Safer and Competent Opioid Prescribing Education

Scope of Pain Podcast Series – Season 2, Episode One

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ILANA HARDESTY: Dr. Williams, a community pharmacist attempts on multiple occasions to contact Dr. Smith, a primary care physician. She is concerned about some of Dr. Smith's patients who are prescribed high dose opioids. She has observed his patients appearing over-sedated at the pharmacy, and a few of them have multiple prescribers of controlled substances as noted on the State Prescription Drug Monitoring Program.

Because of her concerns and because she does not receive a call back from Dr. Smith, she is advised by her pharmacy board to contact the State Board of Medicine to report Dr. Smith's concerning opioid prescribing practices. Dr. Smith is notified on multiple occasions that a community pharmacist wants to speak to him about some of his patients who were prescribed opioids, he does not return her calls because he is too busy and sees no reason to discuss his patients care with the pharmacist. Dr. Smith is then notified by the state board of medicine that a case has been open regarding his opioid prescribing practices over the past year. How could this scenario have been avoided, how can prescribers and pharmacists collaborate to improve patient care? I'm Ilana Hardesty, the host of this special episode of Scope of Pain.

In this episode, I'll be speaking with Dr. Daniel Alford, a primary care physician and an addiction medicine specialist at Boston Medical Center, and on faculty at Boston University School of Medicine, and with Dr. Patrick Kelly, a pharmacist on faculty at the University of Rhode Island College of Pharmacy, about how prescribers and community pharmacists can work together to improve the care of patients on opioid therapy for pain.

If at any point you want more information on receiving credit for this episode, please visit our website at www.scopeofpain.org, there are also resources that accompany the series. Again, find it all at www.scopeofpain.org.

Now, let's start at the beginning. Dr. Kelly, who exactly is a community pharmacist and what training do they receive?

PATRICK KELLY: It's a great question. Pharmacists are highly trained clinical professionals, the pharmacist now goes through six years of formal education at a college or university, and they receive a Doctorate in Pharmacy. And this is the standard of care and has been, for the past 20 years, most pharmacists now in a community setting, they tend to work for larger chains or larger corporations. There's been a movement over the last few decades from smaller independent stores to larger chains. In tandem with that, the practice of Pharmacy has changed in addition to the transactional aspect, the mechanical dispensing of an order to a patient, there are other clinical additions that have occurred as well: Medication Therapy Management,

immunizations, point of care testing, all of this is done in concert with that additional training the pharmacist receives.

DANIEL ALFORD: So Pat, as a primary care physician I've written a lot of prescriptions over the years, and I'm really in the dark about all the steps that a pharmacist goes through before dispensing that medication. Can you go into a little bit more detail?

PATRICK KELLY: Yeah, of course. I wish it was as easy as putting a label on a box, and a lot of people feel like that's the case, but there's so much more to it. So when an order is received, it has to be transcribed, there's that mechanical aspect translating what the physician actually wrote or e-prescribed now, and then the next aspect, this is what is the clinical piece, the pharmacist is going to have to review that order, perform what's called a drug utilization review, figure out is this dose appropriate, is this drug appropriate for the disease state? Are there any drug interactions for this patient, all of that has to occur before it reaches the patient, and then you have to add on the reimbursement piece. The pharmacy is communicating in real time with a third-party payer seeking reimbursement, so from start to finish, there's a multitude of steps that occur from the mechanical aspect to the clinical aspect that the pharmacist is involved in to the final point of sale or distribution to the patient, and then add on any kind of counseling or discussion that has to occur between the pharmacist and the patient.

ILANA HARDESTY: I'll come back to third party reimbursement or insurance, because I know that that's a big topic, but let's turn specifically to prescribing dispensing controlled substances. As an example, let's follow a day in the life of an opioid prescription. First, Dr. Alford, what happens in your office before you write that prescription, what do you consider when you prescribe an opioid for pain?

DANIEL ALFORD: Yeah, so I'm always going to try to make a determination about the appropriateness of the opioid for this particular patient's pain, and if it's a new patient, I want some old medical records, I want to talk to the previous provider, I want to know what else has been tried and if the patient's already on opioids, I want to try to get an assessment of are they benefiting and is there any evidence of harm, and if I'm actually going to write that prescription, I want to do a opioid misuse risk assessment by screening for substance use, mental illness, checking the Prescription Drug Monitoring Program or the PDMP to verify their controlled substance use history, any other prescribers of controlled substances.

I'm going to check a urine drug test, and if I'm going to prescribe opioids for more than three months, if that's the plan, I'll review and have the patient sign a patient prescriber agreement. I also want to think about what is the patient's insurance and am I going to need to do a prior authorization for this specific opioid, and certainly, whenever I start an opioid for a patient who's opioid naive, I'm going to use a short-acting opioid, and I'll set limits on the prescription such as no more than three tablets per day. So, for a new patient or a patient who has some misuse risk issues, I might initially give a very small supply of maybe like one week, and then monitor them and see how they do.

