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Thunder Road: Navigating the Legal Weed Terrain for Pain Management

Jennifer Bolen, JD

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Bolen Disclosures

- Ms. Bolen is a Consultant for Paradigm.Healthcare

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Critical Disclaimers

I am NOT a physician, pharmacist, psychologist, or nurse.

I am a lawyer.

In this setting (public educational forum), it is unethical for me to give you legal advice about a specific patient or fact pattern;

Lawyers generally need to know many other facts before offering counsel.

I am only able to provide general guidance and offer available resources about medico-legal challenges encountered at the intersection of chronic opioid therapy and cannabis.

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Overview

- Frontline healthcare practitioners face their own rendition of "Thunder Road" when it comes to providing quality pain management for their patients.
- We are still in the middle of a pandemic, an economic roller-coaster, and the fledgling era of "Legal Weed" and its impact on treating people in pain.
- Practitioners face continued treatment challenges and regulatory scrutiny stemming from the ever-increasing number of drug overdose deaths by controlled substances and new illicit drug analogs.

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Given the landscape of "Thunder Road"

Maybe legalizing "weed" isn't such a bad idea after all?

BUT WAIT . . .

Is it really about the legal status of cannabis when a patient is using cannabis (medical or recreational) but receiving their chronic opioid therapy from you?

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This talk is NOT about:

- Whether cannabis should be legalized federally and in every state.
- The legal back story from the Department of Justice on whether its prosecutors will or will not defer to state laws regarding cannabis – medical or recreational.
  - DOJ prosecutors do not have to defer to state laws if a prescriber is issuing invalid opioid (or other) prescriptions.
- The medical merits of cannabis with/without opioids.
  - The focus is on the perils of not properly evaluating patients and documenting provider actions and medical reasoning.

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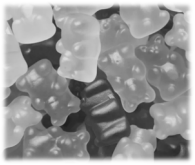
Key Questions We Will Cover During this Talk



- Does "legal" mean truly legal when it comes to cannabis – medical or recreational?
  - Does it matter if the emphasis is on the act of prescribing opioids or other controlled substances to patients who are using cannabis?
- What are the legal implications for a prescriber who actively prescribes controlled medication to patients who are also using cannabis – medical or recreational?
- What is the DEA's current or trending position on cannabis and how does it impact medical decision-making associated with chronic opioid therapy?
- How do I document my way through this gauntlet and show reasoned and sound efforts to individualize patient care?

Gummies, anyone?

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Setting the stage for today's conundrums – Cannabis? Opioids? Both? Neither?

The Beatles, "Got to Get You Into My Life" (1966 Revolver LP)

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Learning Objectives

Objective 1
- Summarize the general tension between the federal and state law regarding the status of cannabis.

Objective 2
- List 5 risk mitigation concepts associated prescribing opioids to patients who use cannabis.

Objective 3
- Review concepts to enhance the practitioner's approach to documentation of medical decision-making when prescribing controlled substances to patients using cannabis – medical or recreational

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No perfect solution. Many Perspectives.

The opioid epidemic is well documented, yet physicians still are wary about whether cannabinoids are better options for chronic pain. Neither is a perfect solution.

- https://labblog.uofmhealth.org/rounds/why-us-doctors-love-opioids-and-hate-marijuana-for-chronic-pain
- June 23, 2016, Perspective

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No perfect solution. Many Perspectives.

Weighing the risks and benefits of both treatments

Most regulatory agencies, such as the Food and Drug Administration, evaluate potential therapies based on benefit versus risk, at both the level of the individual patient and the general public health. If one compares the benefits of opioids versus cannabinoids for chronic pain, the least contentious assessment would be to call it a tie.

SEE ALSO: Fewer Veterans Got Risky Opioid Prescriptions Thanks to National VA Effort

Both classes of drugs are at best modestly effective and work well only in a small subset of patients. Both work in a similar manner to dissociate individuals from the sensory unpleasantness of pain rather than treat the root cause of pain. Opioids may be more effective in pain related to peripheral inflammation or damage, and cannabinoids more effective for neuropathic and centralized pain conditions such as fibromyalgia.

But there are not nearly enough good studies with either class of drug to enable us to say this with certainty. In other therapeutic areas, one would not even consider using any class of drug with such modest benefits. But in the chronic pain field, all of our pharmacological therapies have at best modest effect sizes.

Although the benefits of these two classes of drugs might be comparable, the risks are not.

- https://labblog.uofmhealth.org/rounds/why-us-doctors-love-opioids-and-hate-marijuana-for-chronic-pain
- June 23, 2016, Perspective

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No perfect solution. Many Perspectives.

Meanwhile, in part because there has been scant research on the potential benefits of cannabinoids, many U.S. physicians are stuck back in a *Reefer Madness* era of cannabinoid knowledge, where cannabis will inevitably lead to "death, debauchery or hopeless insanity." We need to adjust our perceptions about these two classes of drugs based on current evidence.

There is no excuse for the common practice in U.S. pain clinics to liberally prescribe opioids while doing drug screens and discharging patients if they test positive for a cannabinoid. There is also no excuse for pharmaceutical companies to continue to market opioids as though they work broadly for chronic pain when we know there is no evidence they have efficacy for common conditions such as fibromyalgia.

It also makes no sense that cannabis is still a Schedule I drug when extracts or synthetic forms of cannabinoids are generally Schedule III. Rescheduling cannabis would enable physicians who are interested in trying to help their patients find an appropriate formulation and dose of a cannabinoid to do so.

Finally, neither opioids nor cannabinoids should be used as first-, second- or third-line therapies for pain, as there are almost always many much more effective and safer drug and nondrug therapies. We can and should do better for our patients.

How did we get here?

