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Reflections of Two Pain Medicine Clinicians in the Era of the Opioid Crisis
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Guest: Dr. Robin Hamill-Ruth recently retired from the University of Virginia where she served as associate professor of anesthesiology and critical care medicine, and director of clinical pain research.

Randye Kaye: Hello, and welcome to this edition of "JALM Talk" from *The Journal of Applied Laboratory Medicine*, a publication of the American Association for Clinical Chemistry. I'm your host, Randye Kaye.

The rise in opioid prescribing and subsequent growth of opioid abuse has led to increased oversight and challenges for clinicians who prescribe opioids to their patients. Recommendations and guidance documents vary when recommending approaches to monitor patients receiving controlled substances.

The Federation of State Medical Boards and the Center for Disease Control differ in the strength of their recommendations to initiate drug testing for patients. Recommendations for the frequency of testing differs as well for both low-risk and high-risk groups. Additionally, legislation varies between states for issues such as dosing frequency and amount, duration of prescriptions, and monitoring compliance.

The confusing landscape was recently explored from the prescriber's perspective to better understand the challenges that clinicians face. A variety of issues may hinder effective laboratory testing for this population that can span the pre-analytic, analytic, and post-analytic phases of testing.

Recognizing common pitfalls and learning to address them is crucial for both laboratory directors and clinicians. Given the current severity of opioid abuse, laboratories are playing an increasingly important role in detecting abuse and monitoring compliance. Despite an increase in urine drug testing, knowledge gaps still exist for many ordering providers.

In this podcast, we will explore drug testing for pain management from the prescriber's perspective. A Laboratory Reflection "Reflections of Two Pain Medicine Clinicians in the Era of the Opioid Crisis" was published in the January 2018 special issue of JALM on Laboratory Support of Pain Management.

The corresponding author is Dr. Robin Hamill-Ruth. Dr. Hamill-Ruth recently retired from the University of Virginia where she served as associate professor of anesthesiology and critical care medicine, and director of clinical pain research, with a focus on improving patient access to high-quality care and safe opioid prescribing. She is our guest for today's podcast. Welcome, Dr. Hamill-Ruth.

Dr. Hamill-Ruth: My pleasure. Thank you so much for having me.

Randye Kaye: My first question is, how has the opioid epidemic changed your clinical practice?

Dr. Hamill-Ruth: I think we've always been fairly careful about the monitoring but with the new regulations and guidelines, it clearly has increased the mandate for compliance monitoring. And I think it made also the practice much more aware. You think you're doing a really good job of it and you realize as you look at the refill that you actually haven't done urine in two years. So, I think we've gotten much more systematic about the drug testing and routinely checking the PMP.

Randye Kaye: I imagine there are some roadblocks and hurdles that might limit the effectiveness of drug testing. If so, what are some of those hurdles?

Dr. Hamill-Ruth: One of the fights that I had for quite a while was actually getting it paid for, and that the charges here at the university were really exorbitant. It could be as much as $2,200 to $2,400 by the time you did the urine drug screen and did validity testing, and did the confirmations on top of that.

So, part of the problem that we had here was that even if people had insurance but they had 20% copay, that's still a lot of money. And for people who didn't have insurance, they might have to pay the entire thing out-of-pocket. So, what we were seeing is particularly the primary care docs weren't doing it to save patients the expense, which of course is not good quality care.

So, we think that with the onus changing, that this really has to get done. One of the things that UVA actually came up with was a contract med screen mostly because I pushed on them for a long time to make it happen. But for $75, they will actually do the screening, the immunoassay screening, validity testing and then actually do confirmations on opioids, and benzodiazepines. And that's all a $75 charge for the patients that are on chronic opioids.

Randye Kaye: Okay, great. So, that's one roadblock and one possible solution that you spearheaded. Any other roadblocks and

since you're kind of lumping it together, what else can be done to address these challenges?

