Risk Assessment: How to Do It, How to Use It

Ted Jones, PhD
Pain Consultants of East Tennessee
Disclosures

- Contract with Ethos Laboratories about an electronic version of the Brief Risk Questionnaire (BRQ)
- Consultant: Prescription Advisory Systems & Technology, Inc. (PAST)
Learning objectives

- Participants will be able to name at least three validated risk assessment tools
- Participants will be able to state one advantage and one disadvantage for each of three popular risk assessment tools
- Participants will be able to state two ways that a patient’s treatment plan could be altered due to him/her being at higher risk
Our Practice

- Two physicians, both boarded in pain medicine
- Eight NPs
- 2 PT, 2 OT, 1 PTA, 1 OTA
- Accredited OP surgery center
- Two full-time psychologists – renting space within
- Clinical trials coordinator and staff
- Clinical laboratory
Recognized as

“distinguished comprehensive multidisciplinary pain care”

One of 37 practices to ever receive this award; one of the few private practices ever recognized.
Risk assessment is important
Prescription drug abuse is a big problem

- From 1999 through 2011, the rate for prescription painkiller deaths almost quadrupled. In 2012, the rate declined slightly, and remained at 5.1 deaths per 100,000 people in 2013. However, prescription painkiller overdose is still a big problem. In 2013, more people died of overdose from prescription painkillers than from illegal drugs.

- Overdose deaths are only part of the problem—for each death involving prescription painkillers, hundreds of people abuse or misuse these drugs.

- Emergency department visits for prescription painkiller abuse or misuse have doubled in the past 5 years to nearly half a million.
And the babies...

- The number of babies born with NAS at East Tennessee Children’s Hospital doubled between 2010 and 2011.
- "In Knox County, we're drowning," Department of Children's Services Attorney Susan Kovac said. "We've seen the number of children in foster care increase by almost 50% over the last few years, and that's just the tip of the iceberg because we're trying to keep the children out of foster care. We've got lots and lots of relatives who are raising drug-exposed infants."

Photos say it all?
Enter Risk Assessment
Opioid risk assessment: the current standard of care

- “A thorough risk assessment and stratification is appropriate in every case.” American Pain Society and the American Academy of Pain Medicine, 2009.
- “Risk stratification pertaining to outcomes associated with the abuse liability of opioids - misuse, abuse, addiction and diversion - is a vital but relatively undeveloped skill for many clinicians.” American Pain Society and the American Academy of Pain Medicine, 2009.
- Risk assessment is a legislated requirement for all patients seen at a registered pain clinic in Tennessee, as of 2012.
- Risk assessment is expected to be completed on every patient before opioids are prescribed for chronic pain per new state regulatory guidelines in TN (2014).
“The revised Model Policy makes it clear that the state medical board will consider inappropriate management of pain, particularly chronic pain, to be a departure from accepted best clinical practices, including, but not limited to the following:

- Inadequate attention to initial assessment to determine if opioids are clinically indicated and to determine risks associated with their use in a particular individual with pain. Not unlike many drugs used in medicine today, there are significant risks associated with opioids and therefore benefits must outweigh the risks.”
“Assessment of the patient’s personal and family history of alcohol or drug abuse and relative risk for medication misuse or abuse also should be part of the initial evaluation, and ideally should be completed prior to a decision as to whether to prescribe opioid analgesics. This can be done through a careful clinical interview, which also should inquire into any history of physical, emotional or sexual abuse, because those are risk factors for substance misuse. Use of a validated screening tool (such as the Screener and Opioid Assessment for Patients with Pain [SOAPP-R] or the Opioid Risk Tool [ORT]), or other validated screening tools, can save time in collecting and evaluating the information and determining the patient’s level of risk.” (pg. 9).
“Based on the combined information of the validated risk assessment results, the Controlled Substances Monitoring Database (CSMD) results and the UDT results and past records, an initial assessment should be made about a patient’s risk of misuse, abuse or diversion of medications. The prescribing of opioids, if medically indicated, shall take this risk assessment information into account in the prescribing of opioids and the patient’s treatment plan.” [italics added]
And

Risk Assessment is Tied to Drug Testing
You’ve heard about Palmetto?