- https://labblog.uofmhealth.org/rounds/why-us-doctors-love-opioids-and-hate-marijuana-for-chronic-pain
- June 23, 2016, Perspective

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A patient on chronic opioid therapy presenting to you in a "One Toke" capacity? Legal Conundrums.

One Toke Over the Line? Brewer and Shipley (1971)

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Objective 1 – Examining the basic "legalities" associated with cannabis - medical and recreational

Does "legal" mean truly legal when it comes to cannabis – medical or recreational?

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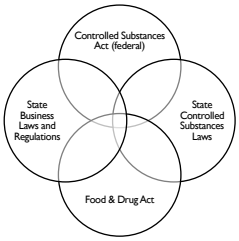
A Complex Web of Laws, Regulations, Policies & Powers



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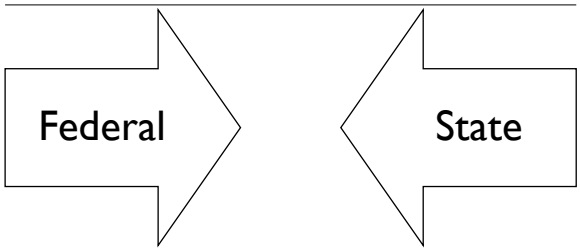
Basic Legal Framework – Cannabis (Marijuana)



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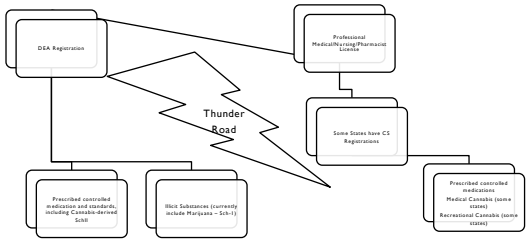
Basic Visual Legal Landscape – Federal & State Controlled Substances Framework



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Understanding your State's Position on Opioids and Cannabis

Legal Status of Cannabis	Professional Licensing Board Rules and Standards	The Rest of the Story
Medical?	General Rules on Controlled Substance Rx	Professional Medical Societies
+/- Recreational?	Specific rules/guidelines on opioid prescribing for pain	Federation of State Medical Boards
	Specific rules/guidelines on medical cannabis recommendation	Cannabis Industry
		Community standards
		Drug Abuse Trends
		Overdose deaths
		On and on and on

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Texas Compassionate Use Act

- Establishes guidelines that allow physicians registered through the Texas Compassionate Use Registry to prescribe medical cannabis to patients with qualifying conditions.
- First effective in June 2015
  - Allowed low-THC medical cannabis to be used as a practical treatment for only intractable epilepsy.
- Modified in June 2019
  - Now allows medical cannabis as a possible treatment for a much broader set of qualifying conditions, including all forms of epilepsy and other seizure disorders, autism, multiple sclerosis, spasticity, Amyotrophic lateral sclerosis (ALS), terminal cancer, as well as other neurodegenerative disorders such as Alzheimer's, Parkinson's, Huntington's disease, Chronic traumatic encephalopathy (CTE), and more.
- As of June 2021,
  - Qualifying medical conditions include all cancer diagnoses and post-traumatic stress disorder (PTSD).
  - Raised the THC cap from 0.5% to 1% through the passage of HB 1525. Bill took effect on September 1, 2021.

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RESOURCES: https://www.texas.gov/health-services/texas-medical-marijuana/, https://guides.sll.texas.gov/cannabis

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What are the legal implications for a prescriber who actively treats patients with controlled medication knowing that the patient ALSO actively uses cannabis – medical or recreational?

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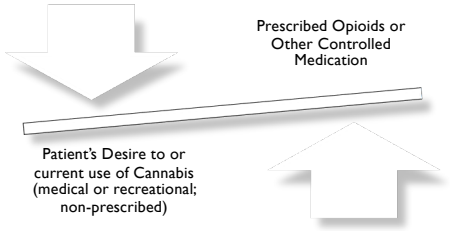
Balancing Act



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What is the DEA's general position on cannabis and how does it impact medical decision-making for opioid prescribing?

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DEA Administrative Case Example – Prescribing Opioids to Patients Using Cannabis (and other drugs)

J.N.'s patient record includes a Discharge Summary from University Medical Center in Tucson, Arizona, which was faxed to Respondent on January 16, 2001. Notably, the first page states that JN had a "history of IV heroin abuse". *Id.* at 13. Continuing, the Summary stated that "she quit several years ago, but started using again one week ago because of increasing abdominal pain." *Id.* at 13–14. The Summary also noted that a urine toxicology screen was "positive for opiates, barbiturates, benzodiazepines, and marijuana." *Id.* at 15.

J.N. died of an overdose on June 18,

J.N.'s record contains no indication that Respondent attempted to monitor her use of controlled substances through drug screens and pill counts. *See generally id.* Moreover, the medical record contains no indication that Respondent questioned J.N. about her use of marijuana, heroin, or the barbiturate (which Respondent had not prescribed to her).

On subsequent visits, Respondent primarily prescribed 120 tablets of Dilaudid 4 mg. (QID—one tablet four times a day), 180 tablets of MS Contin 200 mg. (two tablets every eight hours), Xanax 2 mg. (BID –one tablet twice a day), and Restoril (temazepam) (two tablets at bed time).[24] *Id.* at 5–9. After J.N.'s hospitalization, all of the MS

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- Jeri Hassman, MD, Denial of Application, 2/23/2010, available online at: https://www.deadiversion.usdoj.gov/fed_regs/actions/2010/fr0223.pdf.

