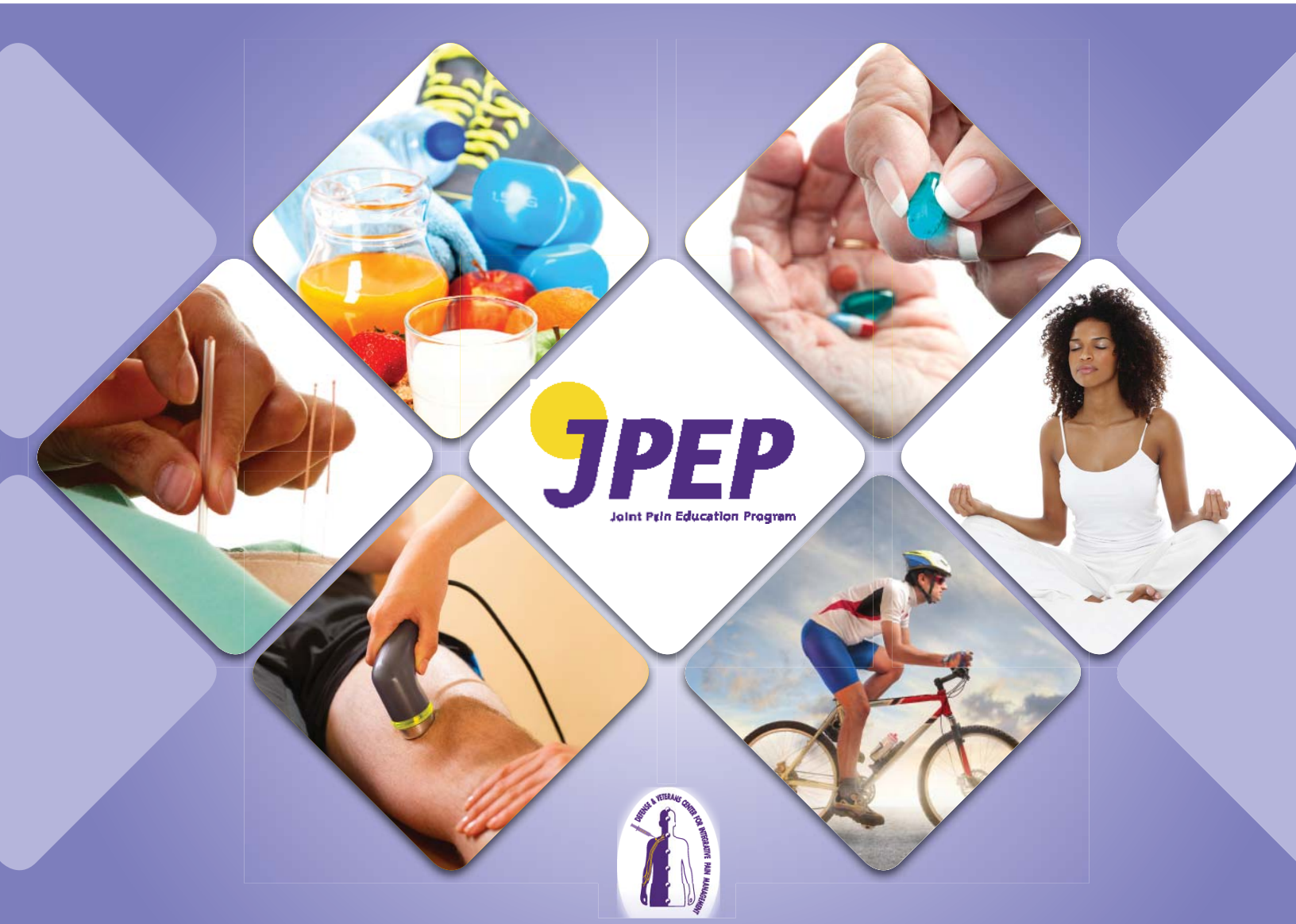
Pain Management for Primary Care

DoD/VHA
JOINT INCENTIVE FUND (JIF)
PROJECT



Series: Five

Long-Term Opioid Therapy (LOT)
for Non-Malignant Pain

Module 5-1

Long-Term Opioid Therapy Risk Evaluation and Mitigation

Module 5-1

Long-Term Opioid Therapy Risk Evaluation and Mitigation

By the end of the module, you will be able to:

- Identify the three components of the Long-Term Opioid Therapy (S.O.S. mnemonic).
- Describe how to utilize the S.O.S. mnemonic to ensure DoD/VHA LOT clinical practice guideline (CPG) compliance and one opioid risk assessment tool.

