Reducing Opioid Abuse by Incorporating Patient Management Strategies from Psychiatry and Behavioral Health

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Recent ADA Webinars

- Detection and Deterrence of Substance Use Disorders and Drug Diversion in the Dental Practice
- Interviewing and Counseling of Patients with Substance Use Disorders (SUDs) and Drug Seeking Behaviors
- Management of Controlled Substances in Dental Practice
Safe Prescribing for Patients with a History of Substance Use Disorders

Federal and State Policy Efforts to Prevent Prescription Opioid Diversion

Prescription Monitoring Programs: Capabilities and Benefits
Addiction is a common disease—As high as 15% in most studies.
It is frequently diagnosed late or not at all.
A high index of suspicion is necessary.
It carries a great deal of misunderstanding and stigma.
Usually higher % of those utilizing Health Care services.
Diversion of Rx Drugs of Abuse is now considered the number 1 public health issue – CDC

If Rx Drug Use tracts similar to Alcohol Use, then approximately 50% of all Rx Opiates, Sedatives and Stimulants are diverted or otherwise abused
Dental providers do prescribe pain medications for invasive dental procedures and invasive dental pathology.

Dentists, along with other prescribers, need to take steps to identify problems and minimize prescription opioid abuse through practices that dentists can implement.

Note: Prescribing practices vary in private practice settings vs. hospital settings.
Dentistry and Pain

- Acute Pain- Usually obvious pathology or condition
  - Acute is usually less than 3 months
- Chronic Pain- Often no obvious pathology
  - Over 3 to 6 months duration
In 2002 dental practitioners prescribed about 12 percent of the opioids in the USA, amounting to about 1 billion doses.

Family medicine physicians wrote 15% of the prescriptions.

The most common opioid medications prescribed were immediate release. Formulations of Hydrocodone and Oxycodone
Surveys of dental practitioners and maxillofacial surgeons indicate that an average of 20 doses of Hydro/Oxy is prescribed after a dental procedure.

Most dental practitioners expected patients to have left over analgesics (2014)
Opioids and Chronic Pain

- Unclear how often dental practitioners prescribe Opioids for the treatment of moderate to severe chronic orofacial pain.
- One would expect very infrequent treatment of these conditions in a dental practice.
- One would expect PCP or pain specialists to handle those patients.
- One would expect collaboration among providers.
The principles of universal precautions in prescribing pain medications developed by Gourlay et al. (2005) identified similarities between patients with chronic pain and infectious diseases and emphasized it is nearly impossible to accurately assess risk on the initial visit and recommend applying risk management strategies to each of these patients.
10 Commandments

- Dx with Differential
- Assessment of Addiction
- Informed Consent
- Treatment Agreement
- Pre and post intervention of pain level & function
- Appropriate trial of opioid with an Adjunct agent
10 Commandments

- Reassessment of pain score and level of function
- Regularly assess the 4 As of pain medicine
- Periodically review pain diagnosis and comorbid conditions including SUD
- Documentation
Model Dental Practice

- Standard Procedure for all patients
- Detailed Pain history
- Evaluation should include complete history of personal and family history of substance abuse.
- Evaluation should include screening for psychiatric conditions as well.
Screening for past and current SU is essential. Use of screening tools integrated with history taking can facilitate the process.

- Screening Tools such as SBIRT and Cage Aid
- Thorough Physical Examination
Use of electronic health records and perhaps a common medical record

Use of Prescription Drug Monitoring Programs (PDMP)
Dental Procedures

If no Addiction history or concerning history - treat adequately and for enough time

If addiction history - may need more aggressive, but very short duration Tx
Focus needs to be on what pain is preventing them from doing? Not – How bad is the pain?

Stand-alone Pain scales are not helpful

Highlight the things they are able to do
○ Detailed Pain Origin/Treatment History

○ Focus needs to be on what pain is preventing them from doing? Not – How bad is the pain?