ILANA HARDESTY: We go into much more detail on all you've mentioned in the full Scope of Pain activity at www.scopeofpain.org. Okay, so the patient gets to the pharmacy to pick up the medication, what happens before the medication can be handed to the patient? Dr. Kelly, can you walk us through that part?

PATRICK KELLY: Absolutely. So in the situation of a controlled substance such as an opioid, there are additional steps that occur, a pharmacist is going to be checking the Prescription Drug Monitoring Program, looking at past fill history for this patient, looking for suspicious combinations, duplications in therapy, high doses, early refills, patterns that don't necessarily fit what the standard of care would be, these are things that the pharmacist is looking through and trying to rule out inappropriate use of the substance, additionally the pharmacist is going to be sending an insurance claim just like any other prescription seeking reimbursement but the extra layers, the pharmacists going to be looking at that patient in front of them, looking for behavioral cues, is there anything amiss here? Is there anything that is out of the ordinary with the patient's behavior, is it different than baseline, is there anything that's worrisome or troublesome, like the case scenario you spoke about earlier.

ILANA HARDESTY: We know that since the opioid crisis prescribers and pharmacists both worry a lot about their own professional risks when prescribing or dispensing opioids, I wonder if you could both talk about the liability issues you face, Dr. Alford.

DANIEL ALFORD: Yeah, it's not surprising that clinicians worry about how, when and whether to prescribe opioids, and this fear of opioid prescribing among my colleagues even predates the opioid crisis, prescribers worry about legal sanctions for opioid prescribing, including malpractice liability if a patient overdoses on your prescription opioid, medical board discipline just like the case that was presented here, and even criminal convictions, from cases that I've reviewed for our medical board, much of the liability rest with not practicing the standard of care, that's using proper assessments and monitoring strategies, and just overall poor documentation about why the opioids are being prescribed and even documentation of some measure of benefit or lack of harm.

PATRICK KELLY: I hear you loud and clear, Dan, pharmacists have a very similar liability, and what we refer to that in the pharmacy world is a term called corresponding responsibility, what that means is, although the pharmacist is not the author of the prescription, they're not the ones generating the order, they still have an obligation, and this is federal language, this is encoded in law, the pharmacist has an obligation to ensure that the prescription is written in good faith and in the due course of normal medical practice. So this is what's in the back of the pharmacist's mind when they're getting ready to dispense an opioid prescription: liability in a clinical context with their board of pharmacy, as well as this corresponding responsibility, this legal requirement that's impose upon them by not just the State Board of Pharmacy, but also the Drug Enforcement Administration, the DEA. This is all going into play when a prescription is dispensed.

DANIEL ALFORD: Pat, you mentioned determining that the prescription is for a legitimate medical purpose, how does a community pharmacist do that when you don't even have access to the medical record or a medical chart?

PATRICK KELLY: It's a tough situation. The pharmacist has to make use of what is available to them, particularly that's going to be past fill history, insurance claims data, if they have that, but the Prescription Drug Monitoring Program looking at that, looking at that patient's fill in the state they reside in, maybe even border states, trying to get a full picture holistically of what is going on with this individual. In addition to that, the pharmacist is going to be looking at the patient themselves, looking for behavioral cues that might be worrisome, is there a pattern of early fills? Is there a pattern of high doses, is there a pattern of obtaining medications for the same thing from multiple prescribers, all of this can help paint a picture for the pharmacist, and that's also examining the actual prescription itself, is there an indication on there. Do we know what we're actually treating. And does this all make sense? Pharmacists are drug experts, they know these medications inside and out, so knowing what we're treating can help a pharmacist figure out, okay, is this product appropriate for the situation at hand.

ILANA HARDESTY: Let's get back to the issue of insurance, these medications can require an insurance prior authorization or PA as they're referred to, I can imagine that the prescriber may not be aware of the PA requirement, and then the patient shows up at the pharmacy only to find out they're not able to get their prescription. This is surely is set up for an unpleasant interaction at the pharmacy. What does that entail on the pharmacy end?

PATRICK KELLY: Great, so insurance companies, third-party payers and prior authorizations. It's an aspect of community practice. A prescription is received by the pharmacy and prescriptions are transmitted to third party payers in real time, that's how we find out, at least when the pharmacist, finds out that a prior authorization is necessary. Once that is received by the pharmacist, generally two things are happening, the pharmacist is communicating with the prescriber by phone or fax to say, "Hey, prescriber, there's some paperwork that you need to complete on your end with the third-party payer." Additionally, many pharmacists will inform the patient and tell the patient, "Hey, this prescription isn't going to be able to be dispensed today because of reimbursement reasons.

And you need to either follow up with the prescriber or follow up with the third-party payer yourself." The pharmacist is in a tough spot because they're seeking reimbursement, but then their hands are tied when a prior authorization needs to be completed, because the pharmacist has no role in filling out that paperwork with the insurance company, that's something the prescriber unfortunately has to do themselves. So the pharmacist is more or less ringing the alarm bell saying, "Hey, prescriber, hey, patient, this is something that needs to get done." And that's why you'll see that communication in both aspects.