We will review:

Topic One: Opioid Risk Mitigation Facts

Topic Two: LOTS Safety Programs

Topic Three: Opioid Adverse Effects and Aberrant Behaviors

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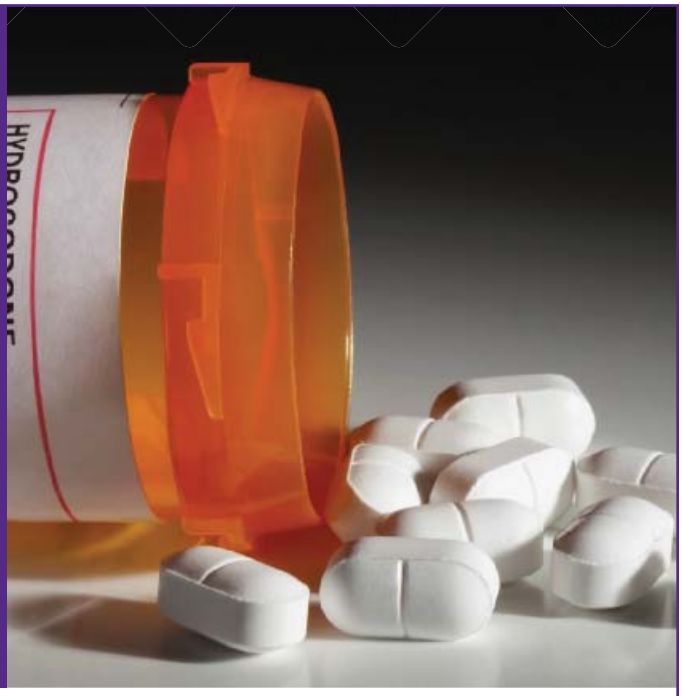
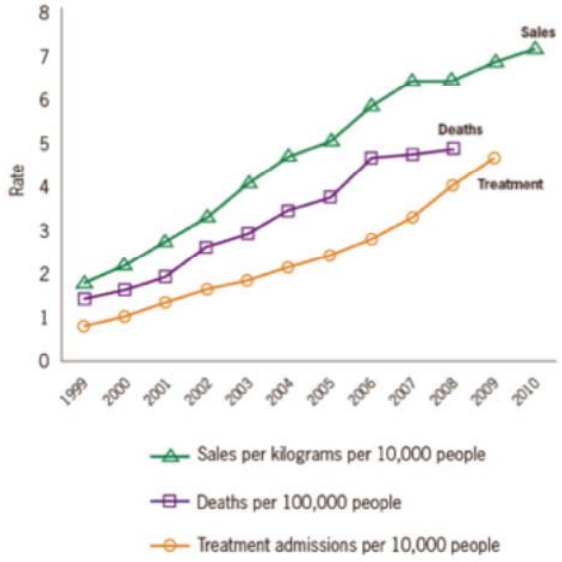
Topic One

Opioid Risk Mitigation Facts



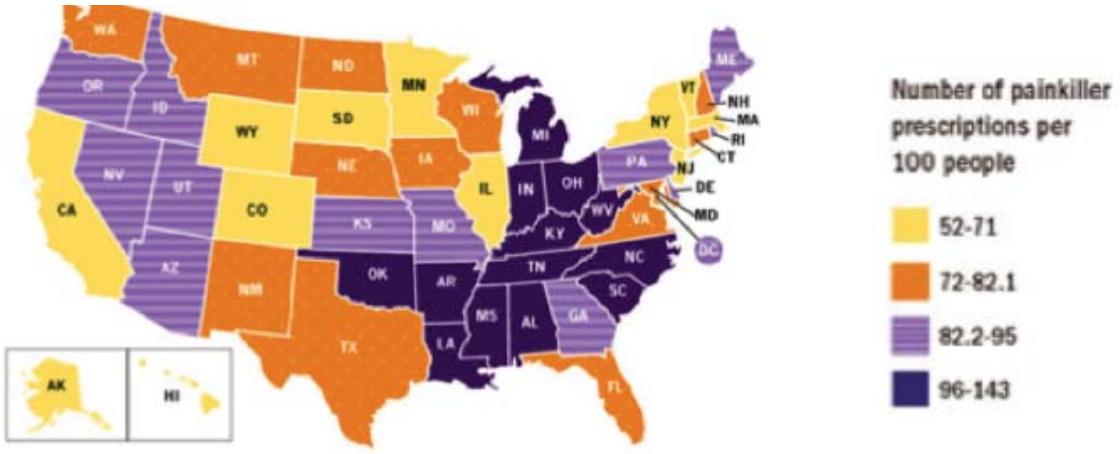
The Centers for Disease Control has defined prescription opioid deaths an epidemic.



Notes

Prescription painkiller overdoses killed nearly 15,000 people in the US in 2008. This is more than 3 times the 4,000 people killed by these drugs in 1999.
In 2010, about 12 million Americans (age 12 or older) reported nonmedical use of prescription painkillers in the past year.
Nearly half a million emergency department visits in 2009 were due to people misusing or abusing prescription painkillers.
Nonmedical use of prescription painkillers costs health insurers up to $72.5 billion annually in direct health care costs.

Ten of the highest prescribing states are in the South.



Notes

Health care providers in some states prescribed far more painkillers than those in other states in 2012.

Southern states had the most prescriptions per person for painkillers, especially Alabama, Tennessee, and West Virginia.

The Northeast, especially Maine and New Hampshire, had the most prescriptions per person for long-acting and high-dose painkillers.

Nearly 22 times as many prescriptions were written for oxymorphone (a specific type of painkiller) in Tennessee as were written in Minnesota.

What might be causing this?

- Health care providers in different parts of the country don't agree on when to use prescription painkillers and how much to prescribe.
- Some of the increased demand for prescription painkillers is from people who use them non medically (using drugs without a prescription or just for the high they cause), sell them, or get them from multiple prescribers at the same time.
- Many states report problems with for-profit, high-volume pain clinics (so-called "pill mills") that prescribe large quantities of painkillers to people who don't need them medically.

