Model Policy Adds Balance To Opioid Management

BY DOUG BRUNK

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SAN DIEGO — A good way to ensure a balanced approach to opioid prescribing is to follow the key principles of the Model Policy for the Use of Controlled Substances for the Treatment of Pain, Dr. Edward Michna advised at the annual meeting of the International Pelvic Pain Society.

Written by the Federation of State Medical Boards in 1998, the model policy was developed so the medical community would adopt consistent standards for prescribing controlled substances for pain (www.fsmb.org/grpol_policydocs.html). The key features include:

► **Evaluate the patient.** "You have to see the patient, you have to take a history and conduct a physical exam," said Dr. Michna, an anesthesiologist who is director of pain trials at Brigham and Women's Hospital, Boston. "Certainly the condition that you're considering must be one of the things that are known to be responsive to opioid therapy."

► **Develop a treatment plan.** Write down the result you expect from placing the patient on opioids and when you plan to evaluate the patient again. "The problem is, most doctors are not good about documentation," he said.

Dr. Michna offered the "four A's" as a reminder of critical areas for optimal opioid management. The first A stands for analgesia. What is the pain level experienced by the patient? "You need to use some sort of measurement, whether it's a visual analog scale or a scale in which you ask them to rate their pain as good, bad, or fair."

The second A stands for activity. What's the patient's activity like? How is their disease state impairing that activity? What do they want to do that they can't do? "I usually ask the patient, 'How do you spend your day?' If they say 'I'm sitting in front of the television with the clicker,' obviously we're not promoting daily living activity," Dr. Michna said.

The third A stands for adverse events or side effects. "When you are taking opioids there are side effects," he said. "You have to monitor them and document what the patient's experience is."

The fourth A stands for aberrancy: "Aberrancy of use of medications and drug diversion, those kinds of things."

► **Establish written consent and agreement for treatment.**

► **Conduct periodic review.** How often you see that patient "depends on how difficult that patient is or prior history," said Dr. Michna, who is a former medical malpractice attorney. "You can't individualize care across the board."

► **Keep accurate medical records.** This is the problem most physicians have, Dr. Michna said. "Even though we know we need to document, the pressures of day-to-day practice are such that you start getting sloppy. It's that sloppiness that can get you into trouble."

► **Stay in compliance with controlled substances legislation and federal laws.** Dr. Michna recommended the new handbook "Responsible Opioid Prescribing: A Physician's Guide," by pain specialist Dr. Scott M. Fishman. The Federation of State Medical Boards Research and Education Foundation will provide state medical boards with printed copies to distribute on a state-by-state basis as funds are raised.

Dr. Michna emphasized the importance of getting as much information as possible during the first visit with patients who are potential candidates for opioid therapy. He and his associates routinely call referring physicians to see if the patient has any history of opioid use or misuse. They also ask the patient if he or she has a history of addiction. "That might not prevent you from treating that patient, but you'd certainly want to know about it," Dr. Michna said.

He and his associates also perform urine screens on the first and every subsequent office visit. Most clinicians use immunochemistry, but the better test is mass spectrometry, which can detect drug levels in nanograms. "The problem is cost," he said. "Immunochemistry is cheaper than any other format."

Patients who like their physicians rarely sue them. "When I was an attorney I never had a patient coming in saying to me that 'I feel bad. I really like my doctor. I don't really want to sue.' It was usually 'I want to get that S.O.B. He did this to me. He didn't answer my phone calls.' You need to care for your patients. You need to make proper referrals." ■

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Reference: 1. Biederman J, Faraone SV, Spencer TJ, et al. Functional impairments in adults with self-reports of diagnosed ADHD: a controlled study of 1001 adults in the community. *J Clin Psychiatry*. 2006;67:524-540.

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