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A professional licensing board's view of recommending cannabis and how professional guidelines impact medical decision-making and documentation

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Licensing Board Case – E. Quainoo (2019 Maryland Consent Order)

IN THE MATTER OF	*	**BEFORE THE**
EBENEZER K. QUAINOO, M.D.	*	**MARYLAND STATE**
Respondent	*	**BOARD OF PHYSICIANS**
License Number: D61765	*	**Case Number: 2217-0007A**

* * * * * * * * * * * * * *

CONSENT ORDER

On April 23, 2019, Disciplinary Panel A ("Panel A") of the Maryland State Board of Physicians (the "Board") charged **EBENEZER K. QUAINOO, M.D.** (the "Respondent"), License Number D61765, under the Maryland Medical Practice Act (the "Act"), Md. Code Ann., Health Occ. ("Health Occ.") §§ 14-101 *et seq.* (2014 Repl. Vol. and 2018 Supp.).

17. The Respondent did not have Patient 2 execute a pain management agreement until two years after he initiated prescribing opioid medications for her. The Respondent ordered toxicology screening that at times was negative for morphine, negative for all substances and/or positive for marijuana. The Respondent failed to address these findings in his progress notes or alter his treatment plan despite these inconsistencies.

18. The Respondent also prescribed a benzodiazepine, alprazolam[3] 0.25 mg BID, with no clear indication in his progress notes.

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Quainoo Consent Order available online at https://www.mbp.state.md.us/BPQAPP/orders/D6176509.039.pdf

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Licensing Board Case – E. Quainoo (2019 Maryland Consent Order)

or documented rationale for why he switched the medication.

28. During the course of treatment, Patient 4 underwent periodic toxicology screening that at times was either positive for illicit drugs (heroin, marijuana) or negative for prescribed opioids and/or benzodiazepines. The Respondent did not document or address these inconsistent findings in subsequent progress notes.

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Quainoo Consent Order available online at https://www.mbp.state.md.us/BPQAPP/orders/D6176509.039.pdf

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33. During the course of treatment, Patient 5 underwent toxicology screening, with inconsistent results. Patient 5 tested positive for marijuana multiple times in 2016, in violation of her pain management agreement. Patient 5 also tested negative for opioid medications prescribed (August 2016). The Respondent failed to address Patient 5's noncompliance and/or document follow-up in his progress notes but continued to prescribe opioid medications for Patient 5, without an alteration in treatment.

Quainoo Consent Order available online at https://www.mbp.state.md.us/BPQAPP/orders/D6176509.039.pdf.

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39. During the treatment interval, the Respondent ordered toxicology screening for Patient 6. Some of those tests were positive for non-prescribed medications (benzodiazepines) and illegal substances (marijuana, cocaine), and negative for prescribed medications (methadone). Despite these findings, the Respondent did not alter or taper Patient 6's opioid regimen.

Quainoo Consent Order available online at https://www.mbp.state.md.us/BPQAPP/orders/D6176509.039.pdf.

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Licensing Board Case – E. Quainoo (2019 Maryland Consent Order)

44. During the treatment interval, Patient 7 underwent toxicology screening that was positive for marijuana on at least three occasions (March 30, 2016; November 15, 2016; March 1, 2017), negative for prescribed opioids on two occasions (March 30, 2016; November 15, 2016) and positive for non-prescribed opioids on one occasion (March 1, 2017).

Quainoo Consent Order available online at https://www.mbp.state.md.us/BPQAPP/orders/D6176509.039.pdf.

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Licensing Board Case – E. Quainoo (2019 Maryland Consent Order)

48. Patient 8 underwent toxicology screening and on numerous occasions in 2013, 2015, 2016 and 2017, tested positive for marijuana. The Respondent failed to address or follow up on these findings in his progress notes.

Quainoo Consent Order available online at https://www.mbp.state.md.us/BPQAPP/orders/D6176509.039.pdf.

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54. The Respondent did not order baseline toxicology screening or obtain verification of prior opioid usage prior to placing Patient 9 on high-dose opioid therapy. The Respondent did not institute toxicology screening until almost three years after he initiated high-dose opioid prescribing. When the Respondent did initiate such screening, he failed to adequately document an interpretation of the results in his progress notes.

Quainoo Consent Order available online at https://www.mbp.state.md.us/BPQAPP/orders/D6176509.039.pdf.

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Licensing Board Case– E. Quainoo (2019 Maryland Consent Order)

ORDER

It is thus by Disciplinary Panel A of the Board, hereby:

ORDERED that the Respondent is **REPRIMANDED**, and it is further

ORDERED that the Respondent is placed on **PROBATION** for a minimum of **TWO (2) YEARS**.[14] During probation, the Respondent shall comply with the following terms and conditions of probation:

1. Within **SIX (6) MONTHS**, the Respondent is required to take and successfully complete two (2) courses. The first course will address the appropriate prescribing of CDS and the second course will address appropriate record keeping. The following terms apply:

   (a) it is the Respondent's responsibility to locate, enroll in and obtain the disciplinary panel's approval of the courses before the courses are started;

   (b) the disciplinary panel will not accept courses taken over the internet;

   (c) the Respondent must provide documentation to the disciplinary panel that the Respondent has successfully completed the courses;

   (d) the courses may not be used to fulfill the continuing medical education credits required for license renewal;

   (e) the Respondent is responsible for the cost of the courses;

2. For the full duration of probation, the Respondent is prohibited from certifying a patient for the medical use of cannabis;

3. During the **first year** of probation:

   (a) the Respondent is prohibited from prescribing and dispensing all opioids, benzodiazepines, and stimulants;

Quainoo Consent Order available online at https://www.mbp.state.md.us/BPQAPP/orders/D6176509.039.pdf

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Overlapping Expectations

Important Guidance Documents: Recommending Medical Cannabis and Prescribing Chronic Opioid Therapy

