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PRACTICAL PAIN MANAGEMENT

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Clinical Best Practices for **Urine Drug Testing in Chronic Pain Patients**

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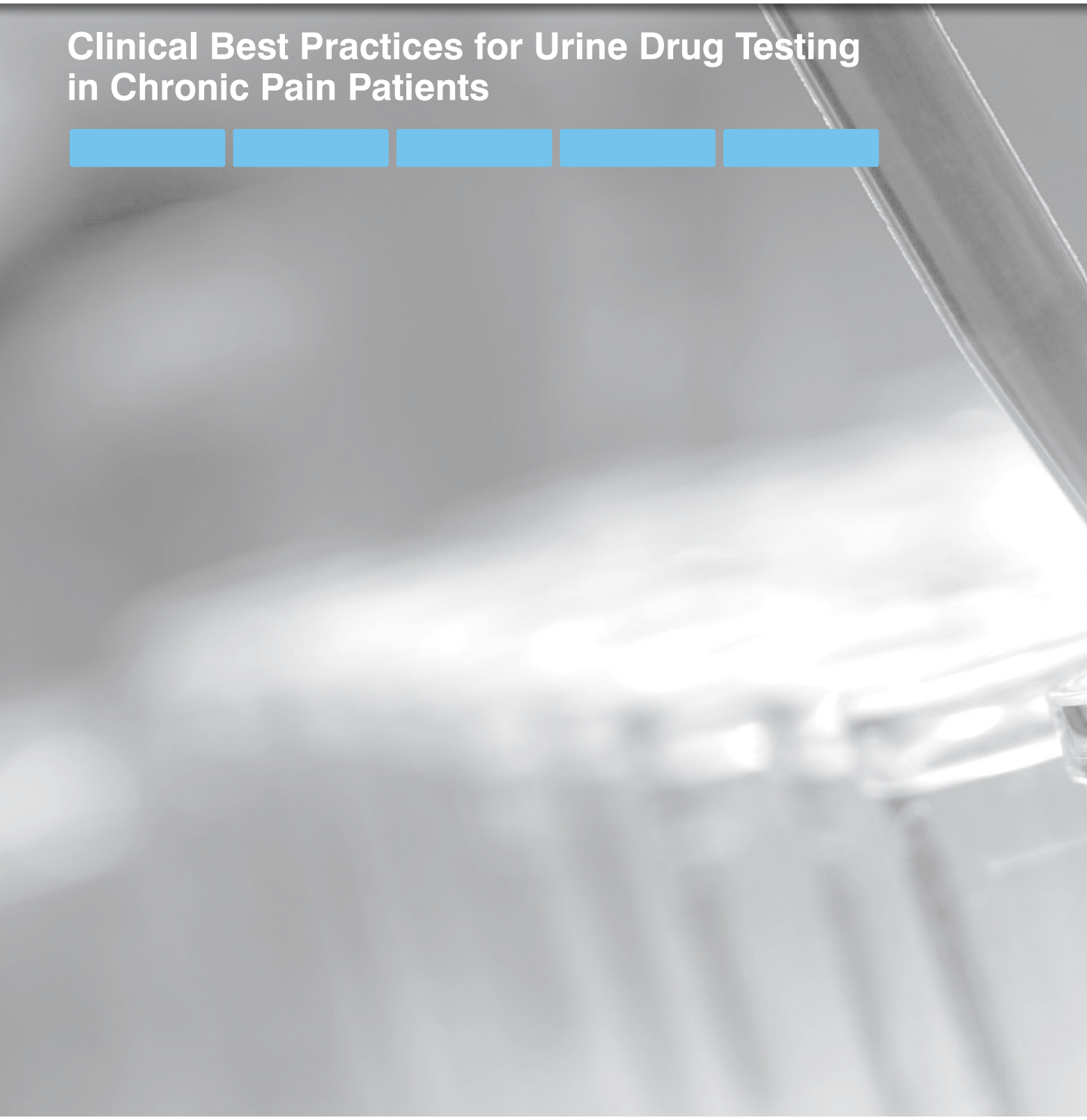

Introduction
Since the 1990s, there has been a dramatic rise in the number of opioid prescriptions written for patients with chronic pain. The results of this increase have been both positive and negative: along with better pain control for many chronic pain patients, there has also been a rise in opioid misuse, abuse, and diversion—resulting in increased rates of addiction and overdose deaths.

