PainWeek

Through the Eyes of an Expert Witness: The Importance of Chart Documentation in the Chronic Pain Patient

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Disclosure

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Objectives

- **Describe the balance of all factors associated with safe opioid prescribing**
- **List specific items that should be included in a complete EHR when caring for chronic pain patients**
- **Explain the pitfalls associated with use of an EHR when caring for the chronic pain patient**

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Symptoms

Demands

Undertreatment

Safety

Adverse Events

Overprescribing

Negative Feedback

Regulatory Action

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The Goal of Pain Management…

INCREASE A PATIENT'S QUALITY OF LIFE

Does the pain number really matter???

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The Electronic Health Record PRO's

A 2008 study in the *Archives of Internal Medicine*, malpractice payouts correlate inversely with EHR use

WHY?

Improved follow-up and legibility,

because it reduces adverse outcomes and made providers more defensible if sued

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The Electronic Health Record CON's

- Beautifully templated and perfectly legible can also be laden with pages of irrelevant repetitions
- Perfect tracking of who accessed the record and when they did so and what changes were made can lead to serious questions about a provider's own conduct
- Prompts designed to ensure that abnormal results are followed-up on and alerts that can avert adverse medication reactions can actually be ignored in a sea of data

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The Electronic Health Record CON's (cont'd)

- Prescriptions that can be generated with a single click can lead to serious errors because they are being done with a degree of automaticity
- EHRs are time-stamped and time-stamping is fully discoverable
- Creates a trail of access and modification, a true "digital fingerprint"

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If You Are Sued

Malpractice carriers now recommend….

- To NOT immediately review the record and to instead wait for a hard copy from the carrier
- A sudden review of the chart can be suggestive of doubts or question of the care they rendered

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EHR "Dulling of the senses"

- "Alert fatigue"
  - 150 alerts a day about matters ranging from redundancy to suggested follow-up to dosage discrepancies to drug interactions
  - Simply start ignoring the alerts
- With so many alerts, we can forget to check pertinent information before prescribing
  - Worsening renal disease vs NSAIDs

There is discoverable digital proof that the red flag was, in fact, waved

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The Problem with Aunt Betty's fall

Cloning your chart: the "COPY AND PASTE" feature can cause trouble!

WATCH OUT

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Establish a diagnosis
pain is not a diagnosis...it's a symptom

Pain management is not without liability

Your liability greatly increases, if you treat a patient with controlled substances without a firm diagnosis

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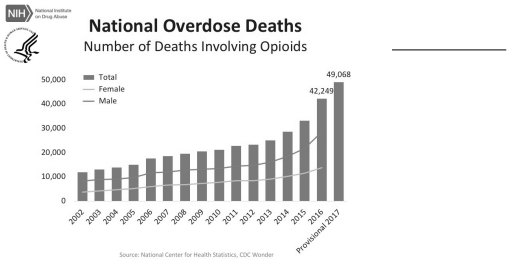

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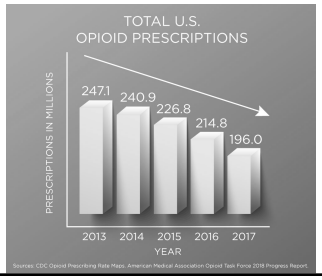
Drugabuse.gov Drug Overdose Death Statistics 2017

EVEN THOUGH...



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What to Consider and What to Document

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What Kind of Pain Is it?

- Neuropathic pain
- Musculoskeletal pain
- Inflammatory pain
- Mechanical/compressive pain

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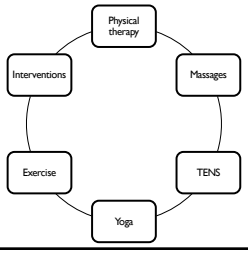
Nonpharmacological Interventions: Document Them!



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Interventions for Pain Treatment:
What has been tried?