- Palmetto GBA is the company that administers the Medicare program in SC, NC, VA, WV.
- “Local Coverage Determination (LCD): Controlled Substance Monitoring and Drugs of Abuse Testing (L34398)”
They want use of validated risk tools

- “...Frequency based on medical necessity and a complete clinical assessment of the individual patient's risk potential for abuse and diversion using a validated risk assessment interview or questionnaire.” [italics added]

- “Qualitative drug testing is reasonable and necessary when titrated to patient risk potential.” [italics added]
The current local standard of care

Based on the referrals we see in our clinic, if there is a chronic pain complaint, most healthcare providers:

1. Refer out to a pain practice as no patients are ever prescribed opioids due to “company policy / the DEA / Obamacare / the new state regulations.”

- Or -

2. Patients are started on opioids with minimal evaluation of the pain and never any behavioral evaluation. The dose is then raised if the patient continues to complain. Doses are increased until there is some sort of medication aberrant behavior, at which time the patient is then referred to a pain practice.
Mrs. Smith
She has chronic pain.

- She has documented rheumatoid arthritis in all of her joints.
- Her hands are deformed.
- She lives alone and struggles to do her housework.
- The medical provider has treated her for many years and knows her well.
- She asks for “some help” in dealing with her pain.
- So she is prescribed some hydrocodone and later some oxycodone for her pain. Three times a day. Not a high dose.
- And there is no need to drug test her, for goodness sake.
- Good job. An elderly person is coping just a little better today because of the pharmaceutical product and the healthcare professional.
Or maybe not.

- Did you know Mrs. Smith sells most of her medication to help make ends meet?
- Did you know Mrs. Smith has “a sponsor” - someone who pays her to come to the office and get opioid medication, and then the medication is sold for a profit?
- Did you know Mrs. Smith feels a significant amount of pain and takes 8-10 pills a day?
- Did you know Mrs. Smith’s granddaughter visits and routinely helps herself to the medication?
- Did you know Mrs. Smith drinks red wine every night with her Xanax?
Would you hire Uber to take your money to the bank?

Why not?
Really?

“ADF’s will save the day”
Abuse deterrent formulations (ADF’s) are being recently touted as the cure for opioid misuse.

Chronic pain patient advocacy groups and pharmaceutical companies are banding together to push ADF’s as a key solution to the opioid abuse problem.

Several states have introduced legislation that would mandate insurance coverage of these (more expensive) products.
In my view

- ADF’s may offer some help, particularly in the treatment of some higher risk patients.
- ADF’s will not have as much impact as it is hoped.
- This is because opioid misuse is driven by many factors.
- Abuse by addicts is only one factor, and is in my view not the major factor in opioid abuse.
- As much as we would like a technological solution to the opioid abuse problem, I think ADF’s will not do as much we would like.
- Not surprisingly, I think a focus on human behavior (risk assessment and patient education) would be more helpful than ADF’s alone.
Tools for Risk Assessment
We started with “red flag” lists

- Smoking
- On welfare
- Normal blood pressure
- Does not have a PCP
- Has had an MVA, fall or fire
- Leaves blanks on forms
- Calls staff by first name
- Multiple dose escalations
- Obtains medications from multiple sources
- Sells medications
- Steals another patient’s medications
- Forges prescriptions

Do you see a little difference between these two columns?
Then came formal risk tools

- The Screener and Opioid Assessment for Patients with Pain (SOAPP) (Butler, 2003).
- The Opioid Risk Tool (ORT) (Webster, 2005).
- The Diagnosis, Intractability, Risk, Efficacy (DIRE) (Belgrade, 2006).
- The Screener and Opioid Assessment for Patients with Pain Revised (SOAPP-R) (Butler, 2007).
Clinical judgment?