Urine drug testing (UDT) can help evaluate for pain medication adherence, and can be an important and useful tool in clinical practice. Developing a regular protocol for drug testing can help you, the primary care provider, identify non-adherent patients and provide them with the help and education they need.

However, UDT in clinical practice also raises a host of difficult questions. Who should you test, and how often? How can you convince your patients of the importance of drug testing in their pain management? What kind of test should you use, and how do you interpret the results?

This document provides practical, hands-on information that will help you make UDT an integral part of your clinical practice. You will find detailed information regarding:

- **Why You Should Test (p. 5)**
  How UDT can benefit your patients, your practice, and the public
- **Who to Test and When to Test (p. 9)**
  A description of patient risk assessment tools and ways to determine how frequently to conduct drug tests
- **How to Test (p. 12)**
  The benefits and limitations of point-of-care and laboratory-based testing procedures, and a discussion of how to interpret results
- **Talking to Your Patients About UDT (p. 15)**
  Information on how to talk to your patients about the importance of UDTs, what to say if someone refuses a test, and how to address unexpected results
- **Frequently Asked Questions (p. 16)**
  Answers to common concerns about the use of UDT in clinical pain practice

Remember: you are in charge of your practice, and you have the ultimate goal of protecting both your patients, your practice, and your community. Urine drug testing can serve as a tool to help you with this goal, and this document can help you better understand how UDT can be incorporated into your practice.

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This document was developed by four nationally known pain experts, in conjunction with an online video series on the same topic.

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Why You Should Test

The case for urine drug testing in clinical practice is one that you have probably heard and considered at some point in your career. The benefits that UDT for pain medication adherence offers to multiple parties (including your patients, your practice, and the public) may seem apparent. However, the reasons why you should regularly incorporate UDT into your already busy, hectic schedule—particularly in cases where you don't expect aberrant behavior—may be less clear.

Some hesitation about regular testing is understandable; the volume of patients you have to see each day, and a lack of time and resources, can make it difficult to prioritize UDT when you have only minutes to meet with each patient. Additionally, you may wonder: why invest time and money on testing patients with whom you have developed long-standing relationships, and whom you trust to cautiously and accurately take their medications as directed?

There are many reasons why you should consider UDT, both in cases where you suspect aberrant behavior with the prescribed medication, and at times when you don't. Developing a drug testing protocol for your practice is not only possible—it is imperative to help stem what has become an epidemic of prescription drug abuse in the United States.

What we know:

- More than 36,000 people died of drug overdoses in 2008, and the majority of those deaths were caused by prescription drugs.[1]
- Approximately 7 million people used psychotherapeutic drugs non-medically in 2010, and more than 5 million of them abused pain relievers.[2]
- Nearly 3 out of 4 drug overdoses are caused by opioids.[3]
- Prescription medications are one of the most common types of drugs abused by adolescents.[2]

The facts are there: prescription drug abuse is a growing problem, and action must be taken to stop it in its tracks. We know it's difficult to imagine adding even one more thing to your practice—but the following sections describe the reasons why it is important and necessary to make regular urine drug testing an integral part of your clinical practice.

3 Ps of Protection

Many individuals benefit from the implementation of UDT on a consistent and strategic basis. Patients who are treatment adherent, and those who are not, can both benefit from regular testing. UDT can help you protect and fortify your practice and demonstrate your commitment to addressing widespread concerns about drug abuse, misuse, and diversion. Finally, the general public can benefit from a concerted effort to reduce levels of addiction, diversion and drug misuse.

Urine drug testing can help you:

• Protect Your Patient • Protect Your Practice • Protect the Public

Protecting Your Patient

Urine drug testing helps you carry out one of the most fundamental tenants of the medical profession—to serve your patient's best interests, and improve his or her clinical well being. This may mean improving your patient's physical health by increasing treatment adherence, or helping your patient go into recovery from the disease of addiction. As a primary care provider, you are in a unique position to evaluate and improve your patient's health over an extended period of time.

Drug abuse and addiction are medical problems that can be addressed with proper diagnosis and treatment. UDT can help you protect vulnerable patients by documenting the test results which contribute to the determination of treatment adherence. Regardless of whether the result of a urine drug test is normal or abnormal, it can help your patient. If normal, the test can support your patient's efforts to stay on track and provide encouragement; if abnormal, it may allow you to act within the "golden moment" and open up further discussion for treatment. Remember, the purpose of UDT in the clinical setting is not to penalize patients; it should be used to educate and improve communication with your patient for good medical care of his or her chronic pain syndrome.