DANIEL ALFORD: Okay, so now I understand why it's often the patient who gets through to me, because they're the ones who are highly motivated to get this prescription filled. And oftentimes, I'm not hearing from the pharmacist or the insurance company. And actually, in our

practice, we've actually had to set up a whole separate system to address the paperwork to obtain these PAs, and unfortunately, it's often the patient who suffers by being without their medication and waiting for the whole PA process to take place. And I'm wondering Pat, if there's a way that a patient can get some of their opioid prescription filled while this whole PA process is being taken. Because obviously, we know that some patients who are on chronic opioids are going to be physically dependent, and we certainly want to avoid opioid withdrawal.

PATRICK KELLY: Absolutely. So in a case with prior authorizations, there's two main kinds. One, there's a prior authorization prior to even initiating a prescription. The insurance company is saying, "Hey, prescriber, you need to justify the medical necessity of this before we pay for it." And in that situation, the patient hasn't been on it yet, so there's not as much of a clinical concern with withdrawal. That's more so a delay in care, you're waiting two, three days for that claim to go through. However, prior authorizations, once they are obtained, many prescribers probably know this, maybe in a six month or 12-month interval, that PA expires, and you have to go through the process again. And that's where Dan, you mentioned the concern for discontinuing therapy and withdrawal, or a manifestation of the underlying disease in that patient. Because they're coming to the pharmacy and the pharmacy is saying, "Oh, the insurance isn't paying for this, we need a prior authorization."

And then you have that two, three-day window where, "Hey, I don't have a paid claim, but this patient needs the medicine. I can't pull the rug out from underneath them, and then they're going to go through withdrawal." So the pharmacist generally has latitude, has professional discretion, and a reasonable and prudent pharmacist would not stop therapy for that reason, because it's a reimbursement issue. You still a lawful order to substantiate dispensing the drug, it's more so you may not get reimbursed right away. So in that situation, a reasonable and prudent pharmacists would continue giving a couple days' worth of that medicine to the patient while the paperwork is filled out in the background. Because it's a reimbursement, not an actual legal issue.

DANIEL ALFORD: So would a pharmacist ask a patient to pay in cash, while the PA is being processed?

PATRICK KELLY: They could. If a PA has been approved in the past, generally it will most likely be approved again once it expires. So, you really wouldn't ask a patient to pay cash, especially if the cost of the medication is very high, expecting that this medicine is going to be approved in several days. So that's generally not the customary practice. Could it happen? Sure, but generally, no, you wouldn't do that. You would continue giving the medicine to hold them over, and then once the paperwork goes through, you'll get reimbursed.

ILANA HARDESTY: In the end, the goal is to help the patient by providing pain management and by keeping them as safe as possible from the risks of these medications. We talked a bit about the path a prescription takes from the clinical office to the pharmacy. Now, let's talk a little bit more about how to make that happen as efficiently as possible. Dr. Kelly, how can the prescriber help you, help the pharmacist, with the job of filling an opioid prescription?

PATRICK KELLY: Right. There's a few things that prescriber can do, including a diagnosis or indication on a prescription, so the pharmacist knows exactly what we're treating, because that plays into the clinical appropriateness of the drug. Additionally, on a prescription, there tends to be room in the comments field, or the notes field, so you have to think about what's going through a pharmacist head. What's this medicine being used for? Why is this medicine being used in this specific person? Those are the questions that are going through a pharmacist head, and if there's ever a situation where someone necessitates a high dose or peculiar regimen that's outside of the standard labeling, having some kind of information on that prescription, acknowledging that... Basically it's communication, that's what it comes down to. The prescriber in a way, letting the pharmacists know, this is what's going on. Because of that corresponding responsibility a pharmacist is tuned in for, is this prescription written in good faith, due course of medical practice, should I be dispensing this?

There's a litany of questions that go through a pharmacist's head, a differential, if you will, for, is this a situation of diversion? And having an indication on there, a diagnosis code, an upper limit, maybe language about, "This prescription should be refilled no sooner than", having a set schedule for refills, to cut down on those questions and concerns that a pharmacist would have. And ultimately that would say phone calls and communication to the prescriber who's very busy, and it saves time for the patient. Because if those questions are satisfied, if that pharmacist can feel comfortable that yes, this is for a legitimate reason and a legitimate medical need, there's no delay in care. They don't have to wait an hour, until that pharmacist can confirm this information with the prescriber, especially if it can just be very quickly jotted on the prescription or included in the comments field on the e-prescription.

ILANA HARDESTY: Dr. Kelly, specifically around opioid prescribing, the collaboration between the pharmacist and the prescriber seems particularly important in many ways, can you talk a little bit more about what that collaboration can do and how it helps the patient?