- The clinical interview – one’s “gut” – has been a widely used tool since the beginning of risk assessment.
- # missing teeth + # of tattoos + # family in the waiting room / age
- However, data from more than one study show physician risk ratings are not accurate (less than 50% accuracy overall; tend to underrate risk). (Bronstein & Rafique, 2010; Bronstein et al, 2010)
Katz et al (2003) found that an inappropriate UDT at the first visit did not predict future misuse of medications.

So a UDT, while important and perhaps mandated by state law, is not in and of itself a good predictor of future behavior in treatment.
The false dichotomy

- Some risk assessment tools were based on the original dichotomous thinking: “Real Pain Patients” versus “Drug Addicts.” Thus, “We need something to tell the difference between the two.”

- This dichotomous thinking leads to:
  - “If a patient has ‘real’ pain, then they are not an addict and I can treat him or her without worry.”
  - Also: “If the patient is an addict or alcoholic, then I should not treat him or her at all. I’d be feeding his/her addiction.”
An expert weighs in.

“Data from national surveys suggest that the increase in the prevalence of prescription opioid abuse is not simply due to opioid abuse by the patients prescribed opioids for pain, but is indicative of a much broader problem of lack of control over what are now large quantities of prescription opioids in the community.” (Sehgal et al, 2012)
To beat a dead horse

- This is NOT an issue of identifying “the legitimate pain patient versus the addict.”
- Think it through. Your patient overdoses and is on life support at the local hospital.
- The attending does not ask for (lumbar) scans to question or support the pain dx.
- The attending asks “Who prescribed this person opioids? It was a bad idea.”
What it is:

- This is an issue of being informed about the risks of engaging a particular person to access, store and administer opioid medications to your patient, and.

- then creating a treatment plan that increases the chances that the opioid medication will be ingested by your patient exactly as you directed.
What exactly?

- “Aberrant drug-related behavior”: A behavior outside the boundaries of the agreed on treatment plan which is established as early as possible in the doctor-patient relationship (Gourlay & Heit, 2008, cited in Chou et al, 2009).

- “These are any medication-related behaviors that depart from strict adherence to the prescribed therapeutic plan of care.” (www.painedu.org)
On the other hand?

“Behaviours that may indicate addiction are known as ‘aberrant drug-related behaviours.’ Generally speaking, these behaviours suggest a loss of control of use of opioids.” (Canadian Mental Health & Addiction Network website, 2010).
I prefer

- The term “medication aberrant behavior.”
- Aren’t we trying to get away from calling these medications “drugs”?
- So we’re talking here about assessing a patient from the likelihood of violating the treatment agreement in some way.
- This includes medication misuse, illicit drug use, keeping the medication secure and generally doing what is asked by the provider.
“Risk Assessment”

- There are actually multiple issues being referred to and which are drawing concern.
- One is what I will call “Behavioral Opioid Risk Assessment.”
- This is the prediction of medication aberrant behaviors (MAB).
- This is to what most of the current literature on “risk assessment” refers.
However,

- There is also parallel concern about overdose deaths, which is a somewhat different issue and a different prediction criterion.
  - That is, some patients can take their medication exactly as prescribed with no MAB and still overdose.
- I will call this “Medical Opioid Risk Assessment.”
As yet...

- There are no tests that measure or predict medical opioid risk assessment.
- *Prescribers need to aware of medical opioid risk factors as well as MAB.*
- There are several known medical factors that are associated with overdose.
Note first

- Data from West Virginia found that the majority of fatal overdoses involved people who did not have a prescription for opioids. (Hall et al., 2008).
- Data on Tennessee overdoses also show that the majority of persons who fatally overdosed on opioids were not currently prescribed opioids (Mutter, 2013).
- *The majority of overdoses are NOT patients being treated for pain.*
That said...

