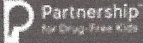


SEARCH AND RESCUE

EMPOWERING PRESCRIBERS TO IDENTIFY OPIOID ABUSE

GET A FREE 1-MINUTE RISK ASSESSMENT SCREENER.

USE OUR TOOLS TO HELP PREVENT OPIOID ABUSE >





RENEW OR SUBSCRIBE TO PPM

Subscription is FREE for qualified healthcare professionals in the US.

RENEW | SUBSCRIBE

 Print

 Tweet

 Subscribe or renew to PPM

Urine Drug Testing: What is Optimal Frequency and Duration?

By Valerie Weed, PsyD (/author/14429/weed) and Ted Jones, PhD (/author/2711/jones)

How often and for how long to screen patients taking high-risk medications was a hotly debated question at this year’s AAPM meeting. But the consensus appears to be that frequent screening early in the course of treatment is the best policy for uncovering medication-aberrant behavior (MAB).

In one study, investigators at Boston PainCare, with affiliations at Tufts School of Dental Medicine, Tufts School of Medicine, and Massachusetts General Hospital, looked at the rates of MAB using urine drug testing (UDT) data over a 12-month period.¹ What they found was that 38% of the patients had a least 1 inconsistent UDT and 7.6% of all UDTs administered were inconsistent over the 12-month period. With this rate of inconsistent UDTs, “monthly screening could take up to 13 months to identify an aberrancy, while semi-annual screening could take up to 78 months,” noted the investigators.

At Boston PainCare, which has its own in-house UDT laboratory, both the frequent screening and clinicians’ knowledge of how to effectively address inconsistent UDTs has reduced their rate of MABs. Patients prescribed opioids are enrolled into a medication management program. Patients are initially screened using an opioid risk evaluation, and offered a medication care plan based on their level of risk.

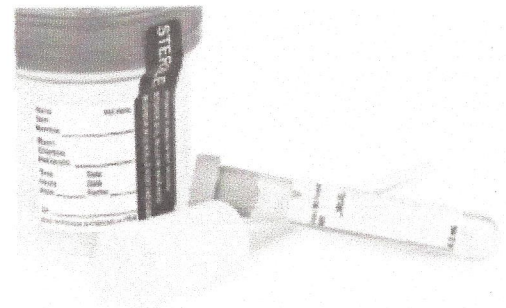
“Our highest-risk patients, perhaps those patients who have complex medical problems or those who have comorbid substance abuse or comorbid psychiatric concerns, are scheduled to come in once a week for eight weeks,” noted Valerie Weed, PsyD, a psychology fellow. “This allows us to provide high-risk patients with structure, behavioral interventions to address concerning medication behaviors, and ensure that they really have the support in place in order to safely use these medications.”

Additionally, before patients are given their first prescription, they are given an opioid contract and are required to attend an education workshop called Med-Ed.

By conducting more frequent UDTs, “we are able to uncover MAB much sooner,” Dr. Weed told *Practical Pain Management*. In addition, “the behavioral staff will provide education about the risks, put into place structure for appropriate use, and implement corrective action if there is a problem. We think that having both this monitoring and response system is really what has been able to decrease our frequency of MABs.”

When to Reduce Frequency of UDT?

Ted Jones, PhD, of Pain Consultants of East Tennessee, in Knoxville, and his colleagues presented a poster that looked at the length of time in treatment and its correlation with MAB.² “We found that if people are going to violate their treatment agreement—test positive for an illicit drug—they are going



(<https://www.practicalpainmanagement.com/sites/default/files/imlarge/images/2015/05/07/2.png>)

to do so within the first year of treatment, in general. Of course, some people will mess up 5 years or 10 years down the road, but, generally, it's [during] the first year [that] most people engage in MAB. We also found that this was true even for high-risk people."

What does this mean in terms of monitoring? "Right now, the field doesn't have a protocol for turning off monitoring. If a patient comes in and they are considered medium- or high-risk, we watch them, we test them, we give them a drug screen every month—and that does not stop." What is not known is what duration of monitoring is enough.

Therefore, Dr. Jones and his colleagues conducted a descriptive analysis of what type of MABs occur over the course of an opioid treatment regimen. Data were gathered on all patients discharged from opioid care between July 1, 2013 and June 30, 2014. For analysis, MABs were broken into 4 categories: illicit drug use, nonprescribed drug use, running out of medication prematurely, or bad behavior.