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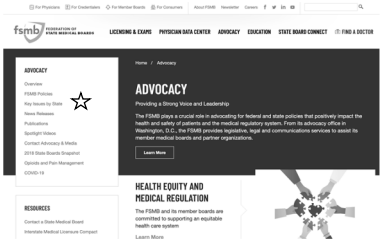
Federation of State Medical Board (FSMB) Materials



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https://www.fsmb.org/advocacy/

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FSMB and Practice Drift (2016)

Position Statement on Practice Drift

Adopted as policy by the Federation of State Medical Boards April 2016

However, changes in physicians' areas of practice may also present risks to patients in circumstances where a physician is not appropriately trained to provide the treatments that fall within their newly chosen area of practice. As such, it is incumbent upon physicians to ensure that they are able to demonstrate competence in their selected area of practice and that they only provide treatments to patients for which they have received adequate and appropriate training. This will often involve seeking additional training by attending educational programs. Physicians are encouraged to seek information about the quality of any such programs by researching their accreditation status and the nature of any oversight involved.

Additional training sought need not always be limited to formal medical training offered through academic medical centers or continuing medical education providers, but can also include observation of procedures performed by recognized experts, followed by provision of these same procedures under the supervision of a qualified physician. Once a physician has taken the appropriate steps to be able to demonstrate competence in an area outside of their recognized area of practice, it is recommended that the physician determine whether their medical liability insurance adequately covers them in the performance of any new procedures.

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Available online at https://www.fsmb.org/advocacy/policies/?s=newest&r=&p=3 (Scroll to Practice Drift – 2016)

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FSMB and Recommending Medical Marijuana in Patient Care (2016)

Model Guidelines for the Recommendation of Marijuana in Patient Care

Report of the FSMB Workgroup on Marijuana and Medical Regulation

Adopted as policy by the Federation of State Medical Boards April 2016

This policy document is intended as a resource to state medical boards in regulating physicians and physician assistants (or other licensees regulated by the board) with a full and unrestricted license participating in marijuana programs and may also be valuable in educating licensees as to the board's expectations when recommending marijuana to a patient for a particular medical condition. The guidelines should in no way be construed as encouraging or endorsing physicians to recommend marijuana as a part of patient care.

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Available online at https://www.fsmb.org/advocacy/policies/?s=newest&r=&p=3 (Scroll to Recommendation of Marijuana in Patient Care)

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FSMB and Recommending Medical Marijuana in Patient Care (2016)

Physician-Patient Relationship: The health and well-being of patients depends upon a collaborative effort between the physician and the patient. The relationship between a patient and a physician is complex and based on the mutual understanding of the shared responsibility for the patient's health care. The physician-patient relationship is fundamental to the provision of acceptable medical care. Therefore, physicians must have documented that an appropriate physician-patient relationship has been established,[7] prior to providing a recommendation, attestation, or authorization for marijuana to the patient. Consistent with the prevailing standard of care, physicians should not recommend, attest, or otherwise authorize marijuana for themselves or family member.

Patient Evaluation: A documented in-person medical evaluation and collection of relevant clinical history commensurate with the presentation of the patient must be obtained before a decision is made as to whether to recommend marijuana for medical use. At minimum, the evaluation should include the patient's history of present illness, social history, past medical and surgical history, alcohol and substance use history, family history with emphasis on addiction or mental illness/ psychotic disorders, physical exam, documentation of therapies with inadequate response, and diagnosis requiring the marijuana recommendation.

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Available online at https://www.fsmb.org/advocacy/policies/?s=newest&r=&p=3 (Scroll to Recommendation of Marijuana in Patient Care)

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FSMB and Recommending Medical Marijuana in Patient Care (2016)

Treatment Agreement: A health care professional should document a written treatment plan that includes:

- Review of other measures attempted to ease the suffering caused by the terminal or debilitating medical condition that do not involve the recommendation of marijuana.
- Advice about other options for managing the terminal or debilitating medical condition.
- Determination that the patient with a terminal or debilitating medical condition may benefit from the recommendation of marijuana.
- Advice about the potential risks of the medical use of marijuana to include:
  - The variability of quality and concentration of marijuana;
  - The risk of cannabis use disorder;
  - Exacerbation of psychotic disorders and adverse cognitive effects for children and young adults;
  - Adverse events, exacerbation of psychotic disorder, adverse cognitive effects for children and young adults, and other risks, including falls or fractures;
  - Use of marijuana during pregnancy or breast feeding;
  - The need to safeguard all marijuana and marijuana-infused products from children and pets or domestic animals; and
  - The need to notify the patient that the marijuana is for the patient's use only and the marijuana should not be donated or otherwise supplied to another individual.
- Additional diagnostic evaluations or other planned treatments.
- A specific duration for the marijuana authorization for a period no longer than twelve months.
- A specific ongoing treatment plan as medically appropriate.

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Available online at https://www.fsmb.org/advocacy/policies/?s=newest&r=&p=3 (Scroll to Recommendation of Marijuana in Patient Care)

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FSMB and Recommending Medical Marijuana in Patient Care (2016)

Consultation and Referral: A patient who has a history of substance use disorder or a co-occurring mental health disorder may require specialized assessment and treatment. The physician should seek a consultation with, or refer the patient to, a pain management, psychiatric, addiction or mental health specialist, as needed.

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Available online at https://www.fsmb.org/advocacy/policies/?s=newest&r=&p=3 (Scroll to Recommendation of Marijuana in Patient Care)

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FSMB and Guidelines for the Chronic Use of Opioid Analgesics (2017)

fsmb FEDERATION OF STATE MEDICAL BOARDS

Guidelines for the Chronic Use of Opioid Analgesics

Adopted as policy by the Federation of State Medical Boards April 2017

This policy document includes relevant recommendations identified by the workgroup, and is in keeping with recent releases of advisories issued by the CDC and FDA. This policy is intended as a resource providing overall guidance to state medical and osteopathic boards in assessing physicians' management of pain in their patients and whether opioid analgesics are used in a medically appropriate manner.

