unScripted
Volume 2 Issue 2 September 2023
*updated October 23, 2023

IN THIS ISSUE

Bridging the Gaps Using Evidence and Morals: Toolkit 1
Medication Diversion 2
Drug Spotlight: Baclofen 3
Put into Practice: Case Discussion 4

Published by

PRESCRIPTION REVIEW PROGRAM
education | collaboration

OATP Opioid Agonist Therapy Program

prp@cps.sk.ca
oatp@cps.sk.ca

The PRP and OATP are programs administered by the

CPSS College of Physicians and Surgeons of Saskatchewan

cps.sk.ca

BRIDGING THE GAPS USING EVIDENCE AND MORALS:

Having Safe Conversations Involving Polarizing Topics

The root cause of divisiveness is often the result of moral, political and ethical ideologies, rather than lack of knowledge. While there may be no "right" answer in a debate, the goal is to arrive at evidence-informed decisions.

Several examples in the literature address polarizing topics in healthcare because such discussions have negative impacts on patients. Unsafe conversations have been found to contribute to provider hesitancy, fear, misinformation and stigma.

Toolkit for Conducting Safe Conversations

Do...

- Create a psychologically safe environment.
- Ensure everyone involved has a baseline understanding of the topic/definitions being debated (i.e. "what defines harm reduction") to reduce misunderstanding and miscommunication.
- Incorporate both emotional statements (specifically, lived experiences) and good quality evidence.
- Leave room for all to state their evidence and emotional viewpoints.
- Self-reflect on bias, moral, and political beliefs.

Use both scientific evidence and emotional engagement when discussing controversial topics.

Do Not...

- Try to change deeply rooted values; it is nearly impossible to do so and often leads to conflict and entrenchment in ideologies.
- Use strong language (explicit language, slurs, insults)
- Exclusively rely on emotional pleas/evidence or view either as superior.
- Selectively incorporate evidence that aligns with personal ideologies.

Cont'd on p.2...

...cont'd from p.1

Thank you to pharmacy student, Julia, for reviewing and summarizing the literature for this article.

References:

Zampini, G.F. Evidence and morality in harm-reduction debates: can we use value-neutral arguments to achieve value-driven goals?. Palgrave Commun 4, 62 (2018). https://doi.org/10.1057/s41599-018-0119-3 https://www.nature.com/articles/s41599-018-0119-3#citeas

Kinston M, Dowell P, Mossburg S, et al. Annual Perspective: Psychological Safety of Healthcare Staff. Patient Safety Network. 2022, March 31. https://psnet.ahrq.gov/perspective/annual-perspective-psychological-safety-healthcare-staff

Rosen MA, DiazGranados D, Dietz AS, Benishek LE, Thompson D, Pronovost PJ, Weaver SJ. Teamwork in healthcare: Key discoveries enabling safer, high-quality care. Am Psychol. 2018 May-Jun;73(4):433-450. doi: 10.1037/amp0000298. PMID: 29792459; PMCID: PMC6361117. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6361117/#:~:text=Teamwork%20and%20Health%20Care%20Worker,%2C%20engaging%2C%20and%20resilient%20workplace.

O'Donovan, R., McAuliffe, E. Exploring psychological safety in healthcare teams to inform the development of interventions: combining observational, survey and interview data. BMC Health Serv Res 20, 810 (2020). https://doi.org/10.1186/s12913-020-05646-z

https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-020-05646-z#citeas

If you would like to write an article and/or have any ideas for topics that you and your colleagues might be interested in, please contact us.

MEDICATION DIVERSION

Diversion of Prescription Review Program (PRP) medications is an ongoing issue in the province of Saskatchewan. Diversion is a safety concern for both the patients and the public. The College of Physicians and Surgeons of Saskatchewan has been asked by members to provide further guidance on prescription diversion, including steps to take when diversion has been identified.

The College's Regulatory Bylaw 18.1 specifies drugs that are potentially abused, misused, or diverted. The PRP monitors for apparent inappropriate prescribing and inappropriate use of the medications included in bylaw 18.1.