- Trigger point Injections
- Epidural blocks
- Implantable pain stimulators
- Botox injections for migraines

Even if these therapies have been failed….
it is important to document

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The 4 Pillars of Oral Pain Therapy

1) Anti-inflammatories
2) Anticonvulsants
3) Mood modulators
   –SNRIs
   –SSRIs
4) Opiates

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When Opioids Are Appropriate

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The Pain Assessment

Clinical Interview: Patient Medical History

Illness relevant to (1) effects or (2) metabolism of opioids

1. Pulmonary disease, constipation, nausea, cognitive impairment
2. Hepatic, renal disease

Illness possibly linked to substance abuse; eg:

Hepatitis	HIV	Tuberculosis	Cellulitis
STIs	Trauma, burns	Cardiac disease	Pulmonary disease

Chou R, et al. *J Pain.* 2009;10:113-30. Zacharoff KL, et al. *Managing Chronic Pain with Opioids in Primary Care.* 2nd ed. Waverly, MA: Inflexion, Inc., 2010. Department of Veterans Affairs, Department of Defense. *VA/DoD Clinical Practice Guideline for Management of Opioid Therapy for Chronic Pain.* 2003.

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Clinical Interview: Pain & Treatment History

Description of pain

What relieves the pain?

What causes or increases pain?

Effects of pain on physical, emotional, and psychosocial function

Patient's pain and functional goals

Henry A. Kerns RD. Psychological and Behavioral Assessment. In: Raj's Practical Management of Pain. 4th ed. 2008:279-91. Zacharoff KL, et al. Managing Chronic Pain with Opioids in Primary Care. 2nd ed. Waverly, MA: Inflexion, Inc., 2010.

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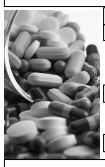
Clinical Interview: Pain & Treatment History (cont'd)

Pain Medications



Past use

Current use

- Query state **PDMP** where available to confirm patient report
- Contact past providers and obtain prior medical records
- Conduct **UDT**

Dosage

- For opioids currently prescribed: opioid, dose, regimen, & duration
  - Important to determine if patient is **opioid tolerant**

General effectiveness

Nonpharmacologic strategies and effectiveness

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Perform Thorough Evaluation & Assessment of Pain

Seek objective confirmatory data → Components of patient evaluation for pain → Order diagnostic tests (appropriate to complaint)

General: vital signs, appearance, posture, gait, & pain behaviors	Musculoskeletal Exam • Inspection • Palpation • Percussion • Auscultation • Provocative maneuvers	Cutaneous or trophic findings
Neurologic exam		

Adapted from: Argoff CE. History and Physical Examination of the Pain Patient. In: Raj's *Practical Management of Pain*. 2008;177-88. Chou R, et al. *J Pain*. 2009;10:113-30.

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Assess Risk of Abuse, Including Substance Use & Psychiatric Hx

Obtain a complete Hx of current & past substance use

- Prescription drugs
- Illegal substances
- Alcohol & tobacco
  - Substance abuse Hx does not prohibit treatment w/ ER/LA opioids but may require additional monitoring & expert consultation/referral
- Family Hx of substance abuse & psychiatric disorders
- Hx of sexual abuse

Social history also relevant

Employment, cultural background, social network, marital history, legal history, & other behavioral patterns

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Risk Assessment Tools: Examples

Tool	# of items	Administered
Patients considered for long-term opioid therapy:		
ORT Opioid Risk Tool	5	By patient
SOAPP® Screener & Opioid Assessment for Patients w/ Pain	24, 14, & 5	By patient
DIRE Diagnosis, Intractability, Risk, & Efficacy Score	7	By clinician
Characterize misuse once opioid treatments begins:		
PMQ Pain Medication Questionnaire	26	By patient
COMM Current Opioid Misuse Measure	17	By patient
PDUQ Prescription Drug Use Questionnaire	40	By clinician
Not specific to pain populations:		
CAGE-AID Cut Down, Annoyed, Guilty, Eye-Opener Tool, Adjusted to Include Drugs	4	By clinician
RAFFT Relax, Alone, Friends, Family, Trouble	5	By patient
DAST Drug Abuse Screening Test	28	By patient
SBIRT Screening, Brief Intervention, & Referral to Treatment	Varies	By clinician

