PART V: RISK MITIGATION IN CHRONIC PAIN

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RISK MITIGATION IN CHRONIC PAIN

- SCREENING FOR RISK
- PREVENTION OF ABUSE
- DETECTION OF ABERRANT BEHAVIOR
- MANAGEMENT OF ABERRANT BEHAVIOR

SCREENING FOR OPIOID ABUSE

- RISK FACTORS FOR OPIOID ABUSE
  - PERSONAL HISTORY OF SUBSTANCE ABUSE
    - HOW LONG?
  - FAMILY HISTORY OF SUBSTANCE ABUSE
  - YOUNG AGE (<45)
  - MALE
  - CONCURRENT PSYCHIATRIC DISEASE

SCREENING TOOLS

- PSYCHOLOGICAL EVALUATION IS IDEAL
  - PRIOR TO INITIATION OF OPIOIDS
  - UPON ACCEPTING PATIENT INTO YOUR PRACTICE

- ALL SCREENING TOOLS SUSCEPTIBLE TO PATIENT MANIPULATION

OPIOID RISK TOOL (ORT)

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

- ?PREADOLESCENT SEXUAL ABUSE
  - POORLY VALIDATED,
  - ? ETHICS OF RECORDING IN EMR
- EASY

SCREENER AND OPIOID ASSESSMENT FOR PATIENTS WITH PAIN (SOAPP)

- MULTIPLE VERSIONS
  - 24 QUESTIONS
  - 14 QUESTIONS
  - 5 QUESTIONS
- AVAILABLE IN SPANISH
- MY PREFERRED SCREENER

SOAPP

Table 2 – Questions asked in the Screener and Opioid Assessment for Patients in Pain (SOAPP) tool[a]

How often:

1. do you have mood swings?
2. do you smoke a cigarette within an hour after you wake up?
3. have any of your family members, including parents and grandparents, had a problem with alcohol or drugs?
4. have any of your close friends had a problem with alcohol or drugs?
5. have others suggested that you have a drug or alcohol problem?
6. have you attended an Alcoholics Anonymous or Narcotics Anonymous meeting?
7. have you taken medication other than the way that it was prescribed?
8. have you been treated for an alcohol or drug problem?
9. have your medications been lost or stolen?
10. have others expressed concern over your use of medication?
11. have you felt a craving for medication?
12. have you been asked to give a urine screen for substance abuse?
13. have you used illegal drugs (eg, marijuana or cocaine) in the past 5 years?
14. have you, in your lifetime, had legal problems or been arrested?

[a] Patients answer the questions using the following scale: 0, never; 1, seldom; 2, sometimes; 3, often; 4, very often. Those who score 8 or higher are considered at risk for medication misuse. A free copy of the SOAPP tool and instructions for its use may be downloaded from www.PainEDU.org.

0 = Never, 1 = Seldom, 2 = Sometimes, 3 = Often, 4 = Very Often

A score of 7 or higher is considered positive.

CURRENT OPIOID MISUSE MEASURE (COMM)