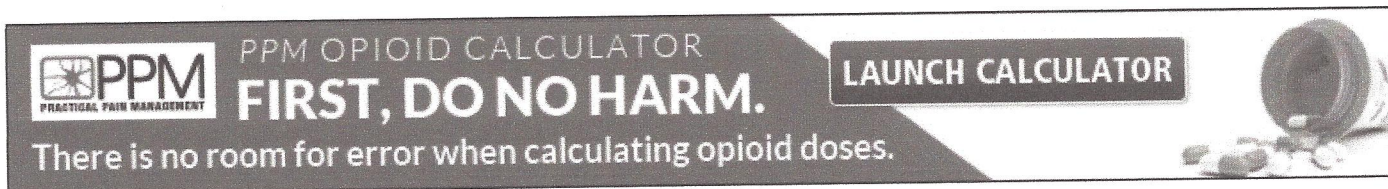
The investigators found that the use of illicit drugs occurs almost exclusively in the first year of treatment, whereas other types of MAB can occur at any point in treatment. This has implications for patient monitoring. For example, noted Dr. Jones, testing for illicit drug use for patients who have been in treatment for more than 1 year could be done less frequently. "This would save Medicare/Medicaid alone hundreds of millions of dollars every year in urine drug screening."

In contrast, Dr Jones said, patients at low- to medium-risk would continue to undergo monitoring that would include pill counts (every visit), routine screens for opioids, prescription drug monitoring (pharmacy checks 2-3 times a year), and twice-yearly random drug screens for illicit substances.

References

Weed V, Alfadhel AS, Wawrzyniak K, Kulich R, Porter R, DiBenedetto D. Impact of urine drug toxicology (UDT) frequency on uncovering aberrant behaviors with chronic opioid therapy: Implications of delay in time of discovery. Presented at: American Academy of Pain Medicine, National Harbor, MD, March 19-22, 2015. Poster 206.

Jones T, Moore T. A descriptive analysis of types of medication aberrant behavior and time in treatment. Presented at: American Academy of Pain Medicine, National Harbor, MD, March 19-22, 2015. Poster 156.



PPM PRACTICAL PAIN MANAGEMENT
PPM OPIOID CALCULATOR
FIRST, DO NO HARM.
There is no room for error when calculating opioid doses.
LAUNCH CALCULATOR

Vertical Health Websites



⊕ SHOW MAIN MENU

⊕ SHOW SUB MENU

Types of Pain

Acute Pain

Post-surgical Pain

Sports and Overuse Injury

Trauma

Cancer PainHeadache

Cluster Headache

Migraine

Post-trauma Headache

Tension Headache

Neuropathic Pain

Carpal Tunnel Syndrome

CRPS/RSD/Causalgia

Diabetic Neuropathy
Multiple Sclerosis
Phantom Limb Syndrome
Postherpetic Neuralgia
Trigeminal Neuralgia
Oral and Maxillofacial Pain
TMJ
Tooth Pain
Rheumatologic and Myofascial Pain
Fibromyalgia
Inflammatory Arthritis
Lupus and Other Autoimmune Disorders
Lyme and Other Infectious Diseases
Osteoarthritis
Plantar Fasciitis
Spine Pain
Discogenic Pain
Facet Syndrome
Myofascial Back Pain
Radiculopathy
Trauma
Other Types of Pain
Abdominal and Pelvis Pain
Brain Injury
General Musculoskeletal Pain
Pain Co-morbidities
Pain Treatments
Complementary Treatments
Acupuncture
Biobehavioral
Homeopathy
Lasers
Magnets
Prolotherapy
Interventional Pain Management
Ablations
Injections
Pumps
Stimulators
Manipulation and Massage
Massage
Osteopathic
Pharmacological
Non-opioids/OTC
Opioids
Psychological
Biofeedback
Cognitive-behavioral Therapy
Rehabilitation
Exercise
Physical Therapy

Resources

Clinical Practice Guidelines Diagnostic Tests Ethics and Legal Clinical Resources Hospice/Palliative Care News and Research Opioid Prescribing and Monitoring Practice Management

PCP Updates

Literature Review

Past Issues

 FOR PATIENTS