In the interest of patient and public safety, physicians should be diligent in the prevention and management of the diversion of high-risk medications by considering the following:

1. To **PREVENT** medications from being diverted when prescribing:

- **Review regulatory bylaw 18.1(h), and ensure all required prescribing requirements are met** to prevent early refills and ensure intended quantities are dispensed. In doing so, if medications are taken as prescribed, there will not be 'extra' medication leftover at the end of that timeframe that could be diverted.
- In initial and follow up visits with patients prescribed PRP medications, **conduct a thorough clinical assessment to ensure that the medications are indicated** for the patients' medical conditions. Patients who are prescribed medications that are not indicated may fill these prescriptions and not take them, which is a potential opportunity for the medication to be diverted.
- **Observe/screen patients for aberrant drug related behaviour and for current and past alcohol, drugs, and illicit drug use.** There is a chance that patients who are struggling with addiction may resort to diverting PRP medications to fund substance use.
- **Assess the patient's social circumstances.** Patients who struggle to make ends meet may feel they must divert PRP medications to afford food/shelter. Refer patients to resources such as food banks and social services if they could benefit.
- **Establish a written treatment agreement** with informed consent to formalize expectations (i.e., patients will take medications as prescribed, medication will be stored safely). You may also choose to request that the patient's pharmacy assist with agreement monitoring.
- **Check PIP prior to prescribing** to ensure patients are not double doctoring (aka doctor shopping) to get multiple PRP prescriptions from multiple prescribers.
- **Ensure that the generic formulation is prescribed** where generics are available since brand-name medications often have a higher sale value.

2. To **MONITOR** for diversion of currently prescribed medications:

- **Observe for signs that a patient who legitimately needs PRP medications may be selling part of their prescription to supplement their income** (asking for larger numbers of pills, common loss of PRP medications or requesting early refills).
- **Perform random urine toxicology screens** as part of assessments to monitor for the presence of prescribed PRP medications in urine. If medication is diverted and

... cont'd on p.3

...cont'd from p.2

not taken as prescribed, it may be absent on a patient's urine drug screen. The 2017 *Canadian Guidelines for Opioids for Chronic Non-Cancer Pain* suggests and provides more information on implementing urine drug screens for patients prescribed opioids.

- **Request random "pill/medication audits" from the patient's pharmacy** whereby the patient must present to the pharmacy with remaining medication to ensure that the amount of medication remaining aligns with the dispensed date.

NEW!

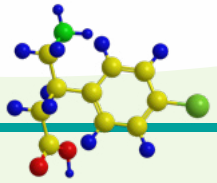
Pregabalin has been added to the Roy Romanow Provincial Laboratory Standard Urine Drug Screen.

3. To **MANAGE** clear evidence of prescription diversion:

- If you suspect a patient of drug diversion, **consider discussing the matter directly with that individual** unless doing so would put you or your staff in danger. Approach the situation in a curious, supportive and compassionate manner.
- **Address any of the patient's unmet needs** that may be contributing to the diversion of their medications. Refer the patient to social services, social workers, food bank, crisis housing, addiction treatment, etc.
- **Re-visit the treatment agreement** and discuss consequences for not following agreed upon requirements. It may also be beneficial to **discuss the indication of PRP prescriptions** with the patient to re-evaluate that the prescribed medications are both indicated and safe for the patient.
- **Reduce the quantity dispensed per fill**. Examples of this could be moving to a weekly/biweekly dispense, or daily witness ingestion dispensing schedule as appropriate.
- **Consider deprescribing or stopping the prescription if risks** (i.e., public, and patient harm from diversion) **outweigh benefits** (i.e., treating the patient). Consider tapering off medications as opposed to stopping abruptly if abrupt discontinuation would cause intolerable withdrawal or harm.
- If a suspected prescription diversion involves a known patient, it is important to **respect the confidentiality of patient health information** in accordance with the Health Information Protection Regulations, 2023. https://publications.saskatchewan.ca/api/v1/products/121741/formats/141021/download.
- Physicians who are unsure about how to proceed in responding to suspected unlawful prescription activity could **contact the CPSS or the CMPA for individual advice**.

All risk mitigation strategies and enhanced prescribing safeguards and decisions should be comprehensively documented. Please be advised that this is not a directive to cease prescribing for this patient and this notification should be used as a tool to assist with treatment planning.

Drug Spotlight: Baclofen



Baclofen is a skeletal muscle relaxant indicated for the treatment of spasticity with conditions such as multiple sclerosis or certain spinal cord injuries. Although it is often used off-label for low back spasms and musculoskeletal pain, there is no evidence for chronic use and should be limited to short term treatment (<1-2 weeks) only.

Similar to pregabalin and gabapentin, baclofen is a GABA analogue and can produce euphoric effects when ingested in excess or in addition to other drugs and alcohol. With reports of baclofen misuse and/or overdoses increasing, caution is warranted if used off-label for alcohol use disorder.