PATRICK KELLY: Of course. So, having good communication between the prescriber and the pharmacist can help facilitate better clinical care. We have to think about how the pharmacist and the prescriber, they have the same clinical aim, understanding what each party is doing in the common care of the patient. The pharmacist understanding what the prescriber is doing and what the prescriber is looking at, the prescriber understanding what the pharmacist is looking at, we're seeing the patient at two different points in time, and we're involved in two different processes in the same common care of the patient. Our goals are aligned, it's just that we're doing different parts of the process. So key communication between the two individuals will help facilitate the process, prevent delays in care, and also help screen for clinically inappropriate combinations, drugs, doses, uses of medications.

ILANA HARDESTY: Dr. Kelly, you mentioned a very interesting point, the community pharmacist sees the patient at another point in time, very different from the prescriber, can you talk about what information you might glean and are there pieces of that that it might be important for the prescriber to understand?

PATRICK KELLY: Of course. So the prescriber sees the patient in one situation, when they're in the office, the pharmacists are potentially seeing a patient multiple times, whereas a prescriber may see them once every three months or every six months, or maybe even every year. A pharmacist might be seeing a patient daily, weekly, multiple times in a single day in some situations, so you're seeing beyond just that one snapshot, you're seeing patients at multiple points in time, and you're seeing in almost real time how they may be responding to that medication, whereas the prescriber will authorize the order and then reassess at a later point, the pharmacist is seeing multiple data points, multiple instances and seeing how someone might be responding to a medication.

DANIEL ALFORD: So Pat, I can imagine as a community pharmacist that you might witness some worrisome behaviors like over-sedation. How are the pharmacist trained to deal with this, I can imagine that there's a real emphasis focus on preventing any kind of commotion at the pharmacy, but then again, you don't want to dispense a medication that may cause the patient harm. So how do you balance that trying to maintain order at the pharmacy, but also not dispensing a medication that you're worried about?

PATRICK KELLY: That's a tough question, Dan. And there's no textbook answer, there's no formalized training on how to deal with worrisome behavior, why? Because worrisome behavior can encompass a wide range of things, so in that situation described you have someone who appears to be impaired, over-sedated, it's something where you have to parse out and understand is this this patient's baseline behavior. Is this something new? Is it a pattern? How severe is it? So you're doing kind of almost a clinical assessment to find out what is going on here, and when we deal with that worrisome behavior, you have to think in the back of your head, I'm going to be dispensing a product that could make the situation worse, although I have a lawful order, and this patient may need the medicine, what is going on in this acute instance, is it clinically appropriate right now?

And that's very tough to deal with, it's tough to say no in these situations, because there is this sense or feeling of, hey, I have someone who authored a prescription, they're expecting me to dispense it, but I have additional information here that changes the dynamic, it may not be reasonable or prudent to give this medicine out, you have to think about what's it going to do to this person who is already appearing over-sedated or impaired. Are they going to overdose? Are they going to be able to even get home, think about people who are driving to and from pharmacies, these are all things that are going through a pharmacist head, when these situations happen, they are rare, they don't happen frequently, but when they do it can be somewhat jarring because there is no manual you can open up to, to say, "oh, what do I do if someone seems over-sedated or impaired?" It's not there, so it takes practice, it takes training and a little bit of professional judgment when you make these decisions.

ILANA HARDESTY: And in the end, I think it sounds like your decisions are facilitated when you get more information from the prescriber. We've had a great deal of food for thought today,

and I appreciate the information we've received from both of you. Before we close out, Dr. Alford, can you give us a summary of the many issues that we've discussed today?

DANIEL ALFORD: Sure, certainly in my role as a primary care physician who manages a lot of patients with acute and chronic pain, I now really appreciate the importance of communicating with my community pharmacists, again, keeping the patient at the center so that we avoid any disruptions in their care, but also that we don't cause any harm with these medications, so I appreciate this second set of eyes in different points in time where the patient is being observed, I think it's important that we cultivate kind of a working relationship between a primary care physician and a pharmacist, but set up systems so that we can efficiently respond to each other's calls, we're all busy doing more than a full-time job, I'm sure. And so we need to create systems to enhance this two-way communication, and more specifically, I think adding information to the actual prescription seems like you can save everybody a lot of time and angst around these prescriptions and again, keep the patients safe, which is the ultimate goal for treating patients with chronic pain.

ILANA HARDESTY: Thank you again, Dr. Alford and Dr. Kelly for joining us today. Scope of Pain was developed in collaboration with our national partners, the council of medical specialty societies and the Federation of State Medical Boards. This educational activity is supported by an independent educational grant from the opioid analgesic risk evaluation and mitigation strategy or REMS program companies. Remember to follow up on any of the material you heard today, please visit our website at www.scopeofpain.org. While there, please take your post-test. I'm your host, Ilana Hardesty. Thank you for listening.

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Safer and Competent Opioid Prescribing Education

Scope of Pain Podcast Series – Season 2, Episode Two

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ILANA HARDESTY: Liz Appleton, a nurse in a primary care practice, takes a phone call from a community pharmacist. The pharmacist is concerned about a patient in the practice who appeared sedated when picking up a prescription yesterday. When Liz reviews the patient's records she notes prescriptions for both high-dose opioids and benzodiazepines. There is little documentation of why the patient is on these medications.

