Teaching safe and responsible opioid prescribing for chronic pain

Payam Sazegar MD CCFP(AM) FCFP

The opioid epidemic is a global problem and Canada has one of the highest rates of opioid-related deaths in the world. A 2013 report from the National Advisory Council on Prescription Drug Misuse[1] showed that Canada has become the second largest prescription opioid consumer in the world, with an estimated 1 in 6 Canadians having taken opioids in the previous year. Opioid-related deaths increased exponentially in the past decade, in part owing to increased emphasis on treating pain. This was perpetuated by many false notions (such as pain being the "fifth vital sign," no need for a ceiling on opioid doses, and OxyContin not being addictive) by both well-meaning physicians and the pharmaceutical industry. Teaching safe and responsible opioid prescribing remains an unmet need in many family medicine residency programs.[2-4]

A responsible opioid-prescribing curriculum for family medicine residents requires a strong academic and clinical component. Academic sessions should be interactive and case based to meet the needs of adult learners, while covering key topics and offering clinical pearls. A clinical curriculum should ideally be multidisciplinary, use technology strategically, and include practice improvement. This can be summarized in the 5 strategies I recommend to medical educators implementing curricula on responsible opioid prescribing (**Figure 1**).

Provide essential knowledge on core topics

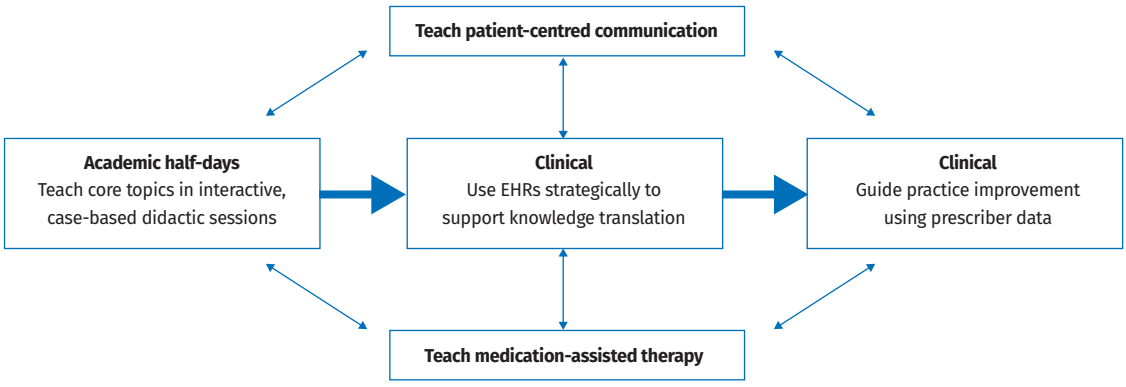
Many online safe-prescribing curricula exist, including those developed by professional medical associations, provincial college chapters, and university health systems (**http://nationalpaincentre.mcmaster.ca/guidelines.html**). Curriculum faculty might wish to adapt these for their academic half-days. Case-based instruction is preferred by learners, according to feedback I receive year after year. A list of suggested key topics to cover is provided in **Box 1**.[5-7]

Providing clinical pearls is highly encouraged (eg, teaching trainees to titrate doses to patient function, not to pain scale scores). Trainees should be taught to recognize opioid-induced hyperalgesia or analgesic overuse headache early, as these are indications for tapering. Learning opioid and benzodiazepine tapering protocols is valuable; the general tapering rule is to decrease the dose by not more than 10% of the total starting dose every 1 to 2 weeks.

Teach patient-centred communication

Many of the patients who refuse to taper opioids are patients who come to us from other providers. Many of them will require tapering, so learning the appropriate language to use is of paramount importance when deprescribing. One technique I have found effective is the Four Habits model,[8] which suggests clinicians should invest in the beginning, elicit the patient's

Figure 1. Five strategies for teaching responsible opioid prescribing



EHR—electronic health record.

Box 1. Key topics for case-based instruction on core topics

The following is a suggested list of key topics to cover:

- The 10 universal precautions[5]
- Provincial college practice standards based on guidelines, including contraindications for opioids[6]
- Monitoring: scales, 5 As of documentation,[5] setting functional goals, drug testing
- Conducting a risk assessment (eg, Opioid Risk Tool[7])
- Review of the clinical evidence about benefits, risks, and adverse effects
- The importance of MME limits
- Opioid overdose prevention
- Nonpharmacologic and nonopioid chronic noncancer pain treatment options
- Relative contraindications (eg, driving, work)
- Tapering indications and protocols
- Diagnosing and treating OUD and pseudoaddiction

MME—morphine milligram equivalent, OUD—opioid use disorder.

perspective, demonstrate empathy, and invest in the end. Patients who feel validated and heard are more likely to adhere to a tapering protocol. One former colleague of mine offers concise tips addressing common scenarios including "managing the patient's resistance to change" and "managing anxiety of the physician and patient."[9] Here are some other common scenarios and suggested responses.