- MONITORING OF PATIENTS ALREADY ON OPIOIDS

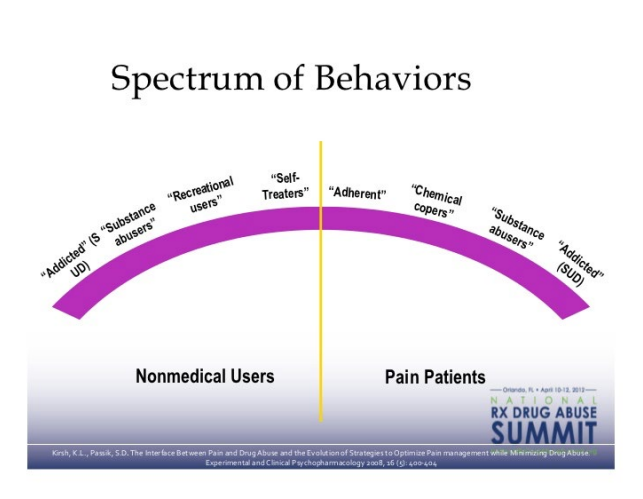
1. In the past 30 days, how often have you had trouble with thinking clearly or had memory problems?	7. In the past 30 days, how often have you been in an argument?
2. In the past 30 days, how often do people complain that you are not completing necessary tasks? (i.e., doing things that need to be done, such as going to class, work or appointments)	8. In the past 30 days, how often have you had trouble controlling your anger (e.g., road rage, screaming, etc.)?
3. In the past 30 days, how often have you had to go to someone other than your prescribing physician to get sufficient pain relief from medications? (i.e., another doctor, the Emergency Room, friends, street sources)	9. In the past 30 days, how often have you needed to take pain medications belonging to someone else?
4. In the past 30 days, how often have you taken your medications differently from how they are prescribed?	10. In the past 30 days, how often have you been worried about how you're handling your medications?
5. In the past 30 days, how often have you seriously thought about hurting yourself?	11. In the past 30 days, how often have others been worried about how you're handling your medications?
6. In the past 30 days, how much of your time was spent thinking about opioid medications (having enough, taking them, dosing schedule, etc.)?	12. In the past 30 days, how often have you had to make an emergency phone call or show up at the clinic without an appointment?
17. In the past 30 days, how often have you had to visit the Emergency Room?	13. In the past 30 days, how often have you gotten angry with people?
	14. In the past 30 days, how often have you had to take more of your medication than prescribed?
	15. In the past 30 days, how often have you borrowed pain medication from someone else?
	16. In the past 30 days, how often have you used your pain medicine for symptoms other than for pain (e.g., to help you sleep, improve your mood, or relieve stress)?

- 0 = Never
- 1 = Seldom
- 2 = Sometimes
- 3 = Often
- 4 = Very Often

- Score of 9 is positive

PREVENTION OF OPIOID MISUSE AND ABUSE

I.E. GOOD PRESCRIBING HABITS!



WHEN TO CONSIDER OPIOIDS

- APPROPRIATE TYPE OF PAIN
  - NOT MYOFASCIAL PAIN
  - NOT GENERALIZED/FIBROMYALGIA PAIN
- NEVER FIRST LINE
  - CONSERVATIVE TREATMENT
  - ADJUNCT MEDICATIONS
  - PHYSICAL, BEHAVIORAL, COMPLEMENTARY THERAPIES
- FAILURE OF MULTIPLE PAST TRIALS OF MEDICATION/THERAPIES

INITIATION OF OPIOIDS

- DOCUMENTATION OF PAIN AND PRIOR INTERVENTIONS, THERAPIES AND MEDICATION TRIALS
- PSYCHOLOGICAL ASSESSMENT
  - SUBSTANCE ABUSE ASSESSMENT
- RISK/BENEFIT DISCUSSION WITH THE PATIENT
- MEDICATION AGREEMENT
  - SPECIFY WHO CAN PRESCRIBE OPIOIDS
  - WHO CAN PRESCRIBE OTHER CONTROLLED MEDICATIONS
  - MANAGEMENT OF ACUTE PAIN

INITIATION OF OPIOIDS

- TRIAL OF OPIOIDS
  - LOW DOSE (HYDROCODONE 5/325 BID-TID)
  - MILD ESCALATION REASONABLE (APPROACHING 30-50MG OME?)
- ASSESSMENT OF IMPROVEMENT
  - PAIN
  - FUNCTION!
- ROUTINELY ASSESS 4 A'S
  - ANALGESIA
  - ACTIVITY
  - ADVERSE EFFECTS
  - ABERRANT BEHAVIOR

PRE-EXISTING OPIOIDS

- MANAGEMENT OF PATIENTS ALREADY ON OPIOIDS
- SAME CONSIDERATIONS
  - APPROPRIATE TYPE OF PAIN
  - FAILURE OF MULTIPLE THERAPIES AND NON-OPIOID MEDICATIONS
  - PSYCHOLOGICAL ASSESSMENT
  - SUBSTANCE ABUSE ASSESSMENT
  - RISK/BENEFIT DISCUSSION WITH THE PATIENT
  - MEDICATION AGREEMENT
- IF NOT APPROPRIATE INFORM THE PATIENT AND DEVELOP PLAN FOR OPIOID TAPER WITH INITIATION OF OTHER TREATMENT
- YOU ARE NOT BEHOLDEN TO PRESCRIBE OPIOIDS JUST BECAUSE ANOTHER PRACTITIONER HAS DONE SO
  - HOWEVER TAPERING OVER TIME CAN PROMOTE THERAPEUTIC RELATIONSHIP WITH PATIENT