Most of the pain cases and opioid prescribing is done in primary care.

- 40% of all outpatient visits are related to pain
- 50% of male veterans and 75% of female veterans report presence of pain
- More than half of all Chronic Non-Cancer Pain (CNCP) is managed by primary care providers

Notes

What do you say with this? Who's problem is this/ it's all of our problem.

One of the challenges in primary care is that whenever chronic pain is discussed patient concerns related to opioid therapy frequently overtake the conversation leaving less time to review other, potentially safer and more effective, options.

Topic Two

Long-Term Opioid Therapy Safety Program

When evaluating a patient for long-term opioid therapy, use the mnemonic SOS.

Screening

- Diagnosis with appropriate differential
- Psychological assessment including risk of addictive disorders
- Appropriate trial of non-opioid therapies

OCA (Opioid Care Agreement)

- Appropriate trial of opioid therapy with adjunctive therapy

Surveillance

- Pre/Post Interventions Assessment of Pain level and Function

Notes

Evaluation - Complete history and physical exam. PQRSTU pain, past treatments, firmly establish non-opioid therapy failed, coexisting disease, effect of pain on physical and psychological function, history of substance abuse.

Identify what you are attempting to treat with opioids and ensure that you are not jumping the gun and going right for long-acting opioids.

TREAT- Written plan with objectives stated to determine success and alternatives plans.

CONSENT-Risks/Benefits of controlled substances, one physician, one pharmacy, urine screen, pill counts, reasons for discontinue.

REVIEW- Monitor compliance, function

CONSULT- Medical Records- documenting all

Patients at overdose and death are:

- Patients over 65
- Patients on high dose (i.e. 100 mg) of Morphine or equivalent per day
- Patients with underlying medial comorbidities
- Patients with comorbid substance use disorder
- Patients with comorbid Mental Health Disorder
- Patients on Benzodiazepines

Notes

DoD/VA quotes data that shows that a patient taking more than 100 mg of morphine have a 7-9% chance of overdosing in the following year.

Absolute contraindications include:

- Severe respiratory disease or severe obstructive sleep apnea
- Acute psychiatric episode or an uncontrolled suicide risk
- Diagnosed substance use disorder not in remission or under treatment
- Active diversion of controlled substances
- Prior trials of specific opioids discontinued due to serious adverse effects
- Potentially lethal drug-drug interaction (methadone only) QTc interval > 500 milliseconds

Notes

This list is part of the DoD/VHA guidelines written in 2010. Patients with these contraindications should not be started on Long term opioid therapy for chronic pain. However, decisions about the approach to opioid therapy in patients with these contraindications already on long term opioid therapy for chronic pain, will need to be made with a very careful risk benefit analysis related to if, and how, to stop opioid therapy.

Patients with relative contraindications require extra monitoring.

- Significant psychiatric co-morbidity
- History of substance use disorder
- Multiple pain complaints
- Medical co-morbidities:
  - Pulmonary (COPD, OSA)
  - Cardiac (arrhythmias, long QTc)
  - Kidney, liver insufficiency
  - GI (constipation, ileus, IBD)
  - History of falls or gait problems
- Concomitant use of alcohol, illicit drugs, benzodiazepines

Notes

Psychosocial factors

- Unstable psychiatric disorder or suicide risk
- Significant personality disorder
- Social instability or other factor that may interfere with opioid adherence
- Suspected cognitive impairment that might interfere with safe use of medications
- Unwillingness to adjust at-risk activities resulting in serious re-injury

Drug and medication use history

- History of medication mismanagement or non-adherence
- Evidence of recent illicit substance use, e.g., positive urine screen
- Substance abuse/dependence history or current substance use disorder under treatment
- No benefit from well-crafted prior opioid trials for the same clinical problem

Pertinent medical history

- Untreated sleep apnea (suspected or verified)
- Chronic pulmonary disease
- Respiratory depression in unmonitored setting
- Hepatic or renal insufficiency
- Cardiac condition (QTc interval 450-500 milliseconds) that makes methadone a risk
- Intestinal motility disorder (constipation, IBS, hx bowel obstruction, paralytic ileus)
- History of falls or gait instability
- Unresolved headache not responsive to other modalities

Whenever possible Long term opioid therapy should not be started when patients are on chronic benzodiazepine therapy. If patients are already on this combination of medications careful evaluation of the best approach with input from primary care, mental health and pain specialists is important.

Even small amounts of alcohol and/or illicit drugs can dramatically increase opioid risks. In addition, alcohol can interact with the sustained release mechanism of Morphine SA products which can lead to drug dumping resulting in large amounts of medication entering the system at once.

Patient education about the risks of all of these interactions is an important part of care.

Screening: use a tool in your practice like ORT (opioid risk tool): 0-3: low risk, 4-7: moderate risk, ≥ 8: high risk.