A new patient joins your practice and is taking a high-risk opioid-benzodiazepine combination

Patient: All of my previous doctors have filled the same medications and never had any concerns. I don't abuse these medications.

Physician: I understand. There are frequently new research findings about the safety of certain medications that might require your physicians to change, adjust, or outright discontinue certain medications to prevent harm. It is similar to how our recommendations changed with cigarettes, bike helmets, and seat belts. I'm your health advocate and your safety is my top priority.

A new patient taking a high morphine milligram equivalent (MME) dose of an opioid is offered naloxone

Patient: I don't need naloxone. That's for addicts. I don't inject.

Physician: Naloxone is also used to prevent "accidental toxicity" from opioids, which can happen when there's a change to your body. For example, if you get dehydrated from a bad infection or get prescribed a drug that interacts with your opioid you can get accidental poisoning and stop breathing. Under these circumstances, a simple puff in the nose can save your life.

Use electronic health records strategically

The electronic health record (EHR) can be optimized with tool kits and time-saving measures that can seamlessly change the way we practise. Widely used EHRs such as Epic and Cerner allow users to build SmartPhrases and Quick Actions, respectively, to simplify and streamline documentation with a few clicks. For example, the user can build a simple template for the 5 *A*s of documentation: *analgesia, activities, adverse effects, aberrant behaviour,* and *affect*.[5] Such a template might contain a drop-down menu that allows you to quickly pick pertinent statements for each *A,* with little freehand typing. Such shortcuts improve clinic work flow and save hours of charting time weekly. **Box 2** provides another example of EHR customization—a template for the periodic health visit.[5,7]

Many tool kits for opioid prescribing already exist, such as Opioid Manager from McMaster University in Hamilton, Ont.[10] Organizations can design their own tool kits and borrow from these assessment tools as they wish. For documenting functional improvement, a quick validated tool is the PEG (pain, enjoyment of life, general activity) scale.[11] Another approach is to let the patient decide what concrete examples to provide to show progress toward functional goals.[12]

Use prescriber data to guide practice improvement

Quality improvement activities can be undertaken to bridge the gap between best practices and current prescribing. Prescription monitoring programs are provincial databases used by physicians to look for aberrant behaviour, multi-doctoring, and dangerous coprescriptions. They can also be valuable tools for medication reviews, which should be done quarterly. Allied medical staff such as clinical pharmacists or nurses in the medical home can be asked to generate quarterly reports of patients taking high MME doses (eg, MME >50) based

Box 2. Example of EHR customization

Another example of EHR customization is to make a template for the periodic health visit that includes sections such as the following:

- Relevant history (eg, 5 *A*s,[5] nonpharmacologic treatments)
- MME dose calculation
- Opioid Risk Tool[7] score
- Outcomes of a pain assessment, functional goals, adherence to a treatment protocol
- Data from a prescription monitoring program
- Findings of a mental status examination (eg, PHQ-2, PHQ-9)
- Laboratory test results (eg, drug screening, endocrine levels)
- Outcomes and expectations of action plans

EHR—electronic health record, MME—morphine milligram equivalent, PHQ—Patient Health Questionnaire.

on dispensing dates, not physician orders. In my practice, we provide these reports to physicians along with peer outreach and opportunities for a virtual continuing medical education practice improvement activity. Thus far, we have seen encouraging reductions in total MME doses per physician, similar to previous studies.[13]

Having a clinic policy on opioids is an acceptable best practice to prevent splitting and to ensure patients receive a clear, consistent message across all providers in your group. Coprescription of opioids with either benzodiazepines or gabapentinoids can raise the risk of overdose by 2-fold or more,[14] and patients with such prescriptions should also be identified for further tapering. Zero-tolerance policies on cannabis are fairly standard given that cannabinoids are known to interact at the hepatic level with opioids, benzodiazepines, and other sedatives including alcohol. Another activity, if feasible, is to have interdisciplinary team meetings with prescribers to discuss patients who refuse to taper.