WHAT YOU NEED TO KNOW

UDT should be done *with* and *for* the patient, not *to* the patient.

Table 1: Organizations that Recommend UDT

- American Academy of Pain Medicine
- American Chronic Pain Association
- American Society of Interventional Pain Physicians
- Federation of State Medical Boards*
- Veterans Affairs
- Washington State Agency Medical Directors' Group

*At the time of publication, 38 states adopted or modified the Federation of State Medical Board's policy statement.

Protecting Your Practice

The harsh reality of opioid abuse is that it also affects your practice. Prescription drug abuse is a real concern for physicians around the world, and it is important to make sure that problems with drug adherence do not put your practice in danger.

In recent years, many federal and state agencies have been on alert about problems with opioid prescriptions; misuse and abuse can have a serious impact on your practice. UDT allows you to keep objective records of patient adherence, progress, and treatment efforts. Besides helping to protect your livelihood, urine drug testing can also help you protect the rest of the patients served by your practice by allowing you to continue to provide them with care.

Protecting the Public

Drug addiction and misuse of opioids is a public health concern which affects our entire community.

It is widely accepted that in most practices, there will be individuals who abuse or misuse drugs. It is the physician's responsibility to help identify these patients and begin implementing a treatment plan.

Addiction to various substances is relatively common in the US (eg, more than 20% of the US population is addicted to nicotine). It is important to note that the percentage of chronic pain patients taking opioids who have a history of some form of addiction is higher than that for the general population. Since recidivism is a fact of life with addicts, physicians need to be highly aware that a patient taking opioids for a pain problem may misuse or abuse occasionally. If the patient is being monitored with UDT, it is more likely that the provider will discover this, and then be able to discuss the behavior with the patient, and possibly continue to give the opioid while helping the patient to comply with the treatment plan.

In conclusion, routine drug testing in pain management may help us protect the health of our patients, protect our practices, and protect the public. If a patient is taking blood pressure medications, it is customary to routinely check his or her blood pressure to confirm compliance with blood pressure medications. The same is true for monitoring blood glucose levels of diabetic patients using glucose medications. In most chronic disease categories, we have objective measures to help us make sure that patients are following their treatment plans. The same diligent observation is needed when it comes to the use of opioid medications and pain management.

Difficult to Know Who Is at Risk

Ideally, patients who are at risk for drug abuse or misuse would be readily identifiable. They would exhibit a set of distinct signs and symptoms that would allow primary care providers to know they need help—and to get them treatment quickly. Some signs of misuse or abuse often do exist (eg, early refill requests, lost or stolen medication, presenting to the office impaired). However, misuse and abuse are undoubtedly difficult to identify in many patients. In fact, a 2003 study by Katz et al.[4] found that behavioral monitoring alone detected only 32% of "problem" patients (defined as

patients who had either an inappropriate positive urine toxicology, or who displayed one or more aberrant drug-taking behaviors). In comparison, urine drug testing was able to identify 49% of those patients. This demonstrates the difficulties in detecting patients who are having problems with treatment adherence. Urine drug testing (in combination with behavioral monitoring) may help physicians identify patients who need help. It is an invaluable tool since it may help in identifying the disease of addiction, which often has no signs.

This section has described the many reasons why urine drug testing in clinical settings is critical to helping protect your patients, your practice, and the general public. Testing may help you identify patients who are having problems with treatment adherence—whether it is abuse or misuse—and start them on the path to better health.

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2. Topics in Brief: Prescription Drug Abuse. National Institute on Drug Abuse Web site. http://www.drugabuse.gov/publications/topics-in-brief/prescription-drug-abuse. Updated December 2011. Accessed December 19, 2012.
3. Policy Impact: Prescription Painkiller Overdoses. Centers for Disease Control and Prevention Web site. http://www.cdc.gov/homeandrecreationalsafety/rxbrief/. Updated November 29, 2012. Accessed December 19, 2012.
4. Katz, NP, Sherburne S, Beach M et al. Behavioral monitoring and urine toxicology testing in patients receiving long-term opioid therapy. *Anesth Analg*. 2003;97(4):1097-102.

Case Study:
Why to Test

Not an actual patient

Patient:
A 78-year-old male with spinal stenosis presents for treatment. He is generally resistant to medication, but has agreed to take it at his daughter's insistence.