Factors in pain patients that are associated with overdose:

- Older age (> 65) (Dunn et al, 2010)
- Higher doses of opioids (Dunn et al, 2010)
- Use of alcohol (Bauer et al, 2008)
- Use of benzodiazepines (Bauer et al, 2008)
- Respiratory problems (Warner-Smith et al, 2001)
- Sleep apnea (Webster et al, 2011)
SO…

- Your patient might be at low behavioral risk of MAB.
- But if he/she is:
  - On any opioid medication
  - Elderly
  - Drinks alcohol
  - Takes a benzodiazepine medication
  - Has COPD or other respiratory problems
  - Has sleep apnea
Medical Opioid Risk

- That patient is at **High Risk medically for overdose**.
- Unfortunately, there is no current scale or algorithm for assessment of medical risk.
- But it is on the legal/regulatory radar, and you should be very aware of it if you prescribe opioids.
So...

- Where we as a field need to get to is to have TWO “risk assessments” of patients before they are started on opioids.

1. One is a behavioral risk assessment that predicts the risk of the patient not getting / taking the opioid medication as prescribed, using illegal drugs while taking opioids, or some other violation of the medication agreement.

2. The other is a medical risk assessment that predicts the risk of overdose, based on medical factors such as age, alcohol use, benzodiazepine use, respiratory problems and sleep apnea.

- We’re not there yet.
Back to Behavioral Risk Assessment
Not all tools are MAB risk tools

- I am presenting tools that try to predict Medication Aberrant Behavior (MAB). Violations of the medication agreement.
- Some other tools are designed to identify opioid addiction, which is a different criterion.
- I encourage use of tools that predict MAB – all types of MAB; all types of risk. Not just drug addiction.
There are four ways that risk tools vary

- **Gather data in different ways** (interview, staff rating, or written questionnaire).
- **Different content areas.** (smoking?)
- **Weigh the data gathered differently.**
  - ORT shows this as it weighs some risk data more heavily based on gender.
  - Personal hx of substance abuse is important, but how important? Does length of sobriety matter?
- **Opaqueness.** How clear it is what the “right” answer is? (to decrease falsification).
The risk tools we have now
Risk assessment tools

- Screener and Opioid Assessment for Patients with Pain (SOAPP). (Butler, 2004)
- Opioid Risk Tool (ORT). (Webster, 2005)
- Diagnosis, Intractability, Risk, Efficacy (DIRE). (Belgrade, 2006)
- Screener and Opioid Assessment for Patients with Pain - Revised (SOAPP-R). (Butler, 2008)
- Prescription Drug Use Questionnaire Self-report (PDUQp). (Compton, 2008)
- Brief Risk Interview (BRI). (Jones, 2013)
- Narcotic Risk Manager (NRM). (Gostine, 2014)
- Brief Risk Questionnaire (BRQ). (Jones, 2015)
- Screen for Opioid-Associated Aberrant Behavior Risk (SOABR) (Ehrentraut, 2014)
SOAPP

- Patient-completed. 14 items. None reverse scored. Risk level is based on total score.
- \( \leq 7 \) is Low. 8+ is High.
- www.painedu.org
- Pros: Widely used. Not very long. May be better than SOAPP-R d/t lower cutoff score.
- Cons: Replaced by the SOAPP-R? No published data about M risk ("off label use")
PMQ

- Patient-completed. 26 items (less in revised version of 2009). 4 reverse scored in original. Risk based on total score.
- <25 “OK for opioids”, ≥ 25 “problematic use,” ≥ 30 “monitor closely” in original. (not exactly L-M-H)
- <20, ≥ 20-29, ≥ 30 in revised version
- (Google)
- Pros: Comparative data indicates original is relatively good at prediction.
- Cons: Hard to get a copy. Two versions with the same name? or “PMQ-R”? New version is apparently proprietary (Vendition Partners).
ORT

- Patient-completed. 10 items. Risk level is based on total score.
- 0-3 Low, 4-7 Medium, 8+ High risk.
- [http://www.opioidrisk.com/node/884](http://www.opioidrisk.com/node/884)
- Pros: Short. Widely used. Easy to score.
- Cons: Blank = “No” is a problem. Several studies have found it poor in predictive accuracy.
DIRE

