

# Educating Medical Practitioners About Safe Opioid Prescribing: Training from the Governor's Institute on Substance Abuse

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There has been a great deal of speculation about what is causing the current epidemic of prescription medication abuse, with possible factors including sociocultural, economic, and medical issues [1]. One concern relates to the prescribing patterns of some clinicians—both primary care providers and specialists—particularly with regard to prescription of opioid analgesics. To address this concern, a number of national and state-level initiatives have aimed to promote safer opioid prescribing practices. In North Carolina, the Governor's Institute on Substance Abuse has played a lead role in these efforts, with the support of the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMHDD-SAS); the Substance Abuse and Mental Health Services Administration (SAMHSA); and other funders.

As far back as 1994, the Governor's Institute, along with Duke University and the *Journal of Law, Medicine and Ethics*, cosponsored a conference devoted to prescription drug abuse and published 2 articles on the need for medical education to address this issue [1, 2]. In 2008, the Governor's Institute collaborated with SAMHSA to provide a series of workshops on safe opioid prescribing as part of a national training initiative. These workshops resulted in increased use of opioid risk screening tools and increased use of the North Carolina Controlled Substances Reporting System, and the success of these workshops demonstrated that prescribers were eager for training in this area. The Governor's Institute then began receiving requests for similar training, which resulted in additional trainings over the next 4 years.

In collaboration with the North Carolina Society of Addiction Medicine and other specialty groups, the Governor's Institute has provided or facilitated a number of

initiatives targeted at a broad range of North Carolina's medical practitioners. These trainings have focused on teaching core skills that will help practitioners balance the need for adequate pain management—including access to opioid medications, when needed—versus the need to minimize the risk of abuse. Topics that have been covered in these trainings include: the role and limitations of opioids in managing chronic pain; risk stratification as an element of treatment planning before initiation of a therapeutic trial; elements of adequate monitoring; and appropriate responses to aberrant medication behaviors, including when to discontinue opioids and when to refer patients for specialty care.

In 2009, with funding from the Kate B. Reynolds Charitable Trust, the Governor's Institute implemented a program for 10 counties in Eastern North Carolina. This initiative developed grassroots awareness of prescription drug abuse and included community awareness campaigns, medication turn-in days, and evening seminars for clinicians. Outreach within the medical community resulted in widespread attendance by primary care physicians, emergency medicine specialists, and pain management clinicians. Over the course of 2 years, 7 trainings were attended by a total of 260 health care providers. This training initiative also included the provision of onsite technical assistance in addressing systems barriers, which include organizational culture, workflow, and reimbursement issues.

The Governor's Institute has also hosted a series of highly successful, practice-oriented conferences every year for the past 4 years. These conferences are formatted to attract both addiction medicine specialists and primary care clinicians. Each conference has focused attention on

(Table 1). A thorough history and a physical examination are essential in determining whether opioids are a reasonable option. If the diagnosis is fibromyalgia, for example, opioids are not indicated [6]. Moreover, patients who have poorly defined pain, those with a somatoform disorder, and those who are receiving compensation (eg, workers' compensa-

tion or Social Security Disability) will likely have a poorer response to opioid therapy [7].

In addition to establishing a diagnosis, physicians should stratify patients according to their risk of addiction and opioid misuse. Risk stratification is key to mitigating these hazards, and it should be an ongoing process in patients with chronic noncancer pain (Table 2). Multiple patient screening tools are available, but these methods have not been compared directly, so it is unclear which is best [8]. Highly rated tools include the Diagnosis, Intractability, Risk, Efficacy (DIRE) Score; the Addiction Behaviors Checklist; and the Screener and Opioid Assessment for Patients with Pain (SOAPP) [1]. These screening tools and others, as well as treatment algorithms, can easily be found online. Community Care of North Carolina (CCNC) also provides online resources for providers who treat chronic pain (<https://www.communitycarenc.org/population-management/chronic-pain-project/>). Such tools can help physicians stratify patients into categories of

**TABLE 1.**  
Steps in the Initial Assessment of Patients Who Are Being Evaluated for Long-Term Opioid Therapy

1. Take the patient's history and perform a physical examination.
2. Assess the risk that the patient will misuse the drug, perhaps by using a screening tool such as the Addiction Behaviors Checklist.
3. Check the North Carolina Controlled Substances Reporting System to see any controlled substance prescriptions the patient may have previously filled in North Carolina.
4. Perform baseline urine drug screening.
5. Have the patient sign a treatment agreement or a pain contract.

abuse of controlled medications, giving particular attention to abuse of opioids and benzodiazepines. Lectures have provided reviews of the literature and standards of treatment, and seminars have focused on in-depth discussions and on how standards of treatment can be implemented in real-world practice settings.

