

Ain't Misbehavin': Decreasing and Managing Medication Aberrant Behavior

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Recognized as

Painweek.



"distinguished comprehensive multidisciplinary pain care"

Disclosures

 Research on risk assessment funded by Collegium Pharmaceutical, Inc.



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The Current Situation

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In case you are not aware...

- There has been a significant regulatory crackdown on opioid prescribing.
- "The Opioid Epidemic" is daily headline news and implicates physicians prescribing opioids for pain (though the data indicates that prescribed opioids are not a major source of the current problem).
- Here is a snapshot of our current legal-social environment...





Right Now

- You can not afford to be casual, lax or nonadherent to best practices with regards to prescribing opioids.
- The stakes are very high and the social-legal environment too threatening.
- If you prescribe opioids at all, you need to be "squeaky clean"—a model of best practices.
- This should have been true all along but it is particularly true now.

This content is based on..

- Some of what I am recommending is based on empirical data
- Some of what I am recommending is based on guidelines
- Some of what I am recommending is based on general psychological principles like behavior-reward connections
- I'll work to distinguish which is which as I go along.



Marketing • What is your first impression of a pain practice who uses these methods of advertising?





Your Practice

- Expectations are important.
- They begin with the referral sources.
- The more you act like a reputable practice, the more you will get reputable patients.
- Work to increase referrals from neurosurgeons, specialists and primary care providers.
- Be an active part of your local healthcare community.

Self-Referrals

- It's nice to have self-referrals.
- But if a large percentage of your patients are self-referred, take a deeper look at what is going on.
- You rarely want to hear the following:
 - -"No one else will help me; I need your help"
 - -"My friend-cousin-uncle said you were the best"
 - -"I'm driving a long way to see you because I've heard you are so good."

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Location

What is your first impression of a pain practice which is housed in these buildings?













First Impressions

- Of course there are good pain practices that advertise in creative ways, and are housed in more relaxed settings.
- But in this current environment, first impressions are very important.
- You may be giving yourself an additional obstacle to overcome by how you present your practice to the community.



Take a look at your office

- When your patient arrives, what will he/she see? The same thing law enforcement or a health investigator will see.
- Get someone(s) to come to your office and tell you what they see. A mystery shopper.
- Don't wait for law enforcement to do this for you.

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The physical environment

- How does your office look?
 - -Does it look like a medical office?
 - -Does it look like your PCP's office?
 - -Who was the previous tenant?
 - -Are people standing and talking in your parking lot?
 - Why would they do that? (no good reason)
- How do the patients there look?
 - -Awake? Talking? Sleeping?



The welcome letter

- A welcome letter outlines what to expect from the practice, particularly at the first visit.
- What should the patient bring?
- What forms need to be completed ahead of time?
- Should the patient expect that you will prescribe opioids at the first visit?

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Prescribing at the first visit

- Do you prescribe opioids at the first visit?
- Never? Sometimes? Always?
- In our experience it is rare to have a substantiated diagnosis for opioids and all risk information available by the end of the first visit.
- Even if you could have all this information, it may not be wise to do so.

Not now

- As a general rule I recommend that you avoid prescribing opioids at the first visit.
- And you should put this in your welcome letter.
- Yes, there are some legitimate patients who could benefit from opioids at the first visit.
- But I recommend that you develop a practice process that discourages this.

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"I only have a few pills left"

- It is all too common for patients to arrive at a first visit that have only a few pills left.
- The temptation is solve this problem with an opioid prescription.
- To prescribe opioids with an intention of filling this gap is to prescribe with the primary intention of treating potential withdrawal – which is different from treating chronic pain.



The Big Picture

- On a group and practice level, not prescribing opioids on the first visit will help decrease drug-seeking patients.
- Prescribe adjuvants. Schedule injections. Document the pain disorder with studies. Gather past records.
- Then meet together another day and develop a treatment plan, which might include a trial of opioids.

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Opioids: A New Day

- Regulatory standards ask that opioids be the last choice for chronic pain.
- It really does not matter (as much we'd like) if a patient has been doing well for years on a certain regime of medications.
- Like it or not, it's a new day and pain treatment has changed.
- We have this conversation with our new patients many times a day.

Once he or she gets there

A Proper Evaluation



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.

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Risk Assessment

- Determines UDT frequency (don't do a full panel on every patient at every visit).
- Helps determine if opioids are to be used.
- Helps determine what opioid medications might be safest.
- Fulfills state and standard of care expectations.