- Staff-completed. 7 ratings (1 of 3 choices). Risk level is based on total score.
- 4 areas: Diagnosis, Intractability, Risk, Efficacy.
- 14-21 “good candidate for long-term opioids”; 7-13 “not a suitable candidate for long-term opioid analgesics.” 2 levels of risk.
- Pros: Staff-completed measure. Fairly well known.
- Cons: Not widely studied. Predicted compliance, treatment efficacy and opioids on discharge.
SOAPP-R

- Patient-completed. 24 items. None reverse scored. Risk level is based on total score.
- Pros: More “opaque” than SOAPP. The industry standard.
- Cons: No data on the M category ("off label use").
PDUQp

- Patient-completed. 31 items. One reverse scored. Risk level is based on total score.
- ≥ 10 is more predictive of MAB
- Pros: Validation data looks good. Developed by a leader in the field.
- Cons: Not studied in other populations. No official L-M-H categories.
**BRI**

- Staff interview (7-15 minutes). 12 areas of inquiry. Each area rated as to risk. Overall risk is the highest rating of any category.

- UDT and records information contributes to the rating.

- www.tedjonesresearch.com

- Pros: Shows best predictive ability of all risk tools.

- Cons: Requires staff time to ask the questions. Might require some staff training to use.
NRM

- Staff-completed. 8 items (age, gender, race, insurance, education, smoking, MH dx, personal hx of substance abuse).
- Information entered on a web site (anonymous information). Risk level is calculated by web site.
- L-M-H risk rating
- [http://www.narcoticrisk.com](http://www.narcoticrisk.com)
- Pros: Easy and quick.
- Cons: No published data on prediction of MAB yet (only concurrent prediction so far)
BRQ

- Patient-completed. 12 items. Each response is weighted. Risk level is based on total score.
- 0-2 Low, 3-8 Medium, 9+ High.
- www.tedjonesresearch.com
- Pros: Short, easy to score. Easy to see where the risk is coming from.
- Cons: New. Needs more study in other populations. Tends to overrate risk?
SOABR

- Designed specifically for pediatric and adolescent oncology and hematology patients.
- Six items, rated yes-no, based on information known about the patient and family from a psychosocial interview.
- Pros: Only tool known for pediatric population.
- Cons: Limited validation data offered in the initial study.
How do different tools compare?
Evaluating a predictive tool

- **Sensitivity**: the % a measure correctly identifies a certain positive criterion (MAB).
- **Specificity**: the % a measure correctly identifies the non-presence of a criterion (no MAB).
- Saying everyone is high risk will mean you are 100% right in sensitivity and way wrong in specificity.
- Clinically speaking, sensitivity is more important.
- **Area Under the Curve (AUC)** is a summary statistic that combines sensitivity and specificity.
### VALIDATION STUDIES

(Sensitivity / Specificity)

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* Scores were calculated by me based on the data in article.
## COMPARATIVE STUDIES (SEN/SPEC)

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* Data for clinical interview that later became the BRI
## AUC for Various Risk Tools

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Study Averages

Sensitivity (Identifying risk)

Specificity (Identifying no risk)
The usefulness of a tool depends.

- It’s not so much of an issue of “good tool” or “bad tool.”
- Risk tools vary and each have pros and cons.
- You need to know the pros and cons of your chosen tool.
So what tool should you use?

It depends on:

- Your staff time and skills.
- Do you think there is a higher percentage of opioid misuse in your geographical area?
- How closely are you monitoring your patients?
- How many “misses” can you tolerate?
- Do you want an automatically scored and scanned risk tool?
What about later in treatment?
Tools for assessment while in tx

- The Addiction Behaviors Checklist (ABC). (Wu, 2006)
- The Current Opioid Misuse Measure (COMM). (Butler, 2007)
- Opioid Compliance Checklist (OCC). (Jamison, 2014)
What these are

- They “predict” how a patient is doing **right now** – Is he/she engaging in MAB at this time?
- Think of it as a monitoring device, in lieu of a UDT/pill count/CSMD check.
- There is NO risk tool that has been offered for the prediction of how an existing patient will do over the next 6-12 months of tx.
But...