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Available online at https://www.fsmb.org/advocacy/policies/?s=newest&r=&p=3 (Scroll to Opioid Guidelines)

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FSMB and Guidelines for the Chronic Use of Opioid Analgesics (2017)

Available online at https://www.fsmb.org/advocacy/policies/?s=newest&r=&p=3 (Scroll to Opioid Guidelines)

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Patient Evaluation and Risk Stratification

The medical record should document the presence of one or more recognized medical indications and absence of psychosocial contraindications for prescribing an opioid analgesic[2] and reflect an appropriately detailed patient evaluation[17]. An evaluation should be completed and documented concurrent with the decision of whether to prescribe an opioid analgesic.

The nature and extent of the evaluation depends on the type of pain and the context in which it occurs. Assessment of the patient's pain should include the nature and intensity of the pain, past and current treatments for the pain, any underlying or co-occurring disorders and conditions, and the effect of the pain on the patient's physical and psychological functioning [17].

For every patient, the initial assessment and evaluation should include a systems review and relevant physical examination, as well as objective markers of disease or diagnostic markers as indicated. Also, functional assessment, including social and vocational assessment, is useful in identifying supports and obstacles to treatment and rehabilitation.

Assessment of the patient's personal and family history of alcohol or drug abuse and relative risk for substance use disorder also should be part of the initial evaluation[3,9,92,17], and ideally should be completed prior to a decision as to whether to prescribe opioid analgesics[87,88]. This can be done through a careful clinical interview, which should also inquire into any history of physical, emotional or sexual abuse, because those are risk factors for substance use disorder[17]. Use of validated screening tools for substance use disorder may be used for collecting and evaluating information and determining the patient's level of risk.

Patients who have a history of substance use disorder as defined by DSM-5 are at an elevated risk for failure of opioid analgesic therapy to achieve the goals of improved comfort and function, and also are at high risk for relapse. Treatment of a patient who has a history of substance use disorder may involve consultation with an addiction specialist before opioid therapy is initiated (and follow-up, as needed). Additionally, patients who have a substance use disorder as defined by the DSM-5, require additional support if opioid therapy is necessitated and should not receive opioid therapy until they are established in a treatment/recovery program[17] or alternatives are established, such as co-management with an addiction professional. Clinicians who treat patients with chronic pain are encouraged to also be knowledgeable about the identification and treatment of substance use disorder, including the

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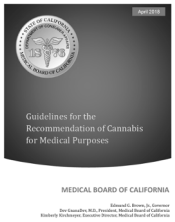
CALIFORNIA MEDICAL BOARD AND CANNABIS RECOMMENDATIONS & RELATED GUIDEANCE ON OVERDOSE PREVENTION



Prescription Medication Misuse and Overdose Prevention

Prescription drug misuse and abuse, specifically opioids, is a huge problem in the United States. The Medical Board of California (Board) has joined forces with the California Department of Public Health, the California State Board of Pharmacy, and many other State agencies and stakeholders to expand prevention and treatment strategies as well as to decrease the amount of misuse in California. However, it is important to recognize that these medications are needed and have "an appropriate use".

The Board is dedicated to working with the "Statewide Opioid Safety Workgroup" in educating and informing physicians and consumers, in conjunction with the Board's number one mission of "consumer protection."

- Resources for Providing Medication-Assisted Treatment for Opioid Use Disorder
- Statewide Opioid Safety Workgroup
  - Statewide Opioid Safety Workgroup Alert - Don't Drop Your Patients
- California's Approach to the Opioid Epidemic
  - California Department of Public Health – Opioids and Pregnancy, What You Need to Know
- Naloxone Prescription Requirements
- Board of Pharmacy Naloxone Information
- Guidelines for Prescribing Controlled Substances for Pain (November 2014)
- SAMHSA Opioid Overdose Prevention Toolkit
- Free Pocket Guide to Tapering Opioids for Chronic Pain Available from the Centers for Disease Control and Prevention
- California Department of Public Health - Prescriber Guidance Letter
- Centers for Disease Control and Prevention - Guideline for Prescribing Opioids for Chronic Pain
- Centers for Disease Control and Prevention - Opioid Overdose
- Centers for Disease Control and Prevention Online Training for Providers
- Medication-Assisted Treatment (MAT)
- Are Your Prescription Forms Compliant?

https://www.mbc.ca.gov/Resources/Medical-Resources/cannabis.aspx

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Individual Assessment of Patient Risk

How do I document my way through this gauntlet and show reasoned and sound efforts to individualize patient care?

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MEDICO-LEGAL RISK CROSSROADS FOR THE PAIN PRACTITIONER

Cannabis Use with Prescribed Controlled Medication

Chronic Opioid Therapy
Your patient – new or established

High Dose

Low Dose

Medical Cannabis User
Recommended by Another Provider?
Recommended by you?
Cannabis Use Disorder?

Just getting started

Don't Get Lost

Behavioral Health Conditions, Substance Use Disorders (Hx of or Active) and Related Medication/Treatment
Risk issues with Benzodiazepine Use and Use of Other Medications to Treat Mental Health and Substance Use Disorders

Recreational Cannabis User
Occasional user?
Regular user?
Cannabis Use Disorder?