PREVENTION OF OPIOID MISUSE/ABUSE

- PRESCRIBER FACTORS
  - DOSE
    - RISKS INCREASE ABOVE 100MG OME, SKYROCKET OVER 200MG OME
  - CONCURRENT CONTROLLED SUBSTANCES
    - RISKS INCREASE WITH CONCURRENT BENZODIAZEPINES OR HYPNOTICS
      - “MUSCLE RELAXANTS” OTHER THAN TIZANDINE/CYCLOBENZAPRINE
      - SLEEP AIDS: AMBIEN/LUNESTA/SONATA, TEMAZEPAM
      - ONLY ONE? ONLY TWO?

DETECTION OF ABERRANT DRUG RELATED BEHAVIOR

Aberrant Drug Related Behaviour (Modified by Passik,Kirsh et al 2002).

Indicator	Examples
*Altering the route of delivery	• Injecting, biting or crushing oral formulations
*Accessing opioids from other sources	• Taking the drug from friends or relatives • Purchasing the drug from the "street" • Double-doctoring
Unsanctioned use	• Multiple unauthorized dose escalations • Binge rather than scheduled use
Drug seeking	• Recurrent prescription losses • Aggressive complaining about the need for higher doses • Harassing staff for faxed scripts or fit-in appointments • Nothing else "works"
Repeated withdrawal symptoms	• Marked dysphoria, myalgias, GI symptoms, craving
Accompanying conditions	• Currently addicted to alcohol, cocaine, cannabis or other drugs • Underlying mood or anxiety disorders not responsive to treatment
Social features	• Deteriorating or poor social function • Concern expressed by family members
Views on the opioid medication	• Sometimes acknowledges being addicted • Strong resistance to tapering or switching opioids • May admit to mood-leveling effect • May acknowledge distressing withdrawal symptoms

★ = behaviours more indicative of addiction than the others.

ABERRANT BEHAVIOR

- LOST OPIOID PRESCRIPTIONS
- OUT OF OPIOIDS EARLY
- INAPPROPRIATE DOPL
- INAPPROPRIATE UDS
- FAILURE TO PARTICIPATE IN NON-OPIOID TREATMENT
- CONCERN FOR OPIOID DIVERSION
- OVERT SEDATION

DETECTION OF ABERRANT OPIOID BEHAVIORS

- URINE DRUG SCREENING
  - PRESENCE OF EXPECTED MEDICATIONS AND METABOLITES
  - ABSENCE OF ILLICIT SUBSTANCES OR OTHER OPIOIDS
  - ONLY AS GOOD AS YOUR TEST!
    - FALSE POSITIVES AND NEGATIVES EXIST – KNOW YOUR PATIENT AND TEST
  - HOW OFTEN?
    - PRIOR TO INITIAL PRESCRIBING
    - Q3-12 MONTHS (Q6 MONTHS AND PRN IS MY PRACTICE)
  - WITNESSED?
    - OR JUST MAKE SURE THEY DON'T TAKE ANYTHING INTO THE BATHROOM?

DETECTION OF ABERRANT OPIOID BEHAVIORS

- PRESCRIPTION DRUG MONITORING PROGRAMS (DOPL)
  - EVERY TIME YOU SEE A PATIENT OR REFILL A MEDICATION
  - HOPEFULLY EVENTUALLY NATIONWIDE
  - CAN SET SURROGATES TO ACCESS THIS UNDER YOUR LICENSE IN UT
    - 3 RNS OR MAS
- PILL COUNTS
  - REQUIRES COORDINATION OF STAFF AND PATIENT
- REQUESTS FOR EARLY MEDICATION REFILLS
- REPORTS FROM FAMILY/FRIENDS
  - CAN LISTEN TO ANY INFORMATION, MAY NOT DISCLOSE ANY
  - FINE LINE TO WALK