FACTOR	MALE PATIENTS	FEMALE PATIENTS
Family history of substance abuse		
• Alcohol	☐ 3 points	☐ 1 point
• Illegal drugs	☐ 3 points	☐ 2 points
• Prescription drugs	☐ 4 points	☐ 4 points
Personal history of substance use		
• Alcohol	☐ 3 points	☐ 3 points
• Illegal drugs	☐ 4 points	☐ 4 points
• Prescription drugs	☐ 5 points	☐ 5 points
Age between 16 and 45	☐ 1 point	☐ 1 point
History of preadolescent sexual abuse	☐ 0 points	☐ 3 points
Psychiatric Disease		
Attention deficit disorder, obsessive-compulsive disorder, bipolar disorder, schizophrenia	☐ 2 points	☐ 2 points
Depression	☐ 1 point	☐ 1 point

Notes

Opioid Risk Tool (ORT) The ORT is a 5-item yes-or-no self-report that is designed to predict the probability of a patient's displaying aberrant behavior when prescribed opioids for chronic pain. It consists of items on family history of substance abuse, personal history of substance abuse, age, history of preadolescent sexual abuse, and psychological disease.

The items on substance abuse contain three subsections covering alcohol, illegal drugs, and prescription drugs, and the item on psychological disease has two subsections that distinguish depression from other disorders. Each positive response is given a score based on patient gender, and then the scores are summed to derive the probability of opioid-related aberrant behavior.

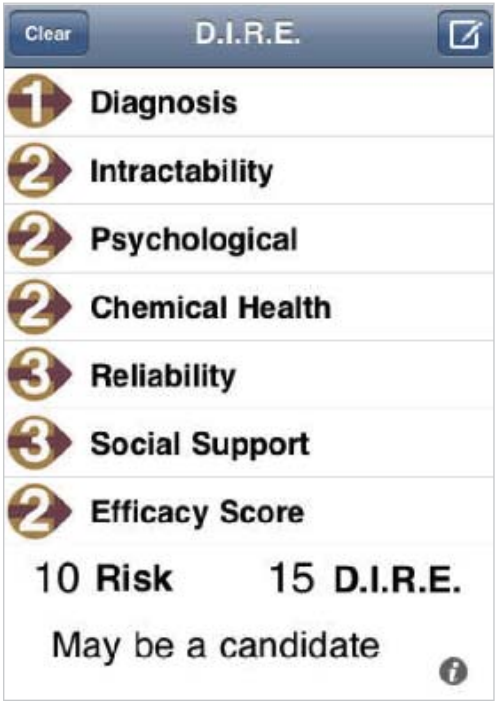
Scores of 0 to 3 are associated with low risk, 4 to 7 with moderate risk, and 8 and over with high risk. Webster and Webster (8) evaluated the ORT in 185 consecutive new patients at a pain clinic. Seventeen of 18 patients (94.4%)in the low-risk category did not display aberrant behavior. In contrast, 40 of 44 patients (90.9%) in the high-risk category and 35 of 123 patients (28.5%) in the moderate-risk category did display aberrant behaviors. The most common aberrant behaviors were solicitation of opioids from other providers, unauthorized escalation of opioid dose, abnormal urine or blood screening, and use of more opioids than those prescribed. The ORT displayed excellent discriminatory ability in both men and women, with observed c statistic values of 0.82 and 0.85, respectively.

Because of its brevity and ease of scoring, the ORT has tremendous clinician appeal and is clearly the easiest way to perform a risk assessment with a tool validated in pain patients and specifically designed to predict problematic behavior in people prescribed opioids for pain. Its lone drawback is its susceptibility to deception. Clinicians will have to decide if guarding against deception is important enough to use a longer and more cumbersome tool or if the documentation of risk assessment (not to mention clear evidence of deception, should it occur) satisfies their requirements.

Or use the DIRE score: Diagnosis, Intractability, Risk, Efficacy.

DO NOT start a patient on opioids if the

D + I + R + E score is less than 13



Notes

The DIRE is a clinician-rated scale designed to predict the analgesic efficacy of, and patient compliance to, long-term opioid treatment in the primary care setting. The scale is intended for use in patients who have chronic non-cancer pain and who are currently being treated with opioids or are being considered for opioid treatment.

Primary Care Providers should complete Behavioral Health Screenings for patients.

The DIRE includes 4 categories: diagnosis, intractability, risk, and efficacy. The risk category is further divided into 4 subcategories: psychological, chemical health, reliability, and social support. Each factor is rated from 1 to 3, with higher scores indicating a more persuasive case for opioid therapy in terms of treatment efficacy and compliance. Patients with scores of 14 and above are considered good candidates for long-term opioid treatment, whereas those with lower scores are not considered good candidates. Belgrade and colleagues (7) performed a retrospective analysis of the DIRE score in 61 patients who had been treated with opioids for chronic non-cancer pain at an outpatient pain management center. Most patients had chronic musculoskeletal back and neck pain (41%), abdominal pain (15%), or neuropathic pain (13%) and were treated with opioids for a median duration of 37.5 months. In this cohort, the DIRE score exhibited high internal consistency, with a Cronbach's alpha coefficient of 0.80. All factors besides diagnosis were significantly related to treatment compliance ($P < .001$), and all except intractability were significantly associated with efficacy ($P < .05$). This was to be expected because, by definition, efficacy is hard to achieve in an intractable condition. Although the diagnosis subscore was not correlated with outcome, it is included in order to avoid treating with opioids patients who do not have a diagnosis or condition that is associated with moderate or severe pain. At a cutoff point of 13, the sensitivity and specificity of the DIRE score for predicting compliance in the study cohort were 94% and 87%, respectively, and for predicting efficacy, 81% and 76%, respectively. Interclass correlation for inter-rater reliability and intra-rater reliability was 0.94 and 0.95, respectively. Comment: The DIRE score performed well in identifying suitable candidates with chronic non-cancer pain for long-term opioid therapy, but the retrospective nature of the study raises several limitations, most notably that investigators scored patients according to case history. Moreover, the study population was relatively small and included a variety of chronic pain etiologies. Prospective analyses in more homogeneous chronic pain populations are still needed for confirming the utility of the DIRE score. However, for pain clinicians who prefer an observer- based, clinician-rated assessment strategy, the DIRE has tremendous potential. Using the DIRE is actually a process of systematizing the clinical judgments that pain clinicians typically make and quantifying them. This process is comfortable for, and familiar to, most pain clinicians and avoids the use of paper-and-pencil measures, where these may be less a part of particular clinics' routines.