As an important part of responding to the current opioid epidemic, treatment needs to be provided for individuals who have moved beyond opioid misuse to opioid addiction. However, clinicians often receive little support in dealing with this problem. To address this need, the Governor's Institute, working with DMHDDSAS, has for the past 4 years facilitated an ongoing mentoring network for those working in opioid treatment programs (methadone clinics). This mentoring has included monthly conference calls that include case discussion, literature review, and emerging standards of care.

For physicians who provide in-office treatment with buprenorphine or naloxone (agonist and antagonist therapies for opioid addiction), the Governor's Institute has sponsored training updates at yearly addiction medicine conferences. These workshops have attracted a majority of the physicians in North Carolina who are treating opioid addiction with buprenorphine or naloxone.

The leaders of Community Care of North Carolina (CCNC) have long been aware of the public health impact of prescription drug abuse. Building on the impressive success of Project Lazarus in Wilkes County [3], CCNC recently initiated the statewide Project Lazarus: Chronic Pain Initiative. As part of this initiative, the Governor's Institute has been asked to develop and implement training for clinicians. This 2-year project, funded by the Kate B. Reynolds Charitable Trust and the North Carolina Office of Rural Health and Community Care, will be the largest training initiative ever implemented in this clinical area in North Carolina. In collaboration with the North Carolina Academy of Family Physicians, 40 training sessions will be provided for approximately 2,500–3,000 clinicians, and

ongoing site-specific case-discussion conferences will be facilitated. The trainings will cover the multidimensional character of chronic pain; the role of opioids in safe and effective management of chronic pain; screening and risk stratification to minimize misuse or abuse; intervening if or when misuse occurs; and networking with local pain management and behavioral health experts.

Ancillary materials for this project will be posted on a Governor's Institute-sponsored Web page that is devoted to providing substance abuse resources for health care providers (<http://www.sa4docs.org/>). This Web page provides training updates and links to other clinical resources, and last year it was visited by 12,805 unique visitors—not only from North Carolina but also from 49 other states and 17 countries. NCMJ

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high, moderate, or low risk, which can help to guide management. High-risk patients and those who have significant psychiatric comorbidities or a history of drug abuse should be managed only by providers who have experience treating this population, and comanagement with a psychiatrist or an addiction specialist is strongly recommended [7].

Patients should give informed consent before opioid treatment is initiated. Adverse effects of opioids are common, and providers should develop a plan for dealing with these issues before starting opioid treatment. Nausea can affect up to 25% of patients but typically resolves with time; if treatment of nausea proves necessary, antihistamines or metoclopramide can often provide relief [9]. Constipation should be prevented with stool softeners and a stimulant laxative. Cognitive impairment and sedation are major risks when starting treatment with opioids, when the dosage is being increased, or when opioids are being taken with other sedating substances (such as alcohol). Patients should be

instructed not to drive when they are feeling impaired [7]. The risk of respiratory depression is much higher when a patient's dosage is increased or when an opioid is combined with another drug, such as a benzodiazepine. Patients also need to be aware of the risks of physical dependence and withdrawal before starting opioid therapy.

Expectations should be clearly agreed upon at the start of opioid therapy, and patients need to understand that total pain relief with opioids is not a realistic goal. The average benefit with opioid therapy is a reduction of 2 or 3 points on a 10-point pain scale [7]. A reasonable expectation is that a successful opioid trial will result in a 30% reduction in pain or a 30% improvement in function [8].

Treatment agreements or pain contracts can be used to document informed consent and expectations. There is fair evidence that treatment agreements may improve compliance [8]. These agreements also set expectations for random urine drug screening, pill counts, and avoidance of excessive