Welcome to the *SCOPE of Pain* podcast series. I'm Ilana Hardesty, your moderator. In this episode I'll be speaking with Dr. Daniel Alford, a primary care physician and an addiction medicine specialist at Boston Medical Center and on the faculty at Boston University; and with Catherine Abrams, a clinical research nurse at Emory University School of Medicine in Atlanta. They'll discuss the roles nurses in primary care practices can play in the care of patients prescribed opioids for the treatment of pain. If at any point you want more information on safer opioid prescribing and/or on receiving credit for this episode, please visit our website at www.scopeofpain.org. Again, find it all at www.scopeofpain.org.

Let's begin discussion of this case with Dr. Alford. Dr. Alford, can you describe what might be going on with the individuals responsible for the care of our patient? What has nurse Liz Appleton learned, and how should she address it?

DANIEL ALFORD: Yeah, I think the first thing that comes to mind, to me, is the importance of developing practice-wide policies and procedures so that everyone's using the exact same procedures around safer opioid prescribing. One, to maximize benefits, and two, to minimize harm. And when I say practice-wide I'm not just talking about primary care. I'm talking about any longitudinal care of patients with chronic pain who may be prescribed long-term opioids. It could be rheumatologists or oncologists or orthopedists, for that matter, although we do oftentimes refer to it as primary care. And these procedures really need to include clearly documenting the rationale for someone to be on opioids, or in this case, high-dose opioids, and other sedatives like benzodiazepines. The best practices should also include what's the standard for monitoring for benefits and harms, including urine drug testing. I've heard folks say, well, that seems like a lot of work to me. And I'll say that in clinical practice, especially in my primary care practice, we do a lot of stuff that's a lot of work. And we just figure out how to get it done. For instance, starting a patient with diabetes on insulin is a lot of work. And I really rely on others in my practice to help me navigate that, educate the patient, and make sure that they're using insulin safely.

So I think that also applies with opioid prescribing. It is a lot of work if you're going to do it well. And we really need to involve the entire team. So I want to turn it over to Catherine and ask you: How do you see the nurse's role in safer opioid prescribing practices? But before we do that, I know that my colleagues in the medical profession have really received very little or inadequate training in pain management and treating substance use disorders. And I'm wondering if that's also true of nursing education. Can you shed some light on that?

CATHERINE ABRAMS: Yes, Dan. In most nursing schools, courses are only offered in substance use disorder and pain management as electives. Therefore, not all nurses get this in-depth knowledge of the subjects during their education. And after graduation, a nurse needs to pass a national exam, which does include some basic pain management and substance use disorder questions, and then become registered in the state where they intend to practice. Nurses can also get more education through continuing education. And continuing education requirements vary by state when they renew their license. Approximately 12 states do not require any continuing education with nursing license renewals. Some of the states have certain number of mandatory CE hours along with a few that require mandatory topics. But unfortunately, only a few states have requirements in pain management and substance use disorder. Some outpatient practices employ licensed practical nurses or LPNs, and their scope of practice varies from state to state. LPNs either work under the supervision of RNs or alongside medical assistants. LPNs complete one year of training and must pass a national exam as well. Going back to the education for a nurse, nurses are required to take pharmacology, which focuses on the safe administration of medication, and that includes opioids and other substances with the potential for misuse.

Nursing schools have made improvements in safer opioid prescribing education by offering the electives for pain management. But many nurses who are interested in learning more have to expand their education on their own. Those nurses that want to become experts in pain management and/or addiction can get certification and credentials by completing the required hours and take an exam. And they can become a pain management nurse or an addiction registered nurse, or even both.

DANIEL ALFORD: Well, Catherine, it's great to hear that there are opportunities for nurses to become specialized in pain and/or addiction treatment. But I know that some of my primary care physician colleagues have told me they'd rather not work with this patient population, never mind becoming specialists. I can imagine you see this among your nursing colleagues. And I wonder if you could shed some light on it and how you would address that.

CATHERINE ABRAMS: Yes, there's reluctance to care for these patients, which also occurs with nurses. And some of the reasons we previously mentioned, which is the lack of training and therefore lack of knowledge and skill in caring for the patients. There's also the factor that patients dealing with chronic pain have high rates of co-occurring mental illness, which include anxiety, depression, and personality disorders. And that can trigger a nurse or anybody. And this can cause them not to want to engage in the therapeutic relationship with the patient. For these reasons it's important for nurses as well as other health care workers to develop a practice of self-care, maintain their own resiliency, and stay grounded while working with anyone, but especially with complex patients.

Providing education on the disease process and the rationale and implementation of safer opioid prescribing procedures can help with the reluctant team member. The proper procedure for a pill count is just as important as learning a sterile dressing change. Performing a pill count incorrectly with judgment or shame can potentially damage that nurse-patient relationship, dysregulate the patient, increasing their chance of risky behavior, which can lead to a possible overdose or even suicide. It's also important for health care workers to be aware of their own biases, and biases especially around disease of addiction. I've experienced nurses who've had family members with addiction and think that all opioids equal addiction.