Use an Opioid Care Agreement when starting treatment that includes:

- Reason for Long Term Opioid Therapy
- Location of Pain
- Goals of Therapy
- Review of Possible Benefits
- Review of Possible Risks
- Review of Alternatives to Opioid Therapy
- Review of Medication Monitoring

Notes

It doesn't matter what opioid care agreement you use, just as long as you have all the elements sited above.

Have the patient sign the agreement.

Understandings

1. I understand that prior to receiving a prescription for opioids, I must secure an agreement from Primary Care provider, Medical Home Team, or referring physician indicating he or she will take over opioid prescribing when my regimen is stabilized.
2. I understand that the main goal of opioid therapy is to help improve my physical and vocational functioning (i.e., working going to school, etc.) If functional improvement does not occur, I understand the opioids may be tapered and discontinued.
3. I understand that any lost prescription may result in tapering or discontinuation of my opioid prescription.

Notes

Having a patient review and sign an opioid care agreement or informed consent is an important part of opioid safety.

1. It educates the patient about the potential risks of opioid therapy.
2. It clearly establishes the policies, procedures and rules for long term opioid therapy. These are very different than other medications prescribed and can be confusing for patients, caregivers, families and significant others if not clearly outlined.
3. It establishes the fact that all long term opioid therapy is a trial and will be discontinued if the risks outweigh the benefits.
4. It reinforces the need for one prescriber of all opioid therapy except in case of emergency and the need to notify that provider if opioids are prescribed by someone else

Opioid risks increase as the dose goes up. However, risks start even at lower doses and a decision to increase opioid dosing must always be made with a careful risk benefit analysis and a review of other options.

Make sure the patient understands which behaviors can result in loss of opioid therapy.

I reaffirm that I understand that the occurrence of any of the following may result in loss of opioid therapy:	
I.	**Illegal or Criminal Behavior**
	• Diversion (sale or prevision of opioids to others)
	• Prescription forgery
	• Stealing drugs from others
II.	**Dangerous Behavior**
	• Motor vehicle crash/arrest related to opioid illicit drug or alcohol intoxication effects
	• Intentional overdose or suicide attempts with opioids
	• Aggressive threatening /belligerent behavior in the clinic
III.	**Behavior that suggests addiction**
	• Use of prescription medications in an unapproved or inappropriate manner (cutting time release preparations, injecting oral formulations, and applying fentanyl topical patches to oral or anal mucosa)
	• Obtaining opioids outside medical setting
	• Concurrent abuse of illicit drugs including marijuana
	• Multiple episodes of medication loss, every loss must obtain police report
	• Repeatedly seeking prescriptions from other clinicians or from emergency room without informing prescriber or after warnings to desist, as agread per after contract
	• Urine toxicity screen not consistent with prescribed medications
IV.	**Aberrant behavior that requires attention**
	• Demanding, specifying drug, dose and route
	• Not following other components of the treatment plan (Physical Therapy, exercise-includes non-compliance with refills of opioid prescriptions

Notes

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Surveillance: Ask the 4 A's at every visit and refill visit.

- Review the diagnosis and co-morbidities
- Assess - 4A's
  - Analgesia- Is there better pain relief?
  - Activities of Daily Living- Is there improved function or quality of life?
  - Adverse Effects- Are there side effects?
  - Aberrant Behavior- Is there non-compliance on the pill counts or urine drug test or on your audit?

Topic Three

Opioid Adverse Effects and Aberrant Behaviors

What adverse effects to look for:

- Sedation and respiratory depression
- Cognitive slowing and impairment
- Constipation
- Nausea/Vomiting
- Pruritis
- Hyperalgesia
- Hypogonadism in men and complaints of low testosterone in men and women

Patients on LOT have 5 times more risk of having constipation.

- Opioid induced constipation (OIC) occurs in 40% to 90% of patients on LOT
- Opioid users are two times more likely to have constipation resistant to laxative therapy
- Approximately one-third of opioid users will decrease or stop therapy to avoid constipation
- OIC treatment includes:
  - Increase fluids, fiber, exercise and toilet time
  - Stool softeners (e.g. Sennokot 2 tabs x2 a day)
  - PO Movantik, on an empty stomach
  - Relistor (methylnaltroxone) SC 8-12 mg

Notes

5x higher than general public

GI profile means a stimulant or stool softner ****avoid bulking agents as will worsen longitudinal flow*****

Epidemiology1-4Constipation is the most common and debilitating adverse effect of opioid therapy. OIC occurs in approximately 40% to 90% of patients who are chronically receiving opioids for pain The incidence of constipation is five times higher in opioid users than the general public. Opioid users are two times more likely to have constipation resistant to laxative therapy Approximately one-third of opioid users will decrease or stop therapy to avoid constipation.