MANAGEMENT OF ABERRANT BEHAVIOR

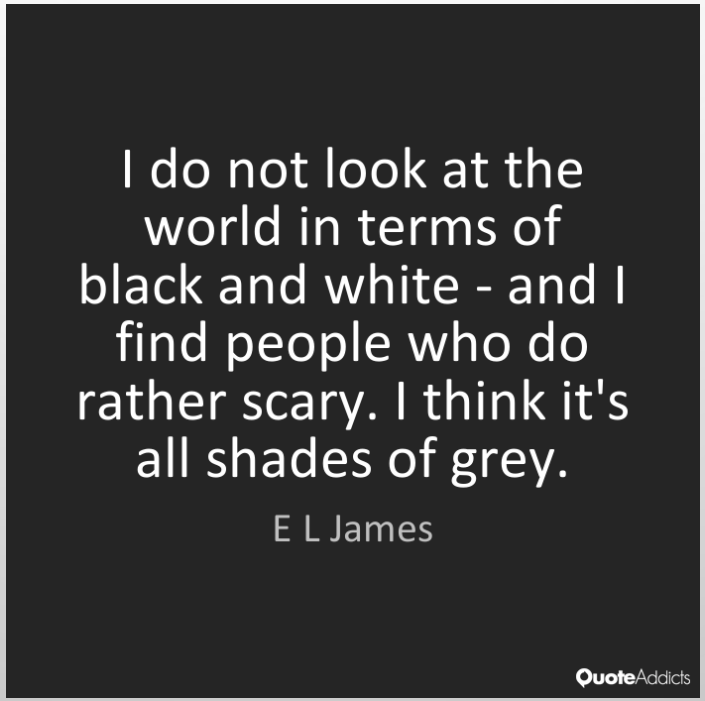
- SAFETY OF PATIENT AND COMMUNITY IS FIRST CONSIDERATION
- VERIFY THE FACTS
  - CONTROLLED SUBSTANCE DATABASE REPORT
  - CALL PATIENT'S PHARMACY OR OTHER PROVIDERS
  - REQUEST RECORDS FROM ED/HOSPITAL
- BASE DECISION ON CONTINUED PRESCRIBING ON SAFETY, FACTUAL INFORMATION, PAIN ISSUE AND INFORM THE PATIENT
  - PROVIDE RESOURCES FOR OPIOID WITHDRAWAL
- YOU MUST CONTINUE TO CARE FOR PATIENTS FOR 30 DAYS AFTER CLINIC DISCHARGE – THIS DOES NOT IMPLY PRESCRIBING OPIOIDS

MANAGEMENT OF ABERRANT BEHAVIOR

- DEPENDS ON SEVERITY
- "COMMON" - EARLY REFILLS, INAPPROPRIATE UDS/DOPL/PILL COUNT
  - VERIFY THE FACTS, GIVE THE PATIENT AN OPPORTUNITY TO EXPLAIN
  - MY PRACTICE: FIRST STRIKE → WARNING, SECOND STRIKE → NO CONTINUED OPIOID PRESCRIBING
- CONCURRENT ILLICIT DRUG USE
  - NO FURTHER OPIOID PRESCRIBING (EXCEPTING MARIJUANA??), REFERRAL FOR TREATMENT
- CONFIRMED OVERDOSE
  - NO FURTHER OPIOID PRESCRIBING, REFERRAL FOR TREATMENT
- CONFIRMED DIVERSION
  - DISCHARGE PATIENT, RECOMMEND TREATMENT
- YOU MUST CONTINUE TO CARE FOR PATIENTS FOR 30 DAYS AFTER CLINIC DISCHARGE – THIS DOES NOT IMPLY PRESCRIBING OPIOIDS

MANAGEMENT OF ABERRANT BEHAVIOR

- HOWEVER…CONSIDER THE OVERALL TRAJECTORY OF THE PATIENT
  - IT'S ALL GREY



THANK YOU!

- QUESTIONS OR COMMENTS?