THE IMPORTANCE OF CHART DOCUMENTATION: THROUGH THE EYES OF A CHART REVIEWER

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DISCLOSURE

• Consultant/Independent Contractor: McNeil Pharmaceuticals, Purdue Pharmaceuticals
• Speaker's Bureau: AstraZeneca, Depomed Pharmaceuticals, Iroko Pharmaceuticals
LEARNING OBJECTIVES

• Describe the balance of all factors associated with safe opioid prescribing.
• List specific items that should be included in a complete EHR when caring for chronic pain patients.
• Explain the pitfalls associated with use of an EHR when caring for the chronic pain patient.
THE GOAL OF PAIN MANAGEMENT

INCREASE A PATIENT’S QUALITY OF LIFE
THE ELECTRONIC HEALTH RECORD PRO’S

A 2008 study in the *Archives of Internal Medicine*, malpractice payouts correlate inversely with EHR use

WHY?

improved follow-up and legibility,

Because it reduces adverse outcomes and made providers more defensible if sued.

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THE ELECTRONIC HEALTH RECORD CON’S

• Beautifully templated and perfectly legible can also be laden with pages of irrelevant repetitions

• Perfect tracking of who accessed the record and when they did so and what changes were made can lead to serious questions about a provider’s own conduct.

• Prompts that are designed to ensure that abnormal results are followed-up on and alerts that can avert adverse medication reactions can actually be ignored in a sea of data.
THE ELECTRONIC HEALTH RECORD CON’S

• Prescriptions that can be generated with a single click can lead to serious errors because they are being done with a degree of automaticity

• EHRs are time-stamped and time-stamping is fully discoverable

• Creates a trail of access and modification, a true “digital fingerprint”.

IF YOU ARE SUED

Malpractice Carriers now recommend….

To NOT immediately review the record and to instead wait for a hard copy from the carrier.

A sudden review of the chart can be suggestive of doubts or question of the care they rendered
EHR “DULLING OF THE SENSES”

• “Alert Fatigue”
  - 150 alerts a day about matters ranging from redundancy to suggested follow-up to dosage discrepancies to drug interactions
  - Simply start ignoring the alerts

• With so many alerts, we can forget to check pertinent information before prescribing
  - Worsening renal disease vs NSAIDs

**There is discoverable digital proof that the red flag was, in fact, waved**

THE PROBLEM WITH AUNT BETTY’S FALL

Cloning Your Chart: The “COPY AND PASTE” feature can cause trouble!

WATCH OUT
ESTABLISH A DIAGNOSIS
PAIN IS NOT A DIAGNOSIS....IT’S A SYMPTOM

• Pain Management is not without liability

• Your liability greatly increases, if you treat a patient with controlled substances without a firm diagnosis

WHAT KIND OF PAIN IS IT?

• Neuropathic pain
• Musculoskeletal Pain
• Inflammatory Pain
• Mechanical/Compressive Pain
NOT A PANACEA

Rate of Unintentional Drug Overdose Deaths in the United States, 1970-2007

NON-PHARMACOLOGICAL INTERVENTIONS
DOCUMENT THEM!

Physical therapy
Massages
Yoga
TENS
Walking
Music/Art
INTERVENTIONS FOR PAIN TREATMENT
WHAT HAS BEEN TRIED?

• Trigger Point Injections
• Epidural Blocks
• Implantable Pain Stimulators
• Botox injections for Migraines

Even if these therapies have been failed…. This is important

THE 4 PILLARS OF ORAL PAIN THERAPY

1) Anti-inflammatories  3) Mood Modulators
   • SNRIs
   • SSRIs

2) Anticonvulsants

4) Opiates
WHEN OPIOIDS ARE APPROPRIATE

THE PAIN ASSESSMENT
CLINICAL INTERVIEW: PATIENT MEDICAL HISTORY

Illness relevant to (1) effects or (2) metabolism of opioids

1. Pulmonary disease, constipation, nausea, cognitive impairment
2. Hepatic, renal disease

Illness possibly linked to substance abuse; eg:
- Hepatitis
- HIV
- Tuberculosis
- Cellulitis
- STIs
- Trauma, burns
- Cardiac disease
- Pulmonary disease


CLINICAL INTERVIEW: PAIN & TREATMENT HISTORY

Description of pain

- Location
- Intensity
- Quality
- Onset/Duration
- Variations/Patterns/Rhythms

What relieves the pain?

What causes or increases pain?