ILANA HARDESTY: Let's think a little bit more about roles. Let me ask you both about how you see your roles within that health care team. If we think about patient-centered care, how do the various team members revolve around that patient? Dr. Alford?

DANIEL ALFORD: It shouldn't really be that complex or that different from what we do in regular care. What do I mean? So we should be thinking along the terms of a risk-benefit framework, similar to what we do for other complex medical conditions. For instance, when we're treating somebody's hypertension or diabetes we start a treatment, we look for an outcome: have we achieved the goal? And then we also look for adverse effects. Is there something that's going to prevent me from continuing using this treatment if it's benefiting the patient based on adverse effects? So it's this kind of risk-benefit framework that we're constantly balancing.

And it's the same thing with treating pain, and especially when we start using medications like opioids. For instance, is there improvement in the patient's pain reports? Has their function improved? Is their quality of life improved on the medication? And is there an absence of risk or harm, like is there opioid misuse, evidence of misuse, loss of control, compulsive use, continued use despite harm? Is there a worsening of function while someone is on opioids? And that certainly can happen. And I'll just say that we spend a lot of time talking about this risk-benefit framework in the *SCOPE of Pain* program at www.scopeofpain.org. So I would encourage people to consider going there. But I really want to turn it over to Catherine and ask you about nursing roles. What are the potential nursing roles in safer opioid prescribing practice?

CATHERINE ABRAMS: Yeah, I first want to start off saying that I agree with you, Dan, with what you said earlier, that each practice should develop and implement practice policies and procedures. And to do this well, I believe nurses should be at the table from the beginning when these practice guidelines are developed. This also helps with nurse buy-in to help with the providers as they need to implement these guidelines. The patients benefit when the primary care clinicians and nurses work together and understand each other's role for safer opioid prescribing. Having documented standard operating procedures in place for all team members can help create the same language. And the standard of care for everyone in the practice, that's including the front desk staff.

You asked about the potential roles of nurses in safer opioid prescribing, and I'm just going to list a few examples, what a nurse can do: A nurse can complete a pain assessment, which includes assessing for treatment benefits; assess for risk of substance use by using validated screening tools; provide patient education, including safe opioid storage and disposal; obtain urine drug screens and performing pill counts; tracking opioid refills to ensure no early refills. Nurses can review the prescription drug monitoring program – PDMP – as allowed by the state; educating patients and their families on signs and symptoms of overdose and use of naloxone. The nurse can also assist the primary care clinician in arranging for treatment of opioid use disorders if required.

With all of these being said, one of the complaints that I hear from nurses and sometimes myself is I don't have enough time to do all of this. Not having enough time can lead to burnout, stress, and as we know, recently there's been some that are really leaving the profession. For me, I get the most satisfaction out of my nursing career by developing effective relationships with patients, and especially those who have complex conditions, like those suffering with chronic pain or the disease of addiction. I've learned that building trust is what allows for that space to have honest conversations, which is important for safety and improves health outcomes. And the more we learn and implement trauma-informed care and lead with kindness and compassion and empathy, and not with, 'what is wrong with

this patient?', but 'what's happened to this patient?' as well as what are the patient's strengths, we can establish trust. And I display these traits most of the time they put a patient at ease, again, allowing for safe space for them to share their fears, concerns, and wishes for themselves and their care.

ILANA HARDESTY: Thank you both for those helpful insights. Let's return now to our case. Upon further chart review, not only was there a lack of documentation for the rationale of the combined high-dose opioid and benzodiazepine prescriptions, there were other gaps in care, including: the patient has not been seen in over six months; there was no monitoring for adherence and safety, including no urine drug tests or mention of reviewing the PDMP. This was especially concerning now that there is evidence, as reported by the community pharmacist, that the patient may be over-sedated on this regimen. Catherine, how would you counsel Liz Appleton to navigate the communications she needs to have with the prescribing physician and any others in her practice?

CATHERINE ABRAMS: Navigating the communication is difficult, and a great guideline for navigating this is found in the American Nursing Association Code of Ethics. Provision 3 states that the nurse promotes, advocates for, and protects the rights, health, and safety of all patients. 3.5 of that provision has a statement with the protection of patients' health and safety by acting on questionable practices. This can be applied to this case. So to summarize, the first step is to discuss the concerns with the provider. If the nurse still has concerns, then they might need to take it to their manager. And if it's still not resolved, then the manager and the nurse might need to discuss this with the head of practice. This is where the nurse's role of patient advocate really plays out. Nurses have a duty to advocate for patient safety and for guideline-based practices.

DANIEL ALFORD: So let me just add that I think this situation highlights the importance of having those written, agreed-upon policies and procedures that everybody in the practice has helped to develop and has agreed upon. There'll certainly need to be some negotiating and compromise when developing these, because there aren't necessarily evidence-based practices that everybody should abide by. But I think you have to decide as a practice, how often should these patients be seen, including virtual visits? And how often should we be doing urine drug testing? And it's going to vary depending on the patient and their risk level. And how and where should documentation of benefits and harms be in the chart?