There are really TWO risks

- Usually "risk assessment" means predicting medication aberrant behavior.
- There is ANOTHER RISK: the risk of overdose.
- The predictors of this are different.
- Overdose is correlated with such factors such as being elderly, hepatic sx, pulmonary sx, sleep apnea, bz use, alcohol use, gabapentin.

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We are not there yet

- There is no validated tool to assess the risk of overdose.
- The RIOSORD (Zedler et al, 2015) is one proposed tool but it is not fully validated.
- Despite this, you should document in some way that you have evaluated risk of overdose, and have considered these risk factors as well.
- Now, back to behavior.



Risk assessment tools

- Screener and Opioid Assessment for Patients with Pain (SOAPP). (Butler, 2004)
- Pain Medication Questionnaire (PMQ). (Adams, 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)
- SOAPPR Short Form (Finkelman, 2016)
- SOAPPR Eight Item (Black, 2017)

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Treat this as an appendix

Quick Snapshots of Each Tool



SOAPP

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

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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)</p>
- ≤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
- Pros: Short. Widely used. Easy to score.
- Cons: Blank = "No" is a problem. Several studies have found it poor in predictive accuracy.

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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.
- <u>http://integratedcare-nw.org/DIRE_score.pdf</u>
- 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.
- Officially L-H risk rating (≥18). Manual mentions L-M-H cutoff scoring.
- http://empainline.org/practioner-resources-pdfs/SOAPP-R.pdf
- There is now a 8-item short form (Black, 2017)
- Pros: More "opaque" than SOAPP. The industry standard. {there 's a 12 item SOAPP-R coming out}
- Cons: No data on the M category ("off label use").

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PDUQp

- Patient-completed. 31 items. One reverse scored. Risk level is based on total score.
- ≥ 10 is more predictive of MAB
- http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2630195/pdf /nihms73559.pdf
- 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.

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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
- <u>http://www.narcoticrisk.com</u>
- 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?

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SOABR

- Designed specifically for pediatric and adolescent oncology and hematology patients.
- 6 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.

Not all risk tools are the same

- There are significant differences between the various risk tools.
- Particularly in terms of sensitivity the accuracy of the tool in identifying those who later engage in medication aberrant behavior.

	Moore, 2009	Jones, 2012	Jones, 2012	Ferrari, 2012	Jones, 2013	Witkin, 2013	Jones, 2014	Jones, 2015	Jones, 201
SOAPP	.72								
ORT	.45	.10	.18		.58	.20	.75	.32	.25
DIRE	.17			"risk rating did not r with MAB"					
SOAPP-R		.32	.41		.53		.25	.33	
PMQ		.22	.36	"r with MAB"					.35
BRI		(.43)*	(.69)*		.73		.83	.79	.69
BRQ								.80	.73





Higher sensitivities

- The SOAPP, the BRQ or the PDUQp have higher sensitivities in identifying risky patients.
- Note: research on the SOAPP-R uses the "official" SOAPP-R cutoff: low & high (18).
- If you use the SOAPP-R it is likely better to use the L-M-H cutoffs (12) which is "unofficial" but likely produces better sensitivity.

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The ORT

- If you are using the ORT, consider asking the questions verbally rather than using the original paper checkbox form.
- One study (Jones & Passik, 2011) has found that asking the questions (personal & family hx of substance abuse, presence of depression, etc.) greatly increases its predictive accuracy.



But the CDC said...

- The fabled CDC report of March 2016 said basically that opioid risk tools were not very good and we should not over-estimate their ability to predict risk.
- I agree and disagree.
- I agree that we should overestimate their helpfulness. We should look at all data available and not rely on a single risk score.

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But also ...

- Risk tools are better than the CDC gives them credit for.
- Our best risk tools successfully predict violation of a treatment agreement about 60-85% of the time.
- I think that is about as good as we can expect in predicting human behavior. 90% is unrealistic.
- They are better than clinical judgment. So I recommend you use them. And likely your state guidelines do too.



"I have a good patient population"

- Maybe you trust your patient population.
- Realize that the literature on risk assessment shows that the majority of pain patients are medium risk or higher.
- If you think most of your patients are low risk, please take a closer look.



Prescribing Opioids

- It is all too often a politicized, moralized issue, framed in an all or none choice.
- My view is that low to moderate dose opioids can be helpful to some patients when prescribed with caution and there is proper monitoring.