Effects of pain on physical, emotional, and psychosocial function

Patient's pain & functional goals

CLINICAL INTERVIEW: PAIN & TREATMENT HISTORY, CONT’D

Pain Medications

<table>
<thead>
<tr>
<th>Past use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current use</td>
</tr>
<tr>
<td>• Query state PDMP where available to confirm patient report</td>
</tr>
<tr>
<td>• Contact past providers &amp; obtain prior medical records</td>
</tr>
<tr>
<td>• Conduct UDT</td>
</tr>
</tbody>
</table>

Dosage

| For opioids currently prescribed: opioid, dose, regimen, & duration |
| Important to determine if patient is opioid tolerant |

General effectiveness

Nonpharmacologic strategies & effectiveness

PERFORM THOROUGH EVALUATION & ASSESSMENT OF PAIN

Seek objective confirmatory data  Components of patient evaluation for pain  Order diagnostic tests (appropriate to complaint)

General: vital signs, appearance, posture, gait, & pain behaviors  Musculoskeletal Exam • Inspection • Palpation • Percussion • Auscultation • Provocative maneuvers  Neurologic exam  Cutaneous or trophic findings

ASSESS RISK OF ABUSE, INCLUDING SUBSTANCE USE & PSYCHIATRIC HX

Obtain a complete Hx of current & past substance use

- Prescription drugs
- Illegal substances
- Alcohol & tobacco
  - Substance abuse Hx does not prohibit treatment w/ ER/LA opioids but may require additional monitoring & expert consultation/referral
- Family Hx of substance abuse & psychiatric disorders
- Hx of sexual abuse

**Social history also relevant**

Employment, cultural background, social network, marital history, legal history, & other behavioral patterns


RISK ASSESSMENT TOOLS: EXAMPLES

<table>
<thead>
<tr>
<th>Tool</th>
<th># of Items</th>
<th>Administered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients considered for long-term opioid therapy:</td>
<td></td>
<td></td>
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<tr>
<td>ORT Opioid Risk Tool</td>
<td>5</td>
<td>By patient</td>
</tr>
<tr>
<td>SOAPP® Screen &amp; Opioid Assessment for Patients w/ Pain</td>
<td>24, 14, &amp; 5</td>
<td>By patient</td>
</tr>
<tr>
<td>DIRE Diagnosis, Intractability, Risk, &amp; Efficacy Score</td>
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<td>By clinician</td>
</tr>
<tr>
<td>Characterize misuse once opioid treatments begins:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PMQ Pain Medication Questionnaire</td>
<td>26</td>
<td>By patient</td>
</tr>
<tr>
<td>COMM Current Opioid Misuse Measure</td>
<td>17</td>
<td>By patient</td>
</tr>
<tr>
<td>PDUQ Prescription Drug Use Questionnaire</td>
<td>40</td>
<td>By clinician</td>
</tr>
<tr>
<td>Not specific to pain populations:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CAGE-AID Cut Down, Annoyed, Guilty, Eye-Opener Tool, Adjusted to Include Drugs</td>
<td>4</td>
<td>By clinician</td>
</tr>
<tr>
<td>RAFFT Relax, Alone, Friends, Family, Trouble</td>
<td>5</td>
<td>By patient</td>
</tr>
<tr>
<td>DAST Drug Abuse Screening Test</td>
<td>28</td>
<td>By patient</td>
</tr>
<tr>
<td>SBIRT Screening, Brief Intervention, &amp; Referral to Treatment</td>
<td>Varies</td>
<td>By clinician</td>
</tr>
</tbody>
</table>
**OPIOID RISK TOOL (ORT)**

Mark each box that applies

<table>
<thead>
<tr>
<th></th>
<th>Female</th>
<th>Male</th>
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</thead>
<tbody>
<tr>
<td>1. Family Hx of substance abuse</td>
<td></td>
<td></td>
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<tr>
<td>Alcohol</td>
<td>□ 1</td>
<td>□ 3</td>
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<tr>
<td>Illegal drugs</td>
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<td>□ 3</td>
</tr>
<tr>
<td>Prescription drugs</td>
<td>□ 4</td>
<td>□ 4</td>
</tr>
<tr>
<td>2. Personal Hx of substance abuse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol</td>
<td>□ 3</td>
<td>□ 3</td>
</tr>
<tr>
<td>Illegal drugs</td>
<td>□ 4</td>
<td>□ 4</td>
</tr>
<tr>
<td>Prescription drugs</td>
<td>□ 5</td>
<td>□ 5</td>
</tr>
<tr>
<td>3. Age between 16 &amp; 45 yrs</td>
<td>□ 1</td>
<td>□ 1</td>
</tr>
<tr>
<td>4. Hx of preadolescent sexual abuse</td>
<td>□ 3</td>
<td>□ 0</td>
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<td>5. Psychologic disease</td>
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<td></td>
</tr>
<tr>
<td>ADD, OCD, bipolar, schizophrenia</td>
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<td>□ 2</td>
</tr>
<tr>
<td>Depression</td>
<td>□ 1</td>
<td>□ 1</td>
</tr>
</tbody>
</table>