I know personally when I'm cross-covering my colleagues it can become quite challenging to not be able to identify why is this person who I'm being asked to refill the prescription, why are they on this medication? And are they actually being helped? And is there any evidence of harm? And so I think it really is important to agree upon the procedures, including where all this should be documented, especially with patients on higher risk regimens, like the patient we've been talking about, which is someone who's on higher dose opioids and combined sedatives like benzodiazepines. Now, moving back to Catherine, I can imagine that talking to this primary care clinician is going to be very anxiety-provoking and quite challenging. And I'm wondering what your thoughts are about how that all occurs.

CATHERINE ABRIAMS: Yes, I agree. I think for a nurse to have a hard conversation around prescribing with a provider is very uncomfortable. But I think it's a nursing responsibility to ensure patient safety. Every practice and institution has its own culture. I remember when I graduated nursing school in the '80s, I was instructed to not only make sure all the charts were available, but I was instructed to give up my seat when the doctor came on the unit. A few years later, I started a new job working in an academic institution, and the culture was very different, as the nurse-doctor relationship was a team approach.

I know currently there are some practices that have a doctor-nurse relationship that is hierarchical. But when a practice implements patient-centered care with the respect of the interprofessional team approach, then the patient benefits with better health care outcomes. I want to state again in the American Nursing Association Code of Ethics that a nurse has a duty to advocate for patient rights as well as health and safety, which means that a nurse has to ask tough questions, needs to seek out guidance, and have those hard conversations. So going back to the case, I would suggest to Liz to share – with no judgment – her concerns with the provider that the patient has not been seen in over six months and might have had a life event that caused stress in their life, which can increase their pain. I would state that there is no documentation of the ongoing monitoring for benefits and harms, which also puts the primary care clinician at risk if there is a bad patient outcome.

ILANA HARDESTY: Okay. So Liz follows your recommendations, Catherine. And the clinician states that she does not want to upset the patient, as she's seen the patient for many years and fears that the patient will be offended if they're asked to leave urine drug tests and bring in pills for pill counts. How would you respond to that, Catherine?

CATHERINE ABRAMS: First, as a nurse, I'd be grateful that the practice had already set up policies and procedures for monitoring opioids. And hopefully, the provider and Liz can work together as a team to develop a care plan as to how to implement these guidelines into patient's care. It may help to explain that these are new practices based on the more current understanding of the potential risk of these medications, and that we need to apply them universally to all patients in order to keep everyone safe from these potential lethal medications.

A good first step is starting with the pain assessment. And a nurse like Liz can do this. It not only establishes the relationship with that patient, but it starts the agreed documentation of the patient's pain, any benefits and function, and any aberrant behavior. It's also a great time to discuss with that patient naloxone at home and education if needed. The patient assessment visit between Liz and the patient can help bridge that gap till the next patient appointment with the provider who then can continue to incorporate the guidelines into the patient's care. Here, strong communication and interpersonal skills are needed by the nurse to navigate not only hard conversations with the patient, but hard conversations with the provider, and do it without judgment.

ILANA HARDESTY: Thank you. Let's talk now a bit about some of the nuances that might present themselves. For example, what happens to the health care team when there is a patient who triangulates, that is, who tells the nurse one thing and the physician something completely different, or reveals something to the nurse but asks the nurse to, "keep it a secret from the physician"? Dr. Alford?

DANIEL ALFORD: So unfortunately, this type of splitting can occur, and does occur. And it's really important to emphasize upfront with the patient, or at any time during conversations with a patient, that you work together. The entire team works together, and we share information in order to improve the patient benefits and care and to keep them safe. And it's also important that we trust each other and respect each other on the team. And with the expectation that we're all practicing using the same agreed-upon standards of care that are outlined in the procedures. But I'm going to turn it over to Catherine and hear your comments.

CATHERINE ABRAMS: When the patient is enrolled in the practice, I agree with you. You've got to establish those communication expectations for the entire team, setting up that the nurse and provider and the patient are working together to ensure safety and also develop a plan of care for pain

management. Patients may feel more comfortable with the nurse, as some patients see the provider as an authority figure. And the patient may ask the nurse not to share something with the provider. Just like setting up policies and procedures upfront in a practice, the nurse and provider need to share the expectations for communication with that patient. If the patient continues to ask the nurse not to share the information, I would get curious and ask why, and what are the concerns, to start an honest conversation with the provider sharing the information and their concerns.

DANIEL ALFORD: You know, thinking back, working with my nurses in my practice, on occasion I've heard that patients don't understand or respect the role of the nurse, because they're not writing the prescription. And so they may say to the nurse, "why are you asking me these questions? You're not the one who's prescribing this medication." So I'm curious what your experience has been, Catherine, and how you would respond to that.