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And

- One essential skill to have if you are prescribing opioids is the ability to say "no" or "stop."
- It can be difficult.
- Opioids can be harmful to a subset of patients and are contraindicated.
- If you are never saying "no" or "stop" to any patient, please reevaluate your process.

Everyone on the same page

- Your practice is best served when everyone is on the same page in how and what opioids are prescribed.
- If one practitioner does it one way and another does it another, you are asking for multiple patient problems and conflicts.
- I recommend that the treatment process is similar and that how and what opioids are prescribed is similar.

RISK:	LOW	MEDIUM	HIGH		
Hydrocodone 5, 7.5, 10 mg	Y	Y	Y (60)		
Oxycodone 5, 7.5, 10 mg	Y	Y	N		
Oxycodone 15, 30 mg	Y	N	N		
Qid dosing SA	Y	Y	N		
More than qid dosing SA	Y	N	N N		
carisoprodol	N	N			
benzodiazepines	N	N	N		
Naloxone?	Based on health and medication factors				
UDT's	2x a year	4X a year	Every visit		
PMP check	lx a year	4X a year	Every visit		
Pill count	Every other visit	Every visit	Every visit		
Visit frequency	Every Other Month	Monthly	Weekly		
Review/re-eval. Point(s)	60 MED dose				

If you do this

- Check your state guidelines.
- Look for "shoulds" and "shalls."
- Many states have explicit standards that you should follow.
- Be aware of current prescribing practices.
- Just because you hear a presenter say "This is a good way to do things," realize that this doesn't make it the standard of care in your area.



Patient Education The current expectation for providers is that you Go over <u>informed consent</u> Have some sort of discussion with the patient about <u>treatment expectations</u> Both are very important, and they are two different things.

The Two

- Informed consent
 - What the patient should expect with opioid treatment. Side effects, potential bad outcomes, appropriate expectations of their effect.
- Treatment agreement
 - What you expect of the patient regarding opioids. Do's and don't's.
 - -Safe storage is an increasingly important aspect of this.



How do you do it now?

- Do you talk to the patient about each of these?
- Does someone hand the patient a document and say "sign here, initial here."
- Who is there to answer any questions? You? Support staff?
- Safe storage: do discuss this? Do you give a pamphlet on this?

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I'm not a fan of pamphlets

- 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?
- They have 8 versions of the safety information video, and most are entertaining.
- Southwest often has entertaining verbal versions as well.



What if...

- What if you arrived today and I handed you a printed copy of my slides and told you to read it, sign the bottom and turn it in for your CME.
- You'd be angry and disappointed. "That's not education!"
- But that's what we do with our patients.
- We need to do better.

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"Medication Class"

- We require that all patients attend a <u>75 minute "medication class"</u> on "How to be a proper 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)

Proper Storage

- Treat your medications as you would:
 - A thousand dollars in cash
 - And a loaded gun"
- Use the same precautions.
- •This is much more memorable than a pamphlet.



When to end opioids

- Are you a "one and done" practice?
- Are you a "three strikes and you are out" practice?
- I recommend neither of these.
- Each medication aberrant behavior should be handled clinically and not arbitrarily.
- You do not HAVE to end opioids in the face of ANY medication aberrant behavior.

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The Ten Questions to Ask

1. Is the (UDT) finding correct and truly inconsistent with what has been prescribed?

-Be sure it really is unexpected.

2. Does the finding reflect a medically dangerous behavior?

-The more medically dangerous or risky the behavior, the more quickly the clinician should discontinue opioid treatment.

3. Does the finding reflect illegal behavior?

–A patient who is engaging in outright illegal behavior (e.g. obtaining opioid medication without a prescription) is more concerning than a patient not engaging in illegal behavior (e.g. being prescribed opioids by another clinician after an outpatient surgery).













Case ideas to consider

- You find on the PMP that a patient has filled an opioid rx from another physician and you knew nothing about it.
- •What to do?
- "One and done?"
- I recommend doing some investigation.

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Variations

- Version A. Patient assessed as low risk. Describes a dental emergency. When asked, patient says he/she tried to call after hours and got no return call. Her phone shows the call.
- Version B. Patient assessed as medium risk. The other rx was for a flare of the chronic pain complaint. Did this at a previous clinic as well. Patient did not call nor mention it at the visit.

Decision?

 Version A: educate patient about your expectations and how to handle it next time. Plan to review PMP quarterly on patient. Document this.

 Version B: consider ending opioids, and going to nonopioid treatment. Perhaps end short-acting opioids at least. Check PMP every month. Document this.



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