

HOSPITALIST'S UPDATE:

Meaningful opioid prescription and patient centered care:

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Pain management is an essential part of the patient-centered-care model, which is a major focus of health care systems nation-wide. The definition of patient centered care includes establishing a partnership among practitioners and patients, leading to decisions that respect patient's needs, and preferences. It provides patients with the education and support necessary to make decisions and participate in their own care. Frequently, the effectiveness of this model is misinterpreted based on results from "patient satisfaction" surveys. The results of such surveys likely influence changes in corporate health care policies that strive for good performance scores. Unintentionally, this may influence and increase physician prescription of opioids which are commonly prescribed medications for effective pain control.^(1,2)

Due to increasing concerns for inadequate pain control since the 1990s, opioids have become one of the most prescribed drugs in the United States. However the Institute of Medicine (IOM) in 2011 reported that 100 million Americans suffer from pain tolling an estimated \$635 billion annually due to treatment and loss of productivity.⁽³⁾ On one side is the battle to control pain that has resulted in a 400% increase in the prescription of opioids since 1998; on the other side is a corresponding increase in the number of deaths from opioid overdose, increased emergency room visits and drug abuse.⁽⁴⁾

The role of opioids in control of acute pain is well established, but the situation is different for chronic non-cancer pain (CNCP). The WHO defined CNCP as pain that lasts beyond 3 months of onset, when the healing process for the etiology of the pain is expected to be complete. Patients with CNCP on chronic opioid therapy (COT) who are admitted with pain exacerbation or new pain from acute medical illness, surgery or trauma, present a challenge for the inpatient medical team due to few known effects from chronic opioid use. These include opioid tolerance (reduced drug effects from long term use), opioid induced hyperalgesia (increased response to normally painful stimulus) and opioid withdrawal, the latter two resulting from abrupt cessation of COT. All three require opioid dose increase, therefore it is of paramount importance to achieve control of the background "chronic pain" to avoid opioid withdrawal and opioid induced hyperalgesia.

Control of "acute pain" also is treated with a dose of opioids that would account for opioid tolerance as well. A balanced and targeted approach to opioid dosing in the inpatient setting can help to avoid the above mentioned adverse effects.⁽⁵⁾ Soon after recognizing patients who require chronic opioid therapy it is essential to carefully consider their history of narcotic use. Attempts must be made to contact the patient's usual prescriber to better understand the risks and benefits of treatment strategy, the choice of opioid drugs, and the realistic goals of therapy. Failing this baseline assessment, pain management gets complicated resulting either in inadequate pain control or increased adverse effects from inappropriately high doses of opioids.

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To guide ambulatory care physicians, the American Association of Pain Management (AAPM) 2009 guidelines enumerate the effective risk assessment strategies prior to initiating chronic opioid therapy (COT), but these strategies are based on expert opinion as no major studies or RCTs are available at this time.⁽⁶⁾ Certain principles help in confident opioid prescribing and these are available from Federation of State Medical Boards (FSMB) in the form a book “Responsible Opioid Prescribing – a clinician’s guide”.⁽⁷⁾ In a state-wide survey of physicians belonging to primary care service, medical and surgical specialties, private and university based practices; who received this book 6 weeks prior to the survey, 57.7% indicated the book to be better than other known publications. The medical specialty services were much less likely than primary care providers to make changes in their practice.⁽⁸⁾

In recent years, the hospitalist team includes a significant number of physicians from medical specialty services. Patients face multiple hospitalists even within the same hospital. Every hospitalist needs to have a focused knowledge about appropriate and meaningful opioid prescription for pain control and these resources serve well. An essential concept is to have functional targets including improved quality of life, improved ambulation and sleep, rather than targeting pain relief alone. This approach may increase patient’s tolerance to pain and the threshold for need of medications thus leading to effective and minimum dose requirements to maintain an acceptable quality of life.⁽⁷⁾ With such meaningful and sensible opioid prescription practices better patient centered care can be provided and institutional goals may be well met.

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