Prescription:
3 hydrocodone/acetaminophen weekly

Patient behavior:
Never calls in early for refills. Due to a recent drug testing policy, laboratory urine drug test is conducted, and the patient tests negative for hydrocodone. The patient says he took a dose 12 hours prior to his test.

Key considerations:

- The low, infrequent dosage may not trigger a positive test result, even if he is taking it as prescribed.
- The patient may not be taking his medication as he describes. A higher prevalence of memory problems and forgetfulness among aging patients may play a role in his treatment adherence.
- Someone in the patient's family may be taking the medicine; he may be the victim of coercion or threats to supply a loved one with drugs.
- The patient may be a fast metabolizer of the medication; he may metabolize the medication faster than the average person, causing a negative test result.
- He may be selling his medication (the possibilities are numerous).

As this case demonstrates, urine drug testing can alert you to a problem and allow you to delve deeper into a patient's behavioral patterns and history. This will allow you to explore all of the possible scenarios that may account for the negative result.

Who to Test and When to Test

Having read about the risks associated with prescribing opioids for chronic pain patients, some physicians may be tempted to consider the option of simply never prescribing opioids. While such a stance may seem to provide a quick and easy solution, it would result in numerous patients suffering unnecessary pain due to under-treatment.

Thus, recognizing that responsible opioid prescribing is an important tool to use when managing chronic pain, it becomes essential that prescribers know how to effectively use UDT to help identify and reduce the risks of misuse and abuse.

There are arguments for and against standardized guidelines for urine drug testing in the clinical pain practice: guidelines could help streamline the process of identifying patients who are misusing or abusing opioids, but they may also prevent the individualized level of treatment that can truly provide the most patient benefit.

In practice, the decision is left up to you, the primary care provider, to help determine the best course of action for each of your patients. This can be difficult—throughout the course of an already busy day, you must determine which patients should be tested, what type of test to use, and how often to test them. Should you conduct random adherence tests? Conduct routine tests every few months?

There are many patient and practice circumstances to take into account—how do you sort through it all and determine the best approach to UDT? This section outlines some best practices in determining which patients to test, and how frequently to test them.

Risk Assessment and Patient Behavior

There is no foolproof method for determining prescription drug misuse or abuse in your patient population. Though some statistics may suggest that you can gauge risk from external factors (for example, men are more likely than women to die of prescription painkiller overdoses[1]), there are no hard and fast rules for determining which patients are at risk.

Your best tools for doing this are to combine interviews and patient observation with one or more risk assessment tools. Several risk assessment tools have been developed to help you strategically determine which patients should be tested, and with what frequency (see following section).

However, it is important to combine these models with your own patient observations and interviews. In general, you should be interested in patients' past and current behaviors, and their history of substance abuse (both their own and family history). You should be on the lookout for the following behaviors/risk factors:

- New patients to be started on opioids (Note: In instances when new patients present with acute pain, UDT may be impractical. However, the provider should still be alert for risk factors.)
- New patients who are already taking opioids when they present for care
- Individuals who are making a major change in rational pharmacotherapy
- Patients who resist a full evaluation
- Patients who request a specific drug (even though it might be a valid request)
- Patients who display aberrant behavior
- Patients who exhibit mental health problems
- Patients who smoke cigarettes

WHAT YOU NEED TO KNOW

You can't judge a book by its cover. There are no clear signs of opioid abuse—but urine drug testing may help.

WHAT YOU NEED TO KNOW

Combine risk assessment models with patient observation to help determine which patients should be considered for UDTs

Risk Assessment Models

Several risk assessment models have been designed to help you assess your patients' risk of prescription drug non-adherence. These include:

- Screener and Opioid Assessment for Patients with Pain (SOAPP® or SOAPP-R)
- Diagnosis, Intractability, Risk Efficacy (DIRE)
- Opioid Risk Tool (ORT)
- Screening, Brief Intervention, and Referral to Treatment (SBIRT)
- Current Opioid Misuse Measure (COMM®)

It is important for you to become familiar with the various tools available, and to get comfortable with a tool before integrating it into your practice. Understanding the types of information that these models attempt to capture, and the benefits and limitations of each tool, can allow you to efficiently implement them in your patient population.

How Often to Screen

As with your decision about which patients to screen, one of your best tools in determining how often to utilize UDT and risk screening is your clinical judgment. What is best for each patient depends on his or her condition and available treatment options.