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Opioid Risk Tool (ORT)

Mark each box that applies	Female	Male
1. Family Hx of substance abuse		
Alcohol	☐ 1	☐ 3
Illegal drugs	☐ 2	☐ 3
Prescription drugs	☐ 4	☐ 4
2. Personal Hx of substance abuse		
Alcohol	☐ 3	☐ 3
Illegal drugs	☐ 4	☐ 4
Prescription drugs	☐ 5	☐ 5
3. Age between 16 & 45 yrs	☐ 1	☐ 1
4. Hx of preadolescent sexual abuse	☐ 3	☐ 0
5. Psychologic disease		
ADD, OCD, bipolar, schizophrenia	☐ 2	☐ 2
Depression	☐ 1	☐ 1
Scoring Totals:		

Administer

On initial visit

Prior to opioid therapy

Scoring (risk)

0-3: low

4-7: moderate

≥8: high

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Webster LR, Webster RM. Pain Med. 2005;6:432-42.

When to Consider a Trial of an Opioid

Pain is moderate to severe

Failed to adequately respond to nonopioid & nondrug interventions

No alternative therapy is likely to pose as favorable a balance of benefits to harms

Potential benefits are likely to outweigh risks

Consider referral to pain or addiction specialist for patients where risks outweigh benefits

Long-acting Opioids: when continuous, around-the-clock opioid analgesic is needed for an extended period of time

Chou R, et al. J Pain. 2009;10:113-30. Department of Veterans Affairs, Department of Defense. VA/DoD Clinical Practice Guideline for Management of Opioid Therapy for Chronic Pain. 2010.

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Initiating & Titrating: Opioid-Naïve Patients

- Drug & dose selection is critical
  - Some ER/LA opioids or dosage forms are only recommended for **opioid-tolerant** patients
  - Check individual drug PI
- Monitor patients closely for respiratory depression
  - Especially within 24-72 h of initiating therapy & increasing dosage
- Individualize dosage by titration based on efficacy, tolerability, & presence of AEs
  - Check ER/LA opioid product PI for minimum titration intervals
  - Supplement w/ IR analgesics (opioids & nonopioid) if pain is not controlled during titration

The ER/LA Opioid Analgesics Risk Evaluation & Mitigation Strategy. Selected Important Safety Information. Abuse potential & risk of life-threatening respiratory depression. www.fda.gov/downloads/Drugs/DrugSafety/UCM244371.pdf. 2012. Chou R, et al. *J Pain.* 2009;10:113-30. FDA. *Blueprint for Prescriber Education for ER/LA Opioid Analgesics.* 8-28-2012. www.fda.gov/downloads/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/UCM311130.pdf

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Reasons for Discontinuing Opioids

- No progress toward therapeutic goals
- Intolerable & unmanageable AEs
- Pain level decreases in stable patients
- Nonadherence or unsafe behavior
  - 1 or 2 episodes of increasing dose without prescriber knowledge
  - Sharing medications
  - Unapproved opioid use to treat another symptom (eg, insomnia)
- Aberrant behaviors suggestive of addiction &/or diversion
  - Use of illicit drugs or unprescribed opioids
  - Repeatedly obtaining opioids from multiple outside sources
  - Prescription forgery
  - Multiple episodes of prescription loss

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Utilize a PPA

Reinforce expectations for appropriate & safe opioid use

- Obtain opioids from a single prescriber
- Fill opioid prescriptions at a designated pharmacy
- Safeguard opioids
  - Do not store in medicine cabinet
  - Keep locked (eg, use a medication safe)
  - Do not share or sell medication
- Instructions for disposal when no longer needed
- Commitments to return for follow-up visits
- Comply w/ appropriate monitoring
  - eg, random UDT & pill counts
- Frequency of prescriptions
- Enumerate behaviors that may lead to opioid discontinuation
- An exit strategy