- The SOAPP, SOAPP-R, DIRE and PDUQp were all validated on existing patient populations rather than on only new patients.
- So there is good reason to believe they would be appropriate for predictive use with existing patients.
A recent study on patients in tx

- Jones (2014).
- Looked at all patients discharged from care for MAB over a one-year period. N=188.
- Examined at what point in their treatment did they show MAB (first MAB and last MAB).
First MAB by time in treatment

Final MAB by time in treatment

Types of MAB

- "Illicit": illegal drugs present in UDT or patient or reliable other report that drug use was occurring, or tampering with the UDT;
- "Non-rx": non-prescribed opioid present in UDT, or information of same by report, PMP, records, calls or alcohol use reported or found in UDT;
- "Out": negative UDT, failed pill count, refused pill count, lost/stolen medications or report of overtaking;
- "Bad": unacceptable behavior such as lying, verbally abusive to staff, excessively rude, repeatedly late, illegal behavior, failure to follow treatment plan or other.
Type of first MAB by time in tx

Number of Medication Aberrant Behaviors

illicit nonrx out bad

Type of last MAB by time in tx

Type of first MAB by time in treatment for Medium + risk patients

So...

- I see a possible protocol:
  - Assess patients for risk for MAB before opioids are ever started,
  - Monitor patients based on their initial risk level for the first year of treatment;
  - Monitor with “the Four P’s” (apologies to Passik):
    - Patient (report and information)
    - Pills (counts)
    - PMP (Pharmacy)
    - Pee (UDT’s)
  - After one year of treatment with opioids with no MAB, monitor patients as low risk.
Using risk results to plan treatment
Risk Score vs Risk Assessment

- The score on one of the above risk tools is not necessarily the patient’s risk.
- A risk score is like a lab test and is not diagnostic by itself.
- Use the score + PMP + UDT + records to come up with an overall risk rating.
- Other pieces of data may increase risk - but likely won’t reduce it.
What to do with risk: Consult or Refer?

- Gourlay & Heit (2009)
  - Medium risk: co-manage with specialty support
  - High risk: refer to specialty clinics

- Chou et al (2009)
  - Consult with mental health or addiction specialists.
So question #1 is

- Should I take this person on as a patient or not?
- Some pain practices are set up to treat and monitor higher risk patients,
- And some are not.
- Do you have the ability to monitor closely, and say "No" if you need to?
- Know your limits.
Two variables related to risk

- **Increased monitoring** of the patient (the 4 P’s)
  - Visit frequency (Patient)
  - UDT’s (Pee)
  - Pill counts
  - PMP checks

- **Tailoring of medication** to risk
  - Medications offered
  - Doses per day (number of pills)
Recommendations from the literature

- For higher risk patients:
  - Increase monitoring (UDT’s, pill counts, PMP checks)
  - Increase visit frequency
  - More referrals / consults
  - Limit rapid-onset analgesics
  - Limit short-acting analgesics
The issue of random UDT’s

- Random pill counts
  - When to
  - How to (local pharmacy)
- “Random” UDT’s – I’m not a fan.
- We use “unannounced” UDT’s.
- “Mid-Month’s” are better / more fair?
  - Performing these for a reason, not “random”
- Be prepared to end opioid medications if a patient does not come in.
Total MEDD

- It is easy to think “It’s only a small opioid dose, it’ll be OK.” That can cause problems.
- Many higher risk patients have tolerance due to a personal or family history of substance abuse.
- So low doses are likely going to be ineffective.
- Restrict MEDD for other reasons, but not risk level.
- potent oxycodone products
- short-acting opioid medication
- UDT frequency
- pill counts
- visit frequency

