# Virginia Opioid Addiction ECHO* Clinic

November 16th, 2018

*ECHO: Extension of Community Healthcare Outcomes

# Helpful Reminders

- Rename your ZOOM screen: Please rename your screen with your full name
  - For attendance, please type your full name and organization into the chat box

- All participants are Muted during the call, Please Unmute yourself before speaking. If you have a question, use the 'hand-raised' future in ZOOM or type your question in the Chat box.

- Speak to the Camera, avoid distractions and for ZOOM issues (such as echoing, audio level etc.), use the chat function to speak with the clinic IT team (Vlad)

# VCU Opioid Addiction ECHO Clinics

VCU Health
VCU School of Medicine

VDH Virginia Department of Health | VDHLiveWell.com | Virginia Department of Behavioral Health & Developmental Services

- Bi-Weekly 1.5 hour tele-ECHO Clinics
- Every tele-ECHO clinic includes a 30 minute didactic presentation followed by case discussions
  - Didactic presentations are developed and delivered by inter-professional experts in substance use disorder
- Website Link: www.vcuhealth.org/echo

VCU

# Hub Introductions

| VCU Team | |
|---|---|
| Clinical Director | Mishka Terplan, MD, MPH, FACOG, FASAM |
| Administrative Medical Director ECHO Hub and Principal Investigator | Vimal Mishra, MD, MMCi |
| Clinical Expert<br><br>Program Manager<br><br>Practice Administrator<br><br>IT Support | Thokozeni Lipato, MD<br>Lori Keyser-Marcus, PhD<br><br>Bhakti Dave, MPH<br><br>David Collins, MHA<br><br>Vladimir Lavrentyev, MBA |

Just for fun: What food are you most looking forward to on Thanksgiving?

# Spoke(Participant) Introductions

- Name
- Organization
- Just for fun:
  - Which food are you most looking forward to on thanksgiving?

# What to Expect

I. Didactic Presentation
    I. Dr. Lipato

II. Case presentations
    I. Case 1
        I. Case summary
        II. Clarifying questions
        III. Recommendations

    II. Case 2
        I. Case summary
        II. Clarifying questions
        III. Recommendations

III. Closing and questions

Lets get started!

Didactic Presentation

# Chronic Opioid Therapy in Patients with Substance Use Disorders

Thokozeni Lipato, MD
Assistant Professor, Internal Medicine
Virginia Commonwealth University School of Medicine

# Disclosure Statement

I have no financial interest or affiliation concerning material discussed in this presentation

# Objectives

- Identify criteria for Diagnosis of Opioid Use Disorder
- Name risk factors for addiction
- Develop strategies for treating chronic pain in SUD patients receiving COT

# DSM – 5 Criteria for Diagnosis of Opioid Use Disorder

- ❑ Opioids often taken in larger amounts or for longer than intended
- ❑ Persistent desire or unsuccessful efforts to cut down or control opioid use
- ❑ Great deal of time spent obtaining, or using opioids, or recovering from its effects
- ❑ Craving, or a strong desire to use opioids
- ❑ Recurrent use results in failure to fulfill major role oblige
- ❑ Continued opioid use despite having persistent or recurrent social or interpersonal problems at work, school or home
- ❑ Important social, occupational or recreational activities are given up or reduced
- ❑ Recurrent opioid use in situations in which it is physically hazardous
- ❑ Continued use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by opioids
- ❑ *Tolerance
- ❑ *Withdrawal (OWS or take medication to treat OWS

* These criteria [illegible] opioids solely under [illegible]

# Prevalence of SUDs in chronic pain patients

- 21,685 enrollees in commercial insurance plans and 10,159 in Arkansas Medicaid
  - Possible misuse at 24% of COT recipients in the commercially insured sample and 20% in the Medicaid sample[1]

- A random sample of 705 chronic pain patients receiving COT in primary care and specialty pain treatment
  - 26% of those reported a current opioid use disorder and 36% had a life-time[2]

# Syndrome of pain facilitation[4]

- Acute pain seems to decrease the euphorogenic (pleasurable) qualities of opioids