Provide training in medication-assisted therapy

Educational opportunities in medication-assisted therapy (MAT) are gaining momentum in postgraduate education and becoming mainstream in family medicine. After all, do we not all have patients with opioid use disorders (OUDs) on our panels? A certain subset of our patients taking long-term opioid therapy will have OUDs and could thus benefit from the MAT options of naltrexone, methadone, or buprenorphine. There is a logical argument that if treatment for OUD is more difficult to access than illicit opioids are, patients will simply continue using illicit opioids. Residency programs thus have a public responsibility to provide MAT training to their physicians and faculty. Electives in inner-city medicine, addiction medicine, pain medicine, and prison medicine provide opportunities for increased clinical exposure, as do specialized clinics and outreach programs developed within the patient-centred medical home.

Dr Sazegar is Clinical Assistant Professor in the Department of Family Practice at the University of British Columbia in Vancouver.

Competing interests
None declared

Correspondence
Dr Payam Sazegar; e-mail **payam.sazegar@vch.ca**

References

1. National Advisory Council on Prescription Drug Misuse. *First do no harm: responding to Canada's prescription drug crisis*. Ottawa, ON: Canadian Centre on Substance Abuse; 2013. Available from: **https://www.ccsa.ca/first-do-no-harm-responding-canadas-prescription-drug-crisis-report**. Accessed 2020 Mar 3.
2. American Academy of Family Physicians. *Chronic pain management. Recommended curriculum guidelines for family medicine residents*. Leawood, KS: American Academy of Family Physicians; 2015. Available from: **https://www.aafp.org/dam/AAFP/documents/medical_education_residency/program_directors/Reprint286_Pain.pdf**. Accessed 2020 Mar 10.
3. Zoberi K, Everard KM. Teaching chronic pain in the family medicine residency. *Fam Med* 2018;50(1):22-7.
4. Gano L, Renshaw SE, Hernandez RH, Cronholm PF. Opioid overdose prevention in family medicine clerkships: a CERA study. *Fam Med* 2018;50(9):698-701.
5. Gourlay DL, Heit HA, Almahrezi A. Universal precautions in pain medicine: a rational approach to the treatment of chronic pain. *Pain Med* 2005;6:107–12.
6. Busse JW, Craigie S, Juurlink DN, Buckley DN, Wang L, Couban RJ, et al. Guideline for opioid therapy and chronic noncancer pain. *CMAJ* 2017;189(18):E659-66.
7. Webster LR, Webster RM. Predicting aberrant behaviors in opioid-treated patients: preliminary validation of the Opioid Risk Tool. *Pain Med* 2005;6(6):432-42.
8. Frankel RMF, Stein T. Getting the most out of the clinical encounter: the four habits model. *J Med Pract Manage* 2001;16(4):184-91.
9. Saal D. Rewriting the script. *JAMA* 2015;313(23):2323-4.
10. Michael G. DeGroote National Pain Centre. *Opioid Manager* [website]. Hamilton, ON: McMaster University; 2011. Available from: **http://nationalpaincentre.mcmaster.ca/opioidmanager/**. Accessed 2020 Mar 11.
11. Krebs EE, Lorenz KA, Bair MJ, Damush TM, Wu J, Sutherland JM, et al. Development and initial validation of the PEG, a three-item scale assessing pain intensity and interference. *J Gen Intern Med* 2009;24(6):733-8. Epub 2009 May 6.
12. Fishman SM. *Responsible opioid prescribing. A clinician's guide*. 2nd ed. Washington, DC: Waterford Life Sciences; 2012.
13. Austin RC, Fusco CW, Fagan EB, Drake E, Pacious J, Dickens H, et al. Teaching opioid tapering through guided instruction. *Fam Med* 2019;51(5):434-7.
14. Gomes T, Juurlink DN, Antoniou T, Mamdani MM, Paterson JM, van den Brink W. Gabapentin, opioids, and the risk of opioid-related death: a population-based nested case-control study. *PLoS Med* 2017;14(10):e1002396.

La traduction en français de cet article se trouve à **www.cfp.ca** dans la table des matières du numéro **d'avril 2020** à la **page e132**.

Teaching tips

- An effective opioid prescribing curriculum should include case-based didactic sessions, electronic health record optimization, and practice improvement activities that promote knowledge translation.
- Learn and teach the language of safe prescribing through emphasis on patient-centred communication.
- Given the current opioid epidemic, family medicine programs should consider making medication-assisted therapy a learning objective and provide training opportunities for their residents.

Teaching Moment is a quarterly series in *Canadian Family Physician*, coordinated by the Section of Teachers of the College of Family Physicians of Canada. The focus is on practical topics for all teachers in family medicine, with an emphasis on evidence and best practice. Please send any ideas, requests, or submissions to **Dr Viola Antao,** Teaching Moment Coordinator, at **viola.antao@utoronto.ca.**