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5 Risk Mitigation Concepts Associated with Prescribing Opioids to Patients who use Cannabis (Objective 2)

- Acknowledge Cannabis Use Presents Risks to COT Patient
- Ongoing Behavioral and Medical Monitoring
- Stop and Evaluate Individual Patient Risks
- Coordination of Care
- Careful Documentation of Clinical Rationale and Decision-Making

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RISKS. PERSPECTIVES. CHOICES. DOCUMENTATION.

- The patient.
- The opioid prescriber.
- The benzodiazepine prescriber.
- The practitioner, who "recommends" medical cannabis.
- The medical licensing board and its medical experts.
- The DEA and its medical experts.

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Assessing Cannabis Use Disorder as Part of Risk Mitigation (CUDIT-R)

Adamson SJ, Kay-Lambkin FJ, Baker AL, Lewin TJ, Thornton L, Kelly BJ, Sellman JD. An improved brief measure of cannabis misuse: the Cannabis Use Disorders Identification Test-Revised (CUDIT-R). Drug Alcohol Depend. 2010 Jul 1;110(1-2):137-43. doi: 10.1016/j.drugalcdep.2010.02.017. Epub 2010 Mar 26. PMID: 20347232.

The Cannabis Use Disorder Identification Test - Revised (CUDIT-R)

Have you used any cannabis over the past six months? YES / NO

If YES, please answer the following questions about your cannabis use. Circle the response that is most correct for you in relation to your cannabis use *over the past six months*

1. How often do you use cannabis?

Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week
0	1	2	3	4

2. How many hours were you "stoned" on a typical day when you had been using cannabis?

Less than 1	1 or 2	3 or 4	5 or 6	7 or more
0	1	2	3	4

3. How often during the past 6 months did you find that you were not able to stop using cannabis once you had started?

Never	Less than monthly	Monthly	Weekly	Daily or almost daily
0	1	2	3	4

4. How often during the past 6 months did you fail to do what was normally expected from you because of using cannabis?

Never	Less than monthly	Monthly	Weekly	Daily or almost daily
0	1	2	3	4

5. How often in the past 6 months have you devoted a great deal of your time to getting, using, or recovering from cannabis?

Never	Less than monthly	Monthly	Weekly	Daily or almost daily
0	1	2	3	4

6. How often in the past 6 months have you had a problem with your memory or concentration after using cannabis?

Never	Less than monthly	Monthly	Weekly	Daily or almost daily
0	1	2	3	4

7. How often do you use cannabis in situations that could be physically hazardous, such as driving, operating machinery, or caring for children:

Never	Less than monthly	Monthly	Weekly	Daily or almost daily
0	1	2	3	4

8. Have you ever thought about cutting down, or stopping, your use of cannabis?

Never	Yes, but not in the past 6 months	Yes, during the past 6 months
0	2	4

This scale is in the public domain and is free to use with appropriate citation:

Adamson SJ, Kay-Lambkin FJ, Baker AL, Lewin TJ, Thornton L, Kelly BJ, and Sellman JD. (2010). An Improved Brief Measure of Cannabis Misuse: The Cannabis Use Disorders Identification Test – Revised (CUDIT-R). *Drug and Alcohol Dependence* 110:137-143.

This questionnaire was designed for self administration and is scored by adding each of the 8 items:
- Question 1-7 are scored on a 0-4 scale
- Question 8 is scored 0, 2 or 4.
Scores of 8 or more indicate hazardous cannabis use, while scores of 12 or more indicate a possible cannabis use disorder for which further intervention may be required.

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Last Dance with Mary Jane?

Different Situations

- Recommend a Patient for Medical Cannabis Use
- Prescribe controlled medications to a patient using Medical Cannabis
- Prescribe controlled medication to a patient using Recreational Cannabis
- Refusing to Prescribe Controlled Substances to a Patient Using Any form of Cannabis

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Summary of Key "Risk" Areas (Overlapping between Chronic Opioid Therapy, Cannabis, and Other CS Use)

Risk Domains for Practitioner Consideration
Patient's Medical History, including co-morbidities that increase patient's risk for adverse event (respiratory, hepatic, renal, other)
Patient Current Medication Regimen, including controlled substances prescribed by the treating MD and any other healthcare practitioner
Patient's Substance Abuse History and Similar Factors, including smoking, alcohol use, and any first-degree family member with such history
Opioid Dose (MEDD)
Any use of Benzodiazepines
Any behavioral health challenges or disorders
Cannabis Use Disorder
Social Setting and Potential Risks (Safe Use, Safe Storage, Safe Disposal)

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No one is worried about it | I might be able to | I don't know

2015 on the Thunder Road Chronology

Documentation Concept:

Medical Cannabis Treatment Agreement for the Pain Practitioner?

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The Use of a Medical Cannabis Treatment Agreement for Patients Being Treated for Chronic Pain

- https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4417655/
- TWO DISCLAIMERS:
- AUTHORS WORK[ED] IN CALIFORNIA
- VA Health Center Based (federal]

HHS Public Access
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The Medicinal Cannabis Treatment Agreement: Providing Information to Chronic Pain Patients via a Written Document

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Documentation Possibility: The Medical Cannabis Treatment Agreement for Patients Using Chronic Opioid Therapy?

Abstract

Over 20 states now approve medical marijuana for a long list of "indications," and more states may well offer access in the near future. Surveys have demonstrated that pain is the most common indication for medical use of cannabis. As more individuals gain access to this botanical product through state ballot initiatives and legislative mandate, the pain specialist is likely to be confronted by patients either seeking such treatment where permitted, or otherwise inquiring about its potential benefits and harms, and alternative pharmaceuticals containing cannabinoids. Whether or not they are in the position to prescribe medical cannabis, pain physicians would seem to have an obligation to understand and inform their patients on key issues of the evidence base on cannabinoid therapeutics. One way to fulfill this obligation might be to borrow from concepts developed in the prescription of opioids: the use of a written agreement to describe and minimize risks. Regrettably, the widespread adoption of opioids was undertaken while harmful effects were minimized; obviously, no one wants to repeat this misstep. This article describes a method of educating patients in a manner analogous to other treatment agreements. Undoubtedly, the knowledge base concerning risks will be an iterative process as we learn more about the long-term use of medicinal cannabis. But we should start the process now so that patients may be instructed about our current conception of what the use of medicinal cannabis entails.