Table 2: Opioid Risk Tool (ORT) Example[2]

Mark each box that applies	Female	Male
1. Family hx of substance abuse Alcohol Illegal Drugs Prescription drugs	❑ 1 ❑ 2 ❑ 4	❑ 1 ❑ 2 ❑ 4
2. Personal hx of substance abuse Alcohol Illegal Drugs Prescription drugs	❑ 3 ❑ 4 ❑ 5	❑ 3 ❑ 4 ❑ 5
3. Age (mark box if 16-45)	❑ 1	❑ 1
4. Hx of preadolescent sexual abuse	❑ 3	❑ 3
5. Psychologic disease ADD, OCD, bipolar, schizophrenia Depression	❑ 2 ❑ 1	❑ 2 ❑ 1
Scoring totals:		

Scoring (Risk)
0-3 Low Risk
4-7 Moderate Risk
≥ 8 High Risk

"I found that the ORT is really very practical and easy to fill out right there in the office. I've timed this—in less than a minute, you can get it filled out." –Bill H. McCarberg, MD

Case Study: Who to Test

Not an actual patient

Patient:
A 55-year-old male with hip pain from avascular necrosis of the right hip refuses surgery. Unemployed.

Prescription:
Taking oxycodone ER, 80mg x 3 day

Patient behavior:
Refuses UDT, says it is an invasion of his privacy.

Key considerations:

- The patient's refusal to test may raise red flags and could signal that there is a problem with adherence.
- It is the patient's right to refuse UDT; however, it also the primary care provider's right to limit treatment choices such as an opioid medication.
- Express to your patient that a treatment plan must be mutually agreed upon by the physician and patient before writing the first prescription for the opioid class of medication; it is not sufficient for only one party to support regular drug testing.
- You may continue to take care of your patient's other health needs, but you can express that you cannot prescribe him pain medications.
- Express that your goal is not to invade his privacy; instead, UDT is a fundamental part of your clinical practice.

While many state boards recommend testing at the start of treatment, this is not always practical or desirable. Some patients may need to be tested more often than others. This will help you gather more data which can help you paint an overall picture of your patient's health and treatment needs.

In general, the higher level of ascertained risk, the more frequently you should test a patient. Besides your patient's health, public health concerns, and the concerns of your practice, the frequency of testing also has economic impacts. It is important to take all of these factors into consideration when developing a plan for UDT frequency.

Remember that UDT is a **part of the ongoing treatment plan.** UDT can help a physician's management of chronic pain, and increase communication and education with the patient. Thus, UDTs give information to make appropriate changes in the treatment plan when indicated.

References

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2. Webster LR, Webster RM. Predicting Aberrant Behaviors in Opioid-Treated Patients: Preliminary Validation of the Opioid Risk Tool. *Pain Med*. 2005;6(6):432-42.

How to Test

At this point, you may have determined that urine drug testing for opioid adherence is important in pain management, and you may have developed a system for identifying which patients to test, and how frequently to test them. Now, where do you start?

This section provides detail on how to conduct urine drug testing, why urine is generally preferred to other substances, such as saliva and blood, and the different types of UDTs you may choose to use.

Why Urine Drug Testing?

Urine drug testing has become the gold standard for drug testing for a number of reasons. First, it has a longer window of detection when compared to blood testing. Next, it is generally less costly than testing blood. Finally, the procedure is non-invasive, which can make it a more convenient and patient-friendly approach to drug testing. Because of these reasons, urine is often considered the best biological specimen for determining the presence of certain agents in the body.

Types of Urine Drug Tests

There are two main types of urine drug tests: point-of-care (POC) tests and laboratory-based tests. POC testing involves a urine drug cup being collected in the office, and then being read immediately by office laboratory or regular office staff.

Several advantages and disadvantages of each type of test must be considered when determining which test you should use for your patients. Laboratory tests are more sensitive than POC tests, and quantitative, confirmatory testing using chromagraphic methods such as GC/MS provides definitive parent drug identification and/or their metabolite. POC tests offer convenience and presumptive identification of positive results. The following chart details the benefits, limitations, and suggested use of POC and laboratory tests.

WHAT YOU NEED TO KNOW

Urine has become the "gold standard" for drug testing because of its window of detection, its cost, and because it is non-invasive.