AGAtechnicalreviewonconstipation:Gastroenterology200;119(6):1766-78.

Yuan C, Wei G, Foss JF, et al. The Journal of Phamacology 2002;300(1):118-123.

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McCallum IJD, Ong S, Mercer-Jones M. Chronic constipation in adults. British Journal of Medicine 2009; 338: 763- 766.

Licup N, Baumrucker SF. Methylnaltrexone: Treatment for opioid-induced constipation. American Journal of Hospice & Palliative Care 2011; 28 (1) 59-61.

Miles C, Fellowes D, Goodman ML, Wilkinson SSM. Laxatives for the management of constipation in palliative care patients. The Cochrane Collaboration. 2009; The Cochrane Library. Issue 1. John Wiley & Sons, Ltd.

Screen for low T complaints. Opioid Induced Androgen Deficiency (OPIAD) is common and a serious comorbidity.

Use in all patients receiving more than 100mg morphine equivalents a day for over 1 month

	Answer YES or NO to each of the following questions:	YES	NO
1.	Do you have a decrease in libido (sex drive)?		
2.	Do you have a lack of energy?		
3.	Do you have a decrease in strength and/or endurance?		
4.	Have you lost height?		
5.	Have you noticed a decreased "enjoyment of life?"		
6.	Are you sad and/or grumpy?		
7.	Are your erections less strong?		
8.	Have you noticed a recent deterioration in your ability to play sports?		
9.	Are you falling asleep after dinner?		
10.	Has there been a recent deterioration in your work performance?		
If you answered YES to questions 1 or 7 or any other questions, you may be experiencing androgen deficiency (low testerone level). A simple salivia test done in the privacy of your home can help you determine your free testosterone level. To order a home-salivia testosterone test click the link below.			

Notes

5x higher than general public

GI profile means a stimulant or stool softener ****avoid bulking agents as will worsen longitudinal flow*****

Opioid induced androgen deficiency is relatively common no matter what the route of delivery. There are a number of secondary side effects of androgen deficiency that can make mood and pain worse. Testosterone replacement therapy has its own risks and is not necessarily an option for many patients.

Male veterans with low testosterone levels:

4X risk of depression within 2 years.

Male veterans over 40 years old with low testosterone levels:

57% (20.1% vs. 34.9%) increase in mortality compared to men with normal testosterone levels over 8 years

- Decreased libido
- Decreased energy
- Irritability
- Dysphoria
- Decreased muscle mass
- Decreased bone mineral density
- Increased fat mass
- Central Obesity
- Insulin Resistance

Knowledge Check

There are many adverse effects to patients taking opioids to treat pain, including_____ and _____.

a. Endorphin Overload; Eczema
b. Hypogonadism; Constipation
c. Low Blood Pressure; Diabetes
d. Fibroids, Personality Disorders

Knowledge Check – Answer

There are many adverse effects to patients taking opioids to treat pain, including_____ and _____.

a. Endorphin Overload; Eczema
b. Hypogonadism; Constipation
c. Low Blood Pressure; Diabetes
d. Fibroids, Personality Disorders

Notes

Read question aloud

Watch out for aberrant behaviors.

Aberrant Behaviors	
Illegal or Criminal Behavior	• Diversion (sale or provision of opioids to others) • Prescription forgery • Stealing drugs from others
Dangerous Behavior	• Motor vehicle crash / arrest related to opioid illicit drug or alcohol intoxication effects • Intentional overdose or suicide attempts with opioids • Aggressive / threatening / belligerent behavior in the clinic
Behavior that suggests addiction	• Use of prescription medications in an unapproved or inappropriate manner (cutting time release preparations, injecting oral formulations, and applying fentanyl topical patches to oral or anal mucosa) • Obtaining opioids outside medical setting • Concurrent abuse of illicit drugs including marijuana • Multiple episodes of medication loss, every loss must obtain police report • Repeatedly seeking prescriptions from other clinicians or from emergency room without informing prescriber, or after warnings to desist, as agreed per after contract • Urine toxicity screen not consistent with prescribed medications
Aberrant behavior that requires attention	• Demanding, specifying drug, dose and route • Not following other components of the treatment plan (Physical Therapy, exercise – includes non-compliance with refills of opioid prescriptions)

Notes

There are times that patient behavior will alert the clinicians caring for the patient that the risks of using opioids is increased. Patient education about the risks of this behavior will be important prior to and during long term opioid therapy for chronic pain.

As agreed upon in the opioid care agreement, use urine drug testing.