Dr. Hamill-Ruth: Well, I think going back to other issues with it, I think that physicians in general are not particularly good at understanding what they're doing and what they're looking at when they do the drug testing. There are a couple of papers out there looking at knowledge basis for primary care docs and they're really pretty abysmal.

And yet, one of them looks at -- I think internal medicine residents -- looked at their confidence level for their ability and their confidence way out-stripped their ability.

So, I think one of the things that needs to happen is we just need to do a much better job of teaching physicians how to actually collect the specimens, what do you need to look for, what information do you need to share with the lab to be able to get decent information back again, how do you interpret the results.

I think often if you don't understand some of the metabolic pathways, you might be tempted to discharge a patient or accuse them of getting alternative medications because there's a metabolite in the urine and you didn't know what was metabolite and we've actually seen that. We had a patient that came to us having been discharged from practice for that very thing.

Randye Kaye: Wow.

Dr. Hamill-Ruth: Yeah, it was really appalling and one of the attendings spent hours trying to get to the primary care doctor that had discharged the patient to educate them and the guy refused to talk to her.

Randye Kaye: That's definitely a roadblock, anything else?

Dr. Hamill-Ruth: I think, even if you have the best of intentions and know how to collect the specimen, just the logistics of doing that, particularly in a very busy primary care practice, needing to ideally having observed urine, knowing that you need to check the temperature and the pH within five minutes, how do you actually store the specimen, how do you transport it, even just understanding that it needs to be done onsite and that it needs to be unannounced.

I think there are lots of practices that will hand the patient a lab slip and tell them to go to the lab and get it done. In my mind, that's an utter waste of money because then they know if they have been sharing their medication or selling most of it or has done a list of substances or whatever they

may stall long enough to be able to have a urine that's going to look better that it would if they did it onsite.

Randye Kaye: So, I'm hearing a lot of roadblocks, and among the solutions help with cost or more efficient systems for cost, better education for the doctors. It's kind of scary when the doctor's confidence outstrips his ability. That phrase is frightening. And putting more systems in place, these are all great things to address those challenges.

Let's talk about lab directors for a second. What role do they play and are there ways that they can actually help practitioners who prescribe opioids in addition to what you've already said?

Dr. Hamill-Ruth: I think, again, the first and foremost is educating providers so that they know how to collect and when to collect, and what to test, where, how to store, how to ship, and then how to interpret the results. I think the other thing is to work collaboratively with the providers to help decide what kind of information should the providers be giving to the lab directors to facilitate their ability to interpret. How can lab directors then report the results to the primary care doctors in a way that is easy to interpret and meaningful to them? And also, is going to help minimize any risk of them interpreting incorrectly.

For example, if some is taking hydrocodone and that the urine comes back with hydrocodone and hydromorphone to say hydrocodone is consistent with -- hydromorphone consistent with metabolite of the hydrocodone. But if, for example, they had quantitative testing and the hydromorphone level was astronomically high, then perhaps the comment could be "Consistent with metabolite of hydrocodone, however could represent exogenous hydromorphone ingestion," something to that effect. So that it doesn't absolutely say, "Yes, thumbs up, thumbs down." But there are some maybes in there.

Randye Kaye: This is great information and I certainly hope it has some effect. Anything else you would like to add before we close the interview?

Dr. Hamill-Ruth: I think the only thing I would maybe suggest is that the lab directors work with the physicians to create a relationship where they are available for phone consultations for confusing or difficult cases. Because again, understanding that the primary care docs in particular are so busy that -- to have ready access or to be able to set up an appointment even to have a conversation about something that's confusing to them, extends the opportunity for the lab directors to further educate and kind of facilitate the

appropriate use of the drug testing and interpretation thereof.

Randye Kaye: That was Dr. Robin Hamill-Ruth from the University of Virginia Health System talking about the JALM "Reflections of Two Pain Medicine Clinicians in the Era of the Opioid Crisis" for this podcast.

Hey, thanks for tuning in for "JALM Talk." See you next time and don't forget to submit something for us to talk about!