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Monitor Adherence and Aberrant Behavior

Routinely monitor patient adherence to treatment plan

- Recognize & document aberrant drug-related behavior
  - In addition to patient self-report also use:
    - State PDMPs, where available
    - UDT
      - Positive for nonprescribed drugs
      - Positive for illicit substance
      - Negative for prescribed opioid
- Family member or caregiver interviews
- Monitoring tools such as the COMM, PADT, PMQ, or PDUQ
- Medication reconciliation (eg, pill counts)

PADT=Pain Assessment & Documentation Tool

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Main Types of UDT Methods

Initial testing w/ IA drug panels:

- Classify substance as present or absent according to cutoff
- Many do not identify individual drugs within a class
- Subject to cross-reactivity
- Either lab based or at POC

Identify specific drugs &/or metabolites w/ sophisticated lab-based testing; eg, GC/MS or LC/MS

- Specifically confirm the presence of a given drug
  - eg, morphine is the opiate causing a positive IA
- Identify drugs not included in IA tests
- When results are contested

GC/MS=gas chromatography/mass spectrometry; IA=immunoassay; LC/MS=liquid chromatography/ mass spectrometry

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The Patient Counseling Document

Use it to help counsel patients

Download:
www.er-la opioidrems.com/IwgUI/rems/pdf/patient_counseling_document.pdf

Order hard copies:
www.minneapolis.cenveo.com/pcd/SubmitOrders.aspx

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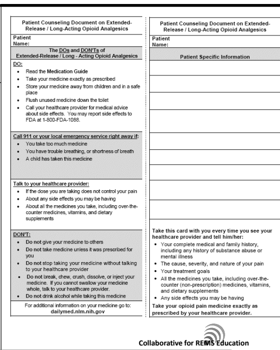

Patient Counseling Document on Extended-Release / Long-Acting Opioid Analgesics

Patient Name:

The DOs and DON'Ts of Extended-Release / Long - Acting Opioid Analgesics

DO:
- Read the **Medication Guide**
- Take your medicine exactly as prescribed
- Store your medicine away from children and in a safe place
- Flush unused medicine down the toilet
- Call your healthcare provider for medical advice about side effects. You may report side effects to FDA at 1-800-FDA-1088.

Call 911 or your local emergency service right away if:
- You take too much medicine
- You have trouble breathing, or shortness of breath
- A child has taken this medicine

Talk to your healthcare provider:
- If the dose you are taking does not control your pain
- About any side effects you may be having
- About all the medicines you take, including over-the-counter medicines, vitamins, and dietary supplements

DON'T:
- **Do not** give your medicine to others
- **Do not** take medicine unless it was prescribed for you
- **Do not** stop taking your medicine without talking to your healthcare provider
- **Do not** break, chew, crush, dissolve, or inject your medicine. If you cannot swallow your medicine whole, talk to your healthcare provider.
- **Do not** drink alcohol while taking this medicine

For additional information on your medicine go to: **dailymed.nlm.nih.gov**

Patient Counseling Document on Extended-Release / Long-Acting Opioid Analgesics

Patient Name:

Patient Specific Information

Take this card with you every time you see your healthcare provider and tell him/her:
- Your complete medical and family history, including any history of substance abuse or mental illness
- The cause, severity, and nature of your pain
- Your treatment goals
- All the medicines you take, including over-the-counter (non-prescription) medicines, vitamins, and dietary supplements
- Any side effects you may be having

Take your opioid pain medicine exactly as prescribed by your healthcare provider.

Collaborative for REMS Education

Clinical Pearls of Documentation

- Don't forget Aunt Betty's fall
- Remember DIAGNOSIS is vital!
- IF the pain increases or changes—
  order appropriate tests and make appropriate referral
- Don't just check a box! Do something and document

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Clinical Pearls of Documentation (cont'd)

- Age matters: extra documentation to support opiates in patients younger than 45 years of age
- NAS (neonatal abstinence syndrome):
  document on all female patients 15-55 years of age
- What did you prescribe, how much, how many?

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