CATHERINE ABRAMS: Yeah, I have had that experience. And there are times when a patient really just wants to work just with that provider. And I think that's where the provider needs to have that communication with the patient that we're a team, and that we both have our roles to provide care for the patient, providing safety for the patient. And by doing this it helps the provider, because they have a limited amount of time in their practice. It also helps the nurse by really working with that patient and establishing the relationship. And again, it goes back to when a nurse really has a good relationship with that patient, it improves that safety. It improves the patient health outcomes as well.

DANIEL ALFORD: I mean, it's interesting, because I've never had a patient push back when I send them to the nurse to get education around their diabetes management or how to use an inhaler. But I have with pain and opioid prescribing. And there's obviously something very different in the patient's mind about how that plays out. But I just find it interesting when I think about it.

CATHERINE ABRAMS: Yeah, I think, again, it goes back to that fear of being judged, maybe, from the patient. Maybe they've had past experiences. So again, it's that nurse's responsibility to come at the conversation without judgment and without shame. And then that builds that sense of trust.

ILANA HARDESTY: It sounds like all of this does get back to those practice policies that we've been talking about all along. But what if a team member thinks that the patient should be discharged for lying to the physician or the nurse? Dr. Alford?

DANIEL ALFORD: I've definitely heard this before as well, that the patient said they weren't using any drugs. And then their urine drug test showed cocaine use. And how can I continue caring for them if I can't trust that they're giving me accurate information and there's this distrust? And for some reason we take that personally, where when patients are not 100% truthful about their exercise or diet or medication adherence, we don't take that personally. And we never think about discharging them from the practice. And so I usually tell my colleagues, "listen, don't take it personally. Patients who have substance use disorders will lie to themselves. They'll lie to their family members. And they may lie to us. And just don't take it personally. Just look at it as a new problem that needs to go on the problem list that needs to be addressed."

It may certainly impact whether or not you want to continue where you feel that it's safe to continue prescribing an opioid. But it doesn't mean you're going to discharge the patient from your practice. You may end up discharging the opioid from the regimen because of your concerns about risk. But there

shouldn't be any patient abandonment here. So I encourage folks not to take that personally and to keep their clinician hat on and take care of the patient. Catherine?

CATHERINE ABRAMS: Yeah, I agree with you, Dan. It's not only the providers who take it personally, but it's also nurses and other staff members that are in a primary care clinic. People who are on pain management and use other substances have high rates of co-occurring mental illness and/or post-traumatic stress disorders. Lying is just one of the many maladaptive coping mechanisms. This is another example of why the nurse's role for advocacy and the need for starting a conversation with the provider regarding the concerns that discharging the patient from the practice might cause harm by increasing the risk of risky behaviors that might lead to overdose and possible suicide.

Hopefully, the nurse and provider can come to an agreement to discuss with the patient the concerns and explore if there's a readiness for change, possible options for rehab, starting on buprenorphine, or the need to taper the opioids and continue to follow the patient for care using other alternatives for their pain management.

I remember a case where I interacted with a patient and I had developed a relationship with them. And they gave me a urine for a urine drug screen, which was cold and clear. And obviously, it was a falsified urine. I stated calmly and without judgment that the urine was not as expected. And I asked him to give me another one. And after he produced that urine that was expected, he left the clinic. And I got a call from him while he was still in his car in the clinic parking lot. And he called and he said he was sorry. He had lied. And he had used cocaine recently. And he was afraid of what would happen with a positive urine. I thanked him for the call. And I said I would share this information with the provider as we both wanted to keep him safe. I believe he felt like he could call me and be honest because we had really developed a level of trust between us. I didn't take it personally that he was trying to trick me because I knew by the documentation in his chart that he had had a history of trauma. And he was using survival skills. And it wasn't personal. The provider and I discussed the next step for this patient with conversation centered on how to keep him safe and then included conversation on how to address his cocaine use along with managing his pain.

ILANA HARDESTY: Thank you, Catherine. That's very, very helpful and a really moving story. Dr. Alford, do you have any last words for us today?

DANIEL ALFORD: I would just summarize in saying that safer opioid prescribing is a lot of work. But we do that in practice in general. And how do we do it? We collaborate with team members in our practice. And the best way to collaborate with team members and making sure everyone's on the same page is to create and use agreed-upon policies and procedures, especially in this area of safer opioid prescribing for pain. But it really is an important opportunity to work together with the patient in the center, obviously, to keep them safe from these potentially lethal medications that may be helping them as well. So I think it just emphasizes the importance of team-based care.

ILANA HARDESTY: Thank you again, Dr. Daniel Alford and Catherine Abrams, for joining us today. SCOPE of Pain was developed by the Boston University Chobanian and Avedisian School of Medicine in collaboration with our national partner, the Federation of State Medical Boards. This educational activity is supported by an independent educational grant from the Opioid Analgesic Risk Evaluation and Mitigation Strategy, or REMS, program companies. Remember, to follow up on any of the material you heard today, please visit our website at www.scopepofpain.org. While there, please take your post-test

to receive continuing education credit for this episode. I'm your host, Ilana Hardesty. Thank you for listening.

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