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- https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4417655/

Documentation Possibility: The Medical Cannabis Treatment Agreement for Patients Using Chronic Opioid Therapy?

Tenet #2 I know that some people cannot control their use of cannabis. One example is using cannabis for reasons other than for the indication for which it was prescribed; like getting stoned. This may lead to not going to work, or not doing my household chores. I agree to discuss this with my doctor if this happens.

- https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4417655/

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Documentation Possibility: The Medical Cannabis Treatment Agreement for Patients Using Chronic Opioid Therapy?

Tenet #5 I will not drive a car or operate heavy machinery for 3-4 hours after use of medicinal cannabis, or longer if large doses are used or the effects of impairment persist. I will use a designated driver for automobile transportation if I have to go out sooner than 3-4 hours after taking this medicine.

- https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4417655/

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Documentation Possibility: The Medical Cannabis Treatment Agreement for Patients Using Chronic Opioid Therapy?

Tenet #5 I will not drive a car or operate heavy machinery for 3-4 hours after use of medicinal cannabis, or longer if large doses are used or the effects of impairment persist. I will use a designated driver for automobile transportation if I have to go out sooner than 3-4 hours after taking this medicine.

- https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4417655/

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Documentation Possibility: The Medical Cannabis Treatment Agreement for Patients Using Chronic Opioid Therapy?

Tenet #7 If thought advisable by my health care provider, I might want to substitute one of the Food and Drug Administration (FDA) approved medicines containing THC rather than take natural cannabis.

- https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4417655/

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Documentation Possibility: The Medical Cannabis Treatment Agreement for Patients Using Chronic Opioid Therapy?

Tenet #11 I know there is no legal precedent to help me if I am terminated from employment if a urine toxicology screen is positive for cannabis

Tenet # 12 I know that I may be asked to reduce or stop my intake of opioids (narcotics), sedative-hypnotics (benzodiazepines), and/or alcohol. This will be done to reduce the risk of side-effects from a combination of medications that affect the central nervous system.

- https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4417655/

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The Wonderful World of Mr. Smoke

Learning Question

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Case-Based Learning Question – Mr. Smoke

- Mr. Smoke is in your office for a follow-up visit. He smells like smoke today and his eyes are bloodshot.
- Mr. Smoke uses low dose opioid therapy plus Gabapentin to help him remain functional so he can work as a machinist at a local plant.
- Mr. Smoke is asking for a slight increase in opioids today, to account for the time he's spending on his feet because he picked up an extra shift to make extra money for the holidays.
- You perform a point of care drug screen on Mr. Smoke and it's positive for THC and OPIATES (you prescribe him hydrocodone).

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Case-Based Learning Question – Mr. Smoke

Select the answer that ***best describes*** *your federal and state licensing obligations when prescribing controlled substances to Mr. Smoke, whom you suspect is using cannabis.*

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Case-Based Learning Question – Mr. Smoke

- A. Cannabis is legal under the federal law and in most states and a DEA Registrant may prescribe it and other controlled substances to patients without concern for the Controlled Substances Act or Licensing Board Regulations.
- B. Though cannabis is illegal under federal law, if the DEA Registrant is licensed and practices in a state that has either "legalized" or "decriminalized" it, a DEA Registrant may prescribe a controlled substance to a patient without evaluating the patient's use of cannabis and risks associated therewith, and without concern for the Controlled Substances Act or Licensing Board Regulations.
- C. Regardless of the legal status of cannabis under federal or state law, a DEA Registrant has a duty to evaluate a patient's risks, including the use of cannabis, and to consider this and related risks in light of the risks and benefits associated with the other controlled substance contemplated for the treatment plan; The law places the emphasis is on the DEA Registrant's act of prescribing controlled substances and the role that cannabis may play in the medical risks to each individual patient
- D. None of the above.

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Learning Question – Mrs. Gum E. Bear

- Mrs. Gum E. Bear is 62 years old and a long-time patient of yours and you generally see her every three to six months, unless something critical arises.
- Mrs. Bear told you some time ago that she occasionally uses "gummies" sent to her by her daughter. Mrs. Bear started doing this during the pandemic to help her relax and pass the time she spends alone. She also uses a small dose of clonazepam every night to help her sleep and relax her nerve-related pain.
- You prescribe Mrs. Bear Oxycodone, 5mg tablets, and tell her to take 1 or 2 tablets, BID-TID, depending on the time of year and her activity level.

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Case Based Learning Question – Mrs. Gum E. Bear

- Mrs. Bear has generally been compliant with your treatment plan with a few hiccups over 10 years regarding her self-escalation of her opioids.
- Mrs. Bear tells you during the visit that her daughter visited her last week, but now is gone and she's sad. Her daughter left because Mrs. Bear had a bad sinus infection and really wasn't interested in company.
- **Should you perform a urine drug test on Mrs. Bear even though she has honestly disclosed her recreational cannabis use in the past? Her last UDT was 6 months ago, and it was positive for THC and OXY.**

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Question – Mrs. Gum E. Bear

- **QUESTION: True or False**
- **Federal law enforcement authorities**, and medical experts working with them, **support a DEA Registrant's decision to omit** "THC" from drug test menus in states where marijuana has been legalized or decriminalized and where the DEA Registrant is prescribing opioids to treat pain.