**Administer**

- On initial visit
- Prior to opioid therapy

**Scoring (risk)**

- 0-3: low
- 4-7: moderate
- ≥8: high

**Scoring Totals**:  

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**WHEN TO CONSIDER A TRIAL OF AN OPIOID**

- Pain is moderate to severe
- Failed to adequately respond to nonopioid & nondrug interventions
- No alternative therapy is likely to pose as favorable a balance of benefits to harms
- Potential benefits are likely to outweigh risks
- Consider referral to pain or addiction specialist for patients where risks outweigh benefits
- Long-acting Opioids: When Continuous, around-the-clock opioid analgesic is needed for an extended period of time

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Department of Veterans Affairs, Department of Defense, VA/DoD Clinical Practice Guideline for Management of Opioid Therapy for Chronic Pain. 2010.
INITIATING & TITRATING: OPIOID-NAÏVE PATIENTS

Drug & dose selection is critical

Some ER/LA opioids or dosage forms are only recommended for opioid-tolerant patients
Check individual drug PI

Monitor patients closely for respiratory depression

Especially within 24-72 h of initiating therapy & increasing dosage

Individualize dosage by titration based on efficacy, tolerability, & presence of AEs

Check ER/LA opioid product PI for minimum titration intervals
Supplement w/ IR analgesics (opioids & nonopioid) if pain is not controlled during titration

REASONS FOR DISCONTINUING OPIOIDS

No progress toward therapeutic goals
Intolerable & Unmanageable AEs
Pain level decreases in stable patients

Nonadherence or unsafe behavior

• 1 or 2 episodes of increasing dose without prescriber knowledge
• Sharing medications
• Unapproved opioid use to treat another symptom (e.g., insomnia)

Aberrant behaviors suggestive of addiction &/or diversion

• Use of illicit drugs or unprescribed opioids
• Repeatedly obtaining opioids from multiple outside sources
• Prescription forgery
• Multiple episodes of prescription loss

UTILIZE A PPA
Reinforce expectations for appropriate & safe opioid use

- Obtain opioids from a single prescriber
- Fill opioid prescriptions at a designated pharmacy
- Safeguard opioids
  - Do not store in medicine cabinet
  - Keep locked (e.g., use a medication safe)
  - Do not share or sell medication
- Instructions for disposal when no longer needed
- Commitments to return for follow-up visits
- Comply w/ appropriate monitoring
  - E.g., random UDT & pill counts
- Frequency of prescriptions
- Enumerate behaviors that may lead to opioid discontinuation
- An exit strategy

31 | © CO*RE 2013

MONITOR ADHHERENCE AN ABERRANT BEHAVIOR
Routinely monitor patient adherence to treatment plan

- Recognize & document aberrant drug-related behavior
  - In addition to patient self-report also use:
    - State PDMPs, where available
    - UDT
      - Positive for nonprescribed drugs
      - Positive for illicit substance
      - Negative for prescribed opioid
- Family member or caregiver interviews
- Monitoring tools such as the COMM, PADT, PMQ, or PDUQ
- Medication reconciliation (e.g., pill counts)

MAIN TYPES OF UDT METHODS

**Initial testing** w/ IA drug panels:
- Classify substance as present or absent according to cutoff
- Many do not identify individual drugs within a class
- Subject to cross-reactivity
- Either lab based or at POC

**Identify specific drugs** &/or metabolites w/ sophisticated lab-based testing; e.g., GC/MS or LC/MS*:
- Specifically confirm the presence of a given drug
- e.g., morphine is the opiate causing a positive IA*
- Identify drugs not included in IA tests
- When results are contested

* GC/MS=gas chromatography/mass spectrometry  IA=immunoassay  LC/MS=liquid chromatography/mass spectrometry


**Use Patient Counseling Document to help counsel**

Download:

Order hard copies:
[www.minneapolis.cenveo.com/pord/SubmitOrders.aspx](http://www.minneapolis.cenveo.com/pord/SubmitOrders.aspx)
CLINICAL PEARLS OF DOCUMENTATION

• Don’t Forget Aunt Betty’s Fall

• Remember DIAGNOSIS is vital!

• IF the pain increases or changes – order appropriate tests and make appropriate referral

• Don’t just check a box – Do something and document

CLINICAL PEARLS OF DOCUMENTATION CONT’D

• Age matters – extra documentation to support opiates in patients younger than 45 years of age

• NAS – Neonatal Abstinence Syndrome….. Document on all female patients 15-55 years of age

• What did you prescribe, how much, how many?
QUESTIONS?

Thank You