Training Helps Generalists Manage Opioid Risk

BY RENÉE MATTHEWS

BETHESDA, MD. — Generalist chief residents who were trained in opioid risk management in immersion programs were more confident in dealing with the risks, showed improvement in their clinical practice skills, and were better prepared and more willing to pass on their knowledge to their trainees, data from a small study of chief residents show.

Such programs, known as Chief Resident Immersion Training (CRIT) programs, are one way of addressing the need for better physician training in opioid risk management, Dr. Daniel P. Alford said at the annual conference of the Association for Medical Education and Research in Substance Abuse.

Dr. Alford, of Boston University, and his colleagues initially targeted generalist chief residents specializing in internal medicine, family practice, and emergency medicine because providers in those specialties are increasingly prescribing opioids for chronic pain at a time when opioid abuse is becoming a public health problem. However, the access of chief residents to training in risk management is inadequate despite screening and monitoring recommendations from professional bodies.

Generalists, such as FPs, are increasingly prescribing opioids for chronic pain at a time when opioid abuse is becoming a public health problem.

The researchers expanded the course content in opioid risk management in the 2007 and 2008 CRIT programs in addiction medicine to include addiction-screening tools, controlled substance agreements, and monitoring strategies such as pill counts and urine drug testing. They conducted electronic surveys of the participants about their confidence in dealing with opioid risk management as well as their clinical and teaching practices at baseline (pre-CRIT) and 6 months after they had completed the program (post-CRIT).

The 43 chief residents were from 36 residency programs. Eighty-six percent specialized in internal medicine, 9% in family medicine, and 5% in emergency medicine. All of them completed the baseline survey; 1 did not complete the 6-month follow-up, and 2 of the remaining 42 did not provide complete responses for all of the questions. The changes in confidence, clinical practices, and teaching practices were rated on a 5-point Likert scale, and a *P* value of .05 was deemed significant.

The changes in confidence from baseline to post-CRIT in identifying substance abuse in chronic pain patients and in treating high-risk patients with chronic pain were significant. Confidence in identifying abuse went from 2.8 at baseline to 3.5 at 6 months (1 = not at all, 5 = very confident) and in treating high-risk patients, it went from 2.2 to 3.7 (*P* less than .0001 for both). One CR did not complete the post-CRIT confidence questions.

In regard to changes in clinical practices, the differences were highly significant for the frequency of using a validated substance abuse screening tool (2.3 to 3.3 [1 = never, 3 = half of the time, 5 = always]; *P* less than .0001) and frequency using agreements or contracts and routine drug testing (2.9 to 3.5 and 2.3 to 3.3, respectively; *P* less than .001 for both). However, when it came to conducting routine pill counts, there was a nonsignificant decrease (2.3 to 2.2; *P* = .46). Dr. Alford said the decrease likely occurred because it is difficult to do a routine pill count during a brief primary care visit. "The count is often done with support staff—for example nursing—assistance, which is not universally available to physicians in training [or] chief residents," he said.

Among the limitations of the study, Dr. Alford listed the absence of a nonintervention control group. He point out that the data were self-reported, which might have resulted in a social desirability bias.

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