○ Stand-alone Pain scales are not helpful

○ Highlight the things they are able to do
Barriers to Detection: Patient Factors

- Poor yield despite excellent interview skills and good practices

- The patient is embarrassed to have an SUD diagnosis, is in denial, is fearful of receiving inadequate treatment, is afraid they might be reported or arrested

- Or the patient’s visit is for criminal purposes
Cost Issues: SBIRT should be part of every dental practitioner’s interviewing process but reimbursement is not universal

- Time constraints

- Practice Setting

- Discomfort of Healthcare professionals
Many healthcare professionals are uncomfortable discussing alcohol and drug use with their patients (more so with drugs).

In a recent survey of dentists in West Virginia, 33% of responders acknowledged they did not routinely ask how new patients about a current or past history of SUD (2015).
Detection of SUD in Dental Practice: Patient Interview Considerations

- Pre-interview data, good observation skills, thorough interview, physical exam and sound clinical judgment

- Goal is to establish difference between a patient legitimately seeking a drug and a drug-seeking patient
Inquire about all:
- Tobacco
- Alcohol-
- Opioids*
- Benzodiazepines/ Z-drugs
- Cannabis and Cocaine
- Amphetamines (includes other stimulants like methylphenidate)
- PRESCRIPTION MEDICATIONS
Detection: Risk Factors for SUD

- Inheritance
- Age of first use
- Availability of addictive substances
Usual Way of inquiry

- Never ask - probably most common
- Do you have a drinking or drug problem?
- Or You don’t have a drinking or drug problem do you?
- How much do you drink or use drugs?
Develop knowledge base and comfort with the topic

Ask different questions

Ask open ended questions

Stay neutral without any hint of judgmental or disapproving attitude
What to do?

- Don’t make a big deal out of it
- Include it as part of the overall conversation
- Make sure the person understands you are not judging
- Emphasize that you need accurate information to care for them
- Educate them on drug-drug interactions
Suspicious patient

- Being on more than one class of controlled substance
- The Patient is focused only on medication treatments only
- The patient reports unique allergy pattern
- The patient asks for medications using street names or terminology
- The patient changes or adds new symptoms
Friends and Family of the adult patient are present and adamant they must be present the whole time.

Impaired friends or family members accompany the patient.
DON'T:

- "take their word for it" when you are suspicious

- dispense drugs just to get rid of drug-seeking patients.

- prescribe, dispense or administer controlled substances outside the scope of your professional practice or in the absence of a formal practitioner-patient relationship.
Management of suspicious patient

- Active listening
- Rapport building with a non-confrontational and non-judgmental approach
- General patient management skills
- Motivational interviewing
- Referral to a proper health care provider (ethical responsibility)
Management of suspicious patient

- Use your state’s Prescription Monitoring
- Obtain random drug screens and for cause testing
- Have a “contract” they sign—lots are available or build your own
- Do pill counts randomly—so have them bring their bottles
How many classes of drugs
How many prescribers
Overlapping Rx’s
How many pharmacies
Amount and frequency
Optimal healthcare requires substance use information for good clinical decisions

All providers need to improve their comfort and skill set in having these discussions
In Sum

Use the tools available:

- Office assistants/hygienist screening patients
- SBIRT, DAST, CAGE, AUDIT questionnaires
- Prescription Drug Monitoring Programs
- Physical Assessment/Exam (nose, mouth, arm)
- Utilize your local pharmacists
“That’s all Folks!”
PCSS-O is a collaborative effort led by the American Academy of Addiction Psychiatry (AAAP) in partnership with: Addiction Technology Transfer Center (ATTC), American Academy of Neurology (AAN), American Academy of Pain Medicine (AAPM), American Academy of Pediatrics (AAP), American College of Physicians (ACP), American Dental Association (ADA), American Medical Association (AMA), American Osteopathic Academy of Addiction Medicine (AOAAM), American Psychiatric Association (APA), American Society for Pain Management Nursing (ASPMN), International Nurses Society on Addictions (IntNSA), and Southeast Consortium for Substance Abuse Training (SECSAT).

- For more information visit: www.pcss-o.org
- For questions, email: pcss-o@aaap.org
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