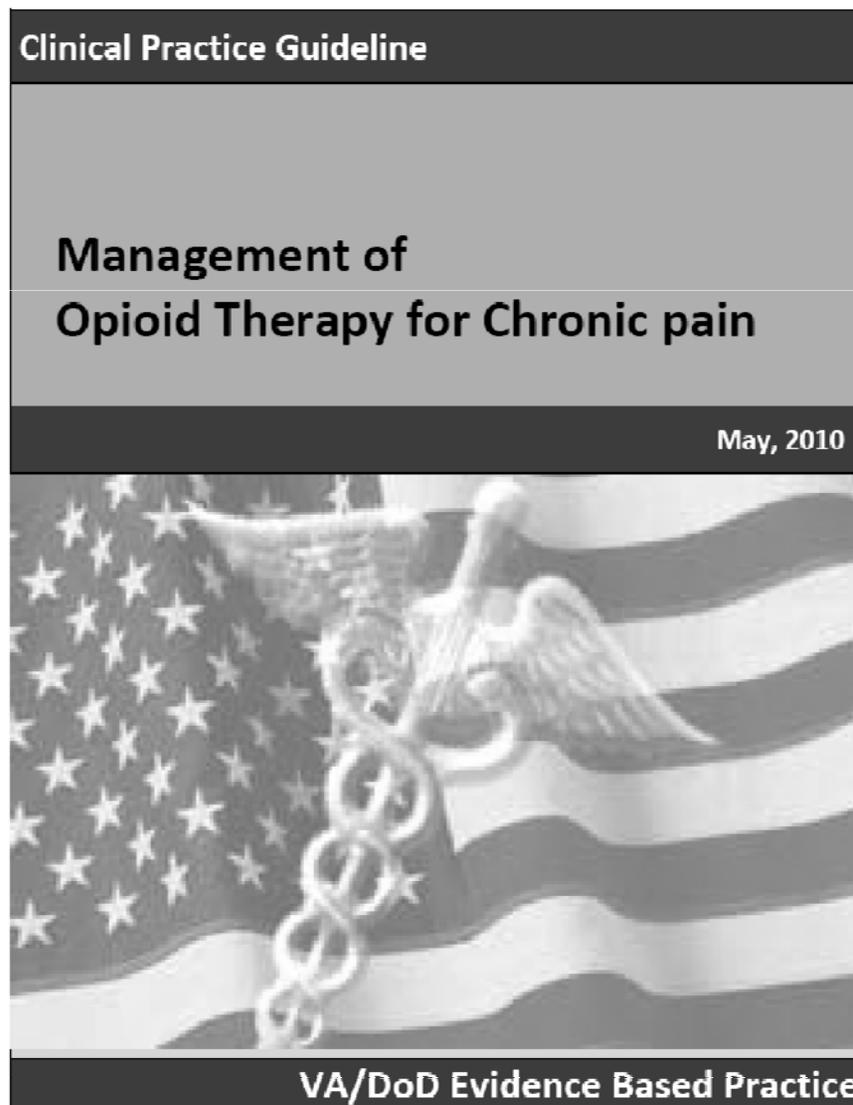
Thank you!

▶ Questions? Comments?



References

- ▶ VA/DoD clinical practice guideline: Management of opioid therapy for chronic pain (2010). Available at: http://www.healthquality.va.gov/Chronic_Opioid_Therapy_COT.asp
- ▶ Chou R, et al, American Pain Society–American Academy of Pain Medicine clinical guidelines for the use of chronic opioid therapy in chronic noncancer pain. *J Pain*. 2009; 10(2):113-130.



References

- ▶ CDC. Vital Signs: Overdoses of prescription opioid pain relievers—United States, 1999–2008. *MMWR* 2011;60:1487–92.
 - ▶ Deshpande A, et al. Opioids for chronic low-back pain. *Cochrane Database of Systematic Reviews*, 2010.
 - ▶ Krebs EE, et al. Primary care monitoring of long-term opioid therapy among veterans with chronic pain. *Pain Medicine*. 2011; 12(5):740-746.
 - ▶ Martell BA, et al. Systematic review: opioid treatment for chronic back pain: prevalence, efficacy, and association with addiction. *Ann Intern Med* 2007;146:116-127.
 - ▶ Morasco BJ, et al. Adherence to clinical guidelines for opioid therapy for chronic pain in patients with substance use disorder. *J Gen Intern Med*; 2011; 26(9):965–71.
 - ▶ Nicolaidis C. Police officer, deal-maker, or health care provider? Moving to a patient-centered framework for chronic opioid management. *Pain Med*. 2011;12(6):890-7.
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References

- ▶ Noble M, et al. Long-term opioid management for chronic noncancer pain. *Cochrane Database of Systematic Reviews*, 2010.
 - ▶ Nüesch E, et al. Oral or transdermal opioids for osteoarthritis of the knee or hip. *Cochrane Database of Systematic Reviews*, 2010.
 - ▶ Starrels JL, et al. Low use of opioid risk reduction strategies in primary care. *J Gen Intern Med* 26(9):958–64.
 - ▶ Starrels JL, et al. Systematic review: Treatment agreements and urine drug testing to reduce opioid misuse in patients with chronic pain. *Ann Intern Med*. 2010;152:712-720.
 - ▶ Substance Abuse and Mental Health Services Administration. *Results from the 2008 National Survey on Drug Use and Health: National Findings*, 2009. Available at www.oas.samhsa.gov.
 - ▶ Sullivan MD, et al. Problems and concerns of patients receiving chronic opioid therapy for chronic non-cancer pain. *Pain* 2010;149: 345–353.
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