Table 3: POC vs Laboratory-based Tests

	Advantages	Disadvantages	Suggested Use
POC	• Convenient • Rapid • Less expensive	• Potential false-positives / negatives • Less sensitive • Higher cutoff • Result interpretation may vary by individual reading • May only identify the class of opioids, not specific opioid in most cases	• Primarily suitable only for emergency settings
Laboratory	• More precise • More sensitive • Able to detect more substances (can identify specific drugs, opioids, and their metabolites)	• Takes longer • Less convenient • More expensive • Testing requires expensive instrumentation and trained staff	• The gold standard for ongoing chronic pain patient care

Cost Concerns

The realities of UDT costs can greatly impact your ability to implement testing in your practice. Some patients may refuse to be tested because of their concerns that the procedure is too expensive.

To address these concerns, it is important that you become as well informed as possible about the cost of UDT at laboratories in your area, and the portion of these costs that is covered by patient insurance. Point-of-care testing does offer a more affordable option than lab testing; however, you should make sure that your patient fully understands the potential for reduced long-term costs with the more sensitive and reliable laboratory-based tests.

Interpreting Results

Interpreting UDT results can be very complex, and an accurate reading is important to both your patients and your practice. Challenges may arise concerning the amount of time the drug is detectable in the urine, the amount of urine necessary for an accurate result, and the existence of other substances that may result in a false-negative or false-positive.

A few procedures can help you ensure that you are improving the reliability of your test results. These include monitoring the color and temperature of the urine, and making sure that you have enough urine for an accurate result.

Another important part of interpreting UDT results is understanding how long various drugs remain in the system. While some drugs can be detected weeks after they have been in the body, others only last for several hours.

Table 4: Detection Times of Common Drugs of Misuse

Drug	Approximate Retention Time
Amphetamines	Up to 3 days
Barbiturates	Short-acting (eg, secobarbital), 24 hours Long-acting (eg, phenobarbital), 2-3 weeks
Benzodiazepines	Dependent on specific drug and quantity use: days to weeks
Cannabinoids	Dependent on grade and frequency of use: • Single use: 1 to 3 days • Chronic use: Up to 30 days
Cocaine	2-4 days, metabolized
Ethanol	2-4 hours
Methadone	Up to 3 days EDDP (methadone metabolite): Up to 6 days
Opiates	2 to 3 days
Phencyclidine	Approximately 8 days Up to 30 days in chronic users (mean value = 14 days)

Case Study:
How to Test

Not an actual patient

Patient:
A 27-year-old female presents with low back pain.

Prescription:
6 oxycodone/acetaminophen

Patient behavior:
Point-of-care care test result is unexpectedly negative. The patient is unwilling to undergo a lab test to confirm due to its perceived expense.

Key considerations:

- A negative urine drug test raises numerous possibilities, such as binging, not having the financial resources to fill the whole prescription, diversion, or being a fast metabolizer.
- Additionally, the young patient and non-specific pain condition also raise the risk of drug abuse.
- However, many other factors may be involved. Examine the patient's complete history; the better overall picture you have, the better your ability to assess the results.
- Is this the first negative test? If all of the previous tests have been positive, have a discussion with your patient to try to determine the causes for the abnormal result.
- If diversion is suspected, randomly ask your patient to bring in her medication and compare it to the amount of drugs she should have left.
- Attempt to strengthen the physician-patient relationship, rather than undermine it—stress that you are trying to get the root of the problem, not accuse her of any wrongdoing.
- POC will not detect a semi-synthetic opioid such as oxycodone unless the immunoassay is specific for that drug.

WHAT YOU NEED TO KNOW

Urine volume should be 30 mL or more.

Urine temperature should be noted within 4 minutes of voiding, and range in temperature from 90°F to 100°F.

Urine with a temperature outside of this temperature range should raise a red flag for the physician.

Talking to Your Patients About UDT

One of the more difficult parts of implementing regular urine drug testing in your practice is determining how to talk to your patients about the benefits of testing. While some patients may comply, others may express hesitation—or even flat out refuse.

Every patient is different, and there is no right or wrong way to talk about UDT. The following sections provide advice for tackling three important UDT conversations with your patients.

Introducing the Patient to UDT

An early conversation with your patient about expectations for drug testing is essential to ensuring that you both agree on their treatment plan. The introduction of a formal, written agreement can help standardize the process and alleviate concerns of being "singled out." Express to your patient that you make an agreement with all of your patients based on their particular needs. Additionally, use this time to answer any questions your patient may have about testing procedures.