- mid-month PC/UDT
- total MEDD
- Random PC/UDT's
# Create a practice protocol

<table>
<thead>
<tr>
<th>RISK:</th>
<th>LOW</th>
<th>MEDIUM</th>
<th>HIGH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hydrocodone 5, 7.5, 10 mg</td>
<td>Y</td>
<td>Y</td>
<td>Y (60)</td>
</tr>
<tr>
<td>Oxycodone 5, 7.5, 10 mg</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Oxycodone 15, 30 mg</td>
<td>Y</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>Rapid onset opioids</td>
<td>Y</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>Qid dosing SA</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>More than qid dosing SA</td>
<td>Y</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>carisoprodol</td>
<td>N</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>benzodiazepines</td>
<td>N</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>UDT’s</td>
<td>2x a year</td>
<td>4X a year</td>
<td>Every visit</td>
</tr>
<tr>
<td>PMP check</td>
<td>1x a year</td>
<td>4X a year</td>
<td>Every visit</td>
</tr>
<tr>
<td>Pill count</td>
<td>Every other visit</td>
<td>Every visit</td>
<td>Every visit</td>
</tr>
<tr>
<td>Visit frequency</td>
<td>Every Other Month</td>
<td>Monthly</td>
<td>Weekly</td>
</tr>
<tr>
<td>Review/re-eval. Point(s)</td>
<td></td>
<td></td>
<td>120 MED dose</td>
</tr>
</tbody>
</table>
Principles in practice
Our universal precautions

- Have a dx that clearly supports the use of opioids.
- Try all non-opioid treatments first
- No opioids at the first visit.
- Pull a PMP on all new patients.
- Obtain a UDT on all new patients
- Obtain (key) past treatment records
And, for all patients:

- Pill count of CS at every visit (state law)
- No more than #120 doses of SA opioids a month (state guideline)
- No carisoprodol or benzodiazepines
- No easily manipulated LA opioids
- No quick-release SA opioids
- No potent pleasure-stimulating SA opioids (oxycodone 15 or 30 mg)
- Go to medication class
Those not appropriate for any opioid

- There are two variables that place patients in the “Very High Risk” category (on the BRI), and rule out a trial of opioids.

1. **Active Addiction.** Refer for some sort of substance abuse treatment

2. **Dishonesty-Lying.** A physician-patient relationship will not be established.
Patient Education

- The current expectation for providers is that they
  - have some sort of discussion with the patient about treatment expectations
  - Perhaps give the patient a handout covering such issues as safe storage and disposal
I’m not a fan

- Do you really read the information about airplane safety in your seat back cushion?
- When was the last time you looked at it?
- Do you fly Delta?
- Did you watch the safety information video they did?
- They have seven versions, and all are entertaining.
So

- I do not think:
  - a brief conversation with the healthcare prescriber,
  - A brief conversation with the pharmacist,
  - A signature that the patient has been educated, or
  - A pretty pamphlet about safe storage and disposal of medication

- Are adequate or sufficient to really educate patients and change behavior.

- So what happens at our practice?
Medication Class?

- We require that all patients attend a 75 minute “medication class” – really a class on “How to be a good patient on opioids.”

- We review such topics as:
  - Why the medication agreement is SO important
  - What to do if you get hurt or have surgery
  - How to carry your medications around legally
  - Storage of medication
  - THC & alcohol use
  - Visit expectations
  - Calling the practice
  - The primary goal of treatment: function, not pain
  - Expectations for pain relief ("takes the edge off" is all)
Storage

“Treat your medications as you would:
- a thousand dollars in cash
- and a loaded gun”

Use the same precautions.
Does this all make a difference? Very likely.

<table>
<thead>
<tr>
<th></th>
<th>Non-rx</th>
<th>-UDT</th>
<th>+ Illicit</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Published studies</td>
<td>14-26%</td>
<td>3-20%</td>
<td>5-29%</td>
<td>32-45%</td>
</tr>
<tr>
<td>Our practice</td>
<td>11%</td>
<td>2%</td>
<td>4%</td>
<td>15%</td>
</tr>
</tbody>
</table>

In the next session we will put these principles to use with more detailed cases


Webster LR, Dove B. Avoiding Opioid Abuse While Managing Pain: A Guide for Practitioners. 2007. Sunrise River Press, North Branch, MN.


“Risk Assessment: How to Do It, How to Use it”

Thank you!