PRP monitoring of baclofen began in 2020; although daily doses of 80mg/day should not be exceeded, doses of 120mg or more are often prescribed throughout Saskatchewan. Ingestions of greater than 200mg produces significant toxicity in healthy adults; CNS and respiratory depression may occur after 50mg in the elderly.

Deprescribing may be considered for patients who are taking baclofen chronically in which there is little evidence to support long-term use (e.g. chronic low back pain) or where there is suspected misuse. Doses should be gradually tapered over 1 to 2 weeks to avoid risk of withdrawal symptoms such as hallucinations, seizures, hyperthermia, and confusion.

References:

Bell C. Baclofen overdose - CPS [Internet]. cps.sk.ca. medSask ; 2017 [cited 2022Nov23]. Available from: https://www.cps.sk.ca/iMIS/Documents/Baclofen%20Overdose.pdf

Regier L. Low Back Pain. RxFiles 13th ed. Saskatoon, SK: RxFiles; 2021.

Lexicomp: Baclofen

Reynolds K, Kaufman R, Korenoski A, Fennimore L, Shulman J, Lynch M. Trends in gabapentin and baclofen exposures reported to U.S. poison centers. Clin Toxicol (Phila). 2020 Jul;58(7):763-772. doi: 10.1080/15563650.2019.1687902.

Coons C, Bareham J. Alcohol Use Disorder (AUD): Drug Comparison Chart. RxFiles Drug Comparison Charts [Internet]. Published July 2023. Accessed August 3,2023. https://www-rxfiles-ca .ezproxy.shirp.ca/RxFiles/uploads/documents/members/CHT-Alcohol-Use-Disorder.pdf

DynaMed: Baclofen. Cited August 3, 2023.

Put into Practice: Case Discussion

Medical Conditions

- Intractable back pain (exacerbation after electrode placement to manage chronic interstitial cystitis)
- Bilateral knee osteoarthritis (awaiting a knee replacement)
- Bilateral foot pain from neuromas and fractures
- Insomnia

Medication Profile

- Oxycodone IR 160mg/day
  (240mg oral morphine equivalents)
- OxyNEO 60mg/day
  (90mg oral morphine equivalents)
- Zopiclone 15mg/day
- Lorazepam 0.5mg PRN

The patient was admitted to hospital for 2 months for pain management. Despite the recommendation by a physician with expertise is chronic pain to transition the patient to buprenorphine/naloxone in a supervised setting, all attending physicians refused due to "lack of qualifications" and/or "fear of reprimand by the CPSS". Thus, the patient was discharged on:

- Hydromorph Contin 36mg/day
  (180mg oral morphine equivalents)
- Hydromorphone 24mg/day
  (120mg oral morphine equivalents)
- Zopiclone 7.5mg/day
- Gabapentin 600mg/day

Pursuant to bylaw 19.1(e), A physician is not required to obtain approval from the Registrar to prescribe buprenorphine in its transdermal form, **nor is a physician required to obtain approval from the Registrar to prescribe methadone or buprenorphine solely for the purpose of pain control**.

There are many strategies for switching patients from a full mu opioid agonist to buprenorphine/naloxone. An example is provided below:

Switching patients from full mμ opioid agonists to buprenorphine/naloxone:

Day	Bup Dosing	Full Opioid Agonist
1	0.5mg SL once daily	Full dose
2	0.5mg SL twice daily	Full dose
3	1mg SL twice daily	Full dose
4	2mg SL twice daily	Full dose
5	4mg SL twice daily	Full dose
6	8mg SL once daily	Full dose
7	8mg SL in Am and 4mg SL in PM	Full dose
8	12mg SL once daily	Stop

Resources

RxFiles has several resources available:

https://www.rxfiles.ca/rxfiles/uploads/documents/books/pain.html

The USask Chronic Pain Clinic offers physician mentorship (306-966-6469).

Reference:

Terasaki D., et al. Transitioning Hospitalized Patients with Opioid Use Disorder from Methadone to Buprenorphine without a Period of Opioid Abstinence Using a Microdosing Protocol. Pharmacotherapy 2019;39(1): 1023-9.

Concerned about Prescription Drug Misuse and/or Trafficking?

Call the Prescription Review Program to report misuse of prescription drugs in your community at

1-800-667-1668

and/OR call your local Law Enforcement.

**The Prescription Review Program will accept anonymous calls if there is a reason the caller does not want to be identified.*