Working with the Hesitant Patient

After you have explained the benefits of UDT for pain management, your patient may express concern about the stigma associated with urine drug testing. *You don't trust me? You think I'm an addict?* Many patients feel that even the suggestion of a test is an accusation that they are doing something wrong. One way to handle this concern is to express that UDT is an important part of your practice, and that you regularly conduct tests to ensure treatment adherence and effectiveness. If your patient still refuses the tests, explain that it is his or her right to do so—but that it may affect the treatment options you are able to provide.

Addressing Unexpected Results

Finally, you must consider the conversation that you will have with a patient if the test results come back and they are inappropriately either positive or negative. If this is the case, you must try to get to the root of the reasons for this unexpected result. Remember, an abnormal test result does not always signal drug abuse. If abuse is suspected, you may wish to consider referring your patient to an addiction specialist so that he or she can receive proper treatment. Referrals should be made whenever you feel that you don't have enough experience or education to address your patient's problem, or if you have cause to feel uncomfortable discussing an unexpected result with your patient.

Talking to your patients about urine drug testing—what it is, why they should have it, how often it is required—and responding to unexpected results, can be difficult. Depending on your relationship with the patient, you may wish to alter your approach to the UDT conversation. In general, a focus on making sure that you listen to patient concerns while gently expressing your own can help facilitate a useful and non-confrontational discussion.

WHAT YOU NEED TO KNOW

Express to concerned patients that UDT is an integral part of your practice, and that you regularly conduct tests to ensure treatment adherence and medication effectiveness.

Frequently Asked Questions

Where can I find more information about my state's recommendations for opioid prescribing?

The Federation of State Medical Boards has developed a policy statement on opioid prescribing which outlines strategies for limiting the risk of opioid addiction, abuse, and diversion. The majority of states have adopted this policy statement (or a modified version); it recommends the appropriate use of urine drug testing to protect patients, medical practices, and society. Contact your state medical board for more information about recommendations and policies in your state.

How accurate are popular risk assessment measures in predicting aberrant drug-related behaviors?

The SOAPP assessment and doctor-conducted ORT have been found to be two of the most predictive models. However, the measures vary in their accuracy rates. Because of this, it is important to combine the models with patient interviews and behavioral assessment so that you have a wealth of information to use when making treatment and testing recommendations. It is important to note that the ORT has been shown to be more accurate when administered by the provider. See the chart below for information on the accuracy of risk assessment measures.

Why aren't hair and blood popularly used in prescription drug testing?

Urine has become the gold standard when performing laboratory drug testing. Other specimens, such as blood, sweat, hair, and nails, all provide different levels of sensitivity and detection time. Hair, for example, is expensive to test, and it raises concerns about racial bias. Blood is difficult to collect, has a shorter window of detection, and can be more expensive than urine testing. For these reasons, urine is generally the preferred substance for drug testing.

A POC test shows that a patient is negative for a prescribed substance. She says that it was an accident—she lost her medications—and she needs a new prescription. I don't want to deny her treatment if it truly was an error. Should I prescribe her more pain medications while I attempt to sort through the abnormal results?

This is a case where you have to use your clinical judgment to determine whether to continue to prescribe pain medications. You may wish to write a smaller prescription than normal—instead of her usual 30 day supply, for example, prescribe just enough medications until you are able to receive a more detailed lab report, or to conduct more interviews with the patient to assess her

Table 5: Accuracy in Predicting Discharge (Aberrant Drug-related Behaviors)

Measure	% Accuracy Rate
Interview	77%
SOAPP	72%
ORT	45%
DIRE	17%

risk of abuse or misuse. While you should not immediately accuse the patient of wrongdoing, you do need to confirm that she is adherent to her treatment regimen.

What should I do if a patient's urine drug test shows a cannabanoid, in addition to the opioids I have prescribed?

This is a common and complex problem. First, you should consider whether you have the education, comfort level, and resources to take care of the patient on your own—you may require the help of a specialist to fully address all of your patient's needs.

Additionally, you may wish to explain that as marijuana is an illicit drug in most states, you are not comfortable prescribing an opioid when he or she is taking marijuana. You should also explain your concerns about possible marijuana-drug interactions.

If the patient tells you that they are using marijuana for medicinal purposes, and that it has been prescribed by another physician, express your discomfort with their receiving two different prescriptions from two different medical professionals for the same condition. It may be helpful to make this clear in your physician-patient treatment agreement.

Notes:

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