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The Wonderful World of Happy Practitioner

CASE VIGNETTE

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Case-Based Learning Application: The Duties of Happy Practitioner when Treating Sam I. Hurt

- Happy Practitioner lives in a state where cannabis has been legalized for both medical and recreational use.
- Happy sees patients from within the state and those who live just over its borders, into states where cannabis is not yet approved for medical and/or recreational use.
- Happy often prescribes controlled substances when treating patients with chronic, non-terminal pain

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Case-Based Learning Application: The Duties of Happy Practitioner when Treating Sam I. Hurt

- Sam I. Hurt has been Happy's patient for several years. Sam lives in the state where cannabis has been legalized but works in a state where it has not yet been addressed.
- Sam has a well-documented, chronic, non-terminal pain condition and receives Oxycodone 10mg, TID, each month.
- Sam's medical chart shows he has been compliant with the treatment plan and agreement, he's working, and essentially experiencing good pain relief with the Oxycodone and an anti-depressant prescribed by Happy.

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Case-Based Learning Application: The Duties of Happy Practitioner when Treating Sam I. Hurt

- During late 2020 and into 2021, Sam began experiencing extra pressure at work, leading him to work longer hours; He has spent more time on his feet at work and gets little time to relax. A friend of Sam's suggested that he try THC-infused gummies when he needed to relax, advising Sam that these gummies are ok for recreational use and could be purchased in small or large mg, depending on how much Sam wanted to spend and how often he will use them.
- Sam decided to try the gummies and has been using them since February 2021. During Sam's July 2021, follow-up visit with Happy, Sam provided a urine sample to Happy's nurse for drug testing. Sam saw that "THC" was listed on the specimen cup and decided he better tell Happy/the nurse about his recent use of gummies.
- **Which answer below provides the checklist of items most consistent with current standard of care expectations when prescribing controlled substances and illustrative of what Happy should do to address Sam's use of THC-infused gummies?**

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Case-Based Learning Answer Choices – Happy Practitioner and Patient Sam I. Hurt

POTENTIAL ANSWER A – Consider/Discuss and Document:

1. Sam's usage of gummies – amounts, last use, frequency and what prompts him to use.

2. Whether Sam thinks his drug screen will be positive and discuss obtaining a quantitative THC test to obtain baseline levels associated with Sam's use of THC-infused products.

3. A Cannabis Use Disorder questionnaire.

4. The risks of using Cannabis alone and with Opioids and other prescribed medication or alcohol.

5. Whether Sam needs to see another physician who specializes in evaluating the patient's behavioral health conditions, including anxiety, depression, etc.

6. Whether to make any changes to Sam's current medication regimen, including the addition of a naloxone kit and any changes to his opioid medication – dose and quantity.

POTENTIAL ANSWER B – Consider/Discuss and Document:

1. Perform the drug screen and get a confirmation test report to quantify the amount of THC in Sam's system.

2. Discuss the results with Sam at the next visit and then decide what impact his THC-use has on his risk/benefit profile for opioid use.

3. Make a note in the chart to consider whether to reduce his opioids or change his anti-depressants after talking with Sam at the next visit. Also make a note to consider whether a referral is in order.

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Case-Based Learning Answer Choices – Happy Practitioner and Patient Sam I. Hurt

POTENTIAL ANSWER C – Consider/Discuss and Document:

1. Remove THC from future drug tests for Sam.

2. Advise Sam not to use his opioids and the THC-infused gummies at the same time.

3. Ask Sam if he'd like to try medical cannabis.

4. Consider changing Sam's anti-depressant to something that works better.

POTENTIAL ANSWER D – Consider/Discuss/Document:

1. Refer Sam to a local psychiatrist for evaluation.

2. Tell Sam that you are going to discontinue opioids and write a tapering prescription.

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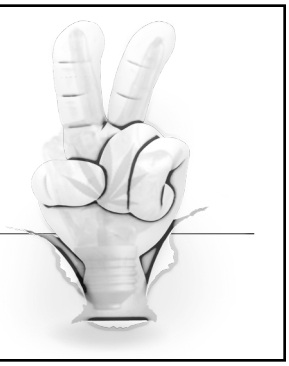
Did Willie Nelson and Merle Haggard get it right after all?

It's All Going to Pot



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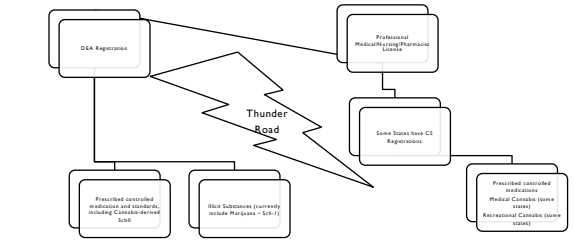
REPRISE: Basic Visual Legal Landscape – Federal & State Controlled Substances Framework



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FIRST NOTE TO SELF:

1. I am a DEA Registrant with a professional medical/nursing license.

2. The current medico-legal issues surrounding my patient's use of cannabis ARE MORE FOCUSED on my prescribing of opioids and other controlled substances than on the ever-growing legality of Cannabis.

3. See second note to self if my personal opinion is that cannabis is no big deal on top of other controlled substance use.

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SECOND NOTE TO SELF:

1. I am a Healthcare Practitioner with a Professional License from a Medical/Nursing Board.

2. The current medico-legal issues surrounding my patient's concomitant use of cannabis and opioids/other prescribed controlled substances is about sound medical decision-making and minimizing potential for harm.

3. I may not be able to control my patient's use of cannabis, but I can control their access to prescribed controlled medication.

4. Think it over. What is the reasonably prudent course of action given the patient's individual circumstances?

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Thank you!

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