Enzyme-Multiplied Immunoassay (EMIT)*	Gas Chromatography-Mass Spectrometry (GC-MS)
Initial testing	Confirmatory testing
Qualitative	Quantitative
Contains specific antibodies against drugs and their metabolites	Breaks down drug molecules into ionized fragments and identifies substances based on mass-to-charge ratio
Rapid, inexpensive, widely available	Time consuming, expensive
↑ sensitivity, ↓ specificity	↑ sensitivity, ↑ specificity

***Higher potential for false positives**

Notes

The table in essence shows that quantitative urine drug testing (UDT) although more expensive is a more accurate and reliable method to screen and evaluate patients on LOT.

UDT increases compliance and the potential for improved LOT efficacy, increased productivity, decreased use of healthcare resources. The estimated cost is $300 for low risk and $900 for high risk analysis.

Many studies have shown that clinicians are not very good at predicting which patients are using medications as directed and which are not. It takes the full array of opioid safety strategies that include full record review, history, physical, PDMP check and urine drug testing to improve the chance that a clinician will be able to prescribe opioids in the safest way possible.

UDT:

- Improve ability to safely manage long-term opioid therapy
- Enhance patient motivation to adhere to treatment plan
- Determine compliance with prescribed medications
- Identify and reduced use of undisclosed substances and high risk
- Evidence of reduced misuse / abuse / diversion
- As many as 49% of patients on LOT with normal behavioral screening had positive urine screens for either an illicit drug or non prescribed controlled medication.

Patients on opioid agreement – knew they might undergo UDT!

Urine drug screening is an immunoassay that can serve as the initial check on patient compliance and the possible use of drugs or non-prescribed medications. It is important to know the drugs and medications routinely checked in your facility so that others can be added when indicated.

There are frequently times that the screen will need to be followed up with a confirmation to give an accurate assessment of what is in the patient's urine.

GC- MS drug confirmations will frequently give a more accurate picture of what is in the urine. In many facilities this is automatically added for a positive screen. In other facilities it will need to be requested separately. It is also important to keep in mind that the cutoff for screens may be too high to detect lower levels of medications or drugs and a confirmation may be helpful in a patient with a negative screen as well.

Remember, quantitative tests are more accurate than qualitative tests (dip stick).

- Urine drug screens are a useful tool that provide valuable objective information to assist with decision making.
- UDT should be performed at least annually in long-term opioid therapy and more frequently in high risk patients.
- The window of detection for most drugs and their metabolites in urine is 1 - 3 days .
- Marijuana
  - Positive is highly predictive of use
  - Sensitive to adulterants
- Cocaine
  - Positive is highly predictive of use

Notes

The window for marijuana detection can be a month or more in chronic daily users. There are some false positives for marijuana that include Protonix, some NSAIDS that include Ibuprofen and Dranabinol. There are also case reports of false positives with some underlying medical problems such as diabetes, kidney disease or liver disease. While false positives with marijuana are rare , an unexplained positive test should always be confirmed. The impact of passive inhalation of marijuana on urine drug screens has been extensively studied and been shown to register well below the screening cut off 50 ng/ml. It may show up as a lower reading of 10-20 ng/ml in a confirmation.

Benzodiazepines
Based on diazepam metabolite
Confirmation test may be necessary to rule out false-negatives

Amphetamines/methamphetamines
Confirmation test recommended due to high rate of false-positives

Opiates
Primarily morphine metabolites
Should use specific immunoassay or GC-MS to detect semisynthetic and synthetic opioids or distinguish among opiates (Codeine, Morphine and Heroine all test positive for opiates)

A positive test for cocaine metabolites is highly predictive of use and rarely requires a confirmation. However, the window of detection for cocaine can be quite short (4 days or less) and a negative test may be obtained if the patient has not used cocaine during the few days prior to the test.

Refer to your Prescription Drug Monitoring Program (PDMP) at every visit and refill visit.

- Supports access to legitimate medical use of controlled substances
- Identifies and deters or prevents drug abuse and diversion
- Facilitates identification of substance use disorder and encourages treatment
- Informs the public of use and abuse trends and assists in creating evidence based public health policies

Notes

Prescription drug monitoring programs is an important safety and educational feature to utilize whenever it is available. In some circumstances it can identify doctor shoppers who are using opioids for profit or have an opioid substance use disorder. In other situations it can serve as a valuable educational tool when patients unknowingly get additional opioids (that are frequently unnecessary) from other health care providers such as dentists, ED physicians or consultants.

Knowledge Check

Informed consent agreement, patient education, and treatment clinicians/clinics are components of the _____ step of the SOS Method.

a. OCA
b. Slow Taper
c. Screening
d. Surveillance

Knowledge Check – Answer

Informed consent agreement, patient education, and treatment clinicians/clinics are components of the _____ step of the SOS Method.

a. OCA
b. Slow Taper
c. Screening
d. Surveillance

Notes

Read question aloud

Knowledge Check

Diagnosis, Risk Assessments, and Baseline UDT are activities that fall under the _____ step of the SOS Method.

a. Surveillance
b. OCA
c. Screening
d. Slow Taper

Knowledge Check – Answer

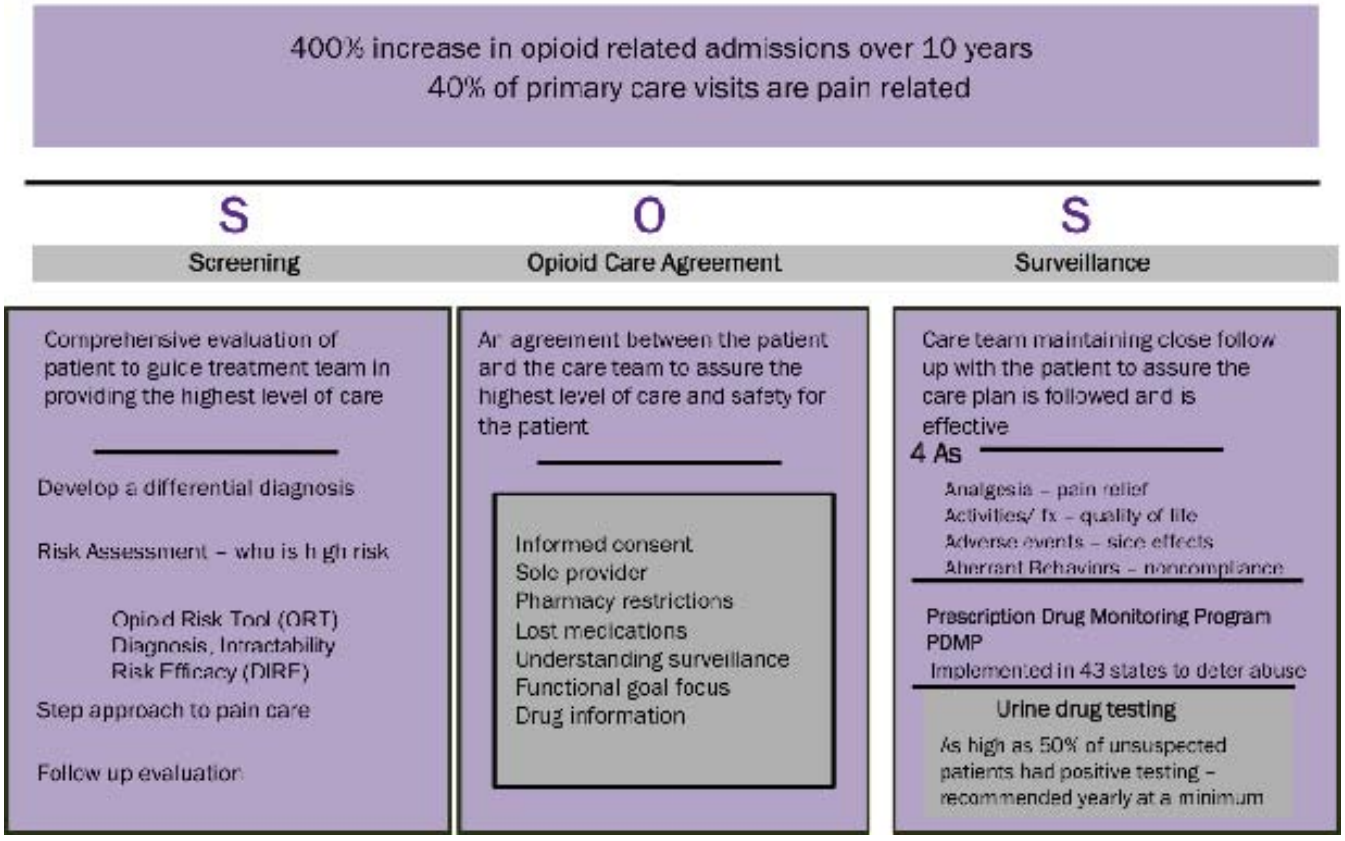
There are many adverse effects to patients taking opioids to treat pain, including_____ and _____.

a. Surveillance
b. OCA
c. Screening
d. Slow Taper

Notes

Read question aloud

Opioid Risk Mitigation Overview - Defining the PCM/Team's Role



Summary

Be confident and use the SOS program (screening – opioid care agreement – surveillance) when starting chronic opioids.

Look for 4 A's (analgesia; activity; adverse effects; aberrant behavior) at every routine follow up and refill visit.

Use urine drug testing and the prescription drug monitoring program referring to good clinical practice guidelines.

Notes

Risk assessment is a complex process requiring time and frequent follow-up appointments.

Patient education is crucial for success and treatment works. Do not give up.

Coordination of care with multiple specialties may be necessary.

Treating addiction with ongoing opiate therapy will create more problems and eventually take more time.

Pain treatment and opiates are not necessarily the same thing.

Functional improvement is critical to ongoing success.

Screening (Includes Risk Assessments – DIRE and Baseline UDT)

OCA (Includes Education/Informed Consent and Sole Clinic/Clinician)

Surveillance (Includes Risk Benefit Ration, Efficacy, Safety, and Compliance)

Opioid Risk Tool – ORT

- http://www.partnersagainstpain.com/printouts/Opioid_Risk_Tool.pdf

Diagnosis, Intractability, Risk, Efficacy- DIRE

- http://integratedcare-nw.org/DIRE_score.pdf

The Screening Instrument for Substance Abuse Potential -SISAP

- http://www.pulsus.com/journals/abstract.jsp?jnlKy=7&atlKy=2908&isuKy=520&isArt=t
- http://www.opioidrisk.com/node/896

Screener Opioid Assessment for Patients with Pain –SOAPP

- http://nhms.org/sites/default/files/Pdfs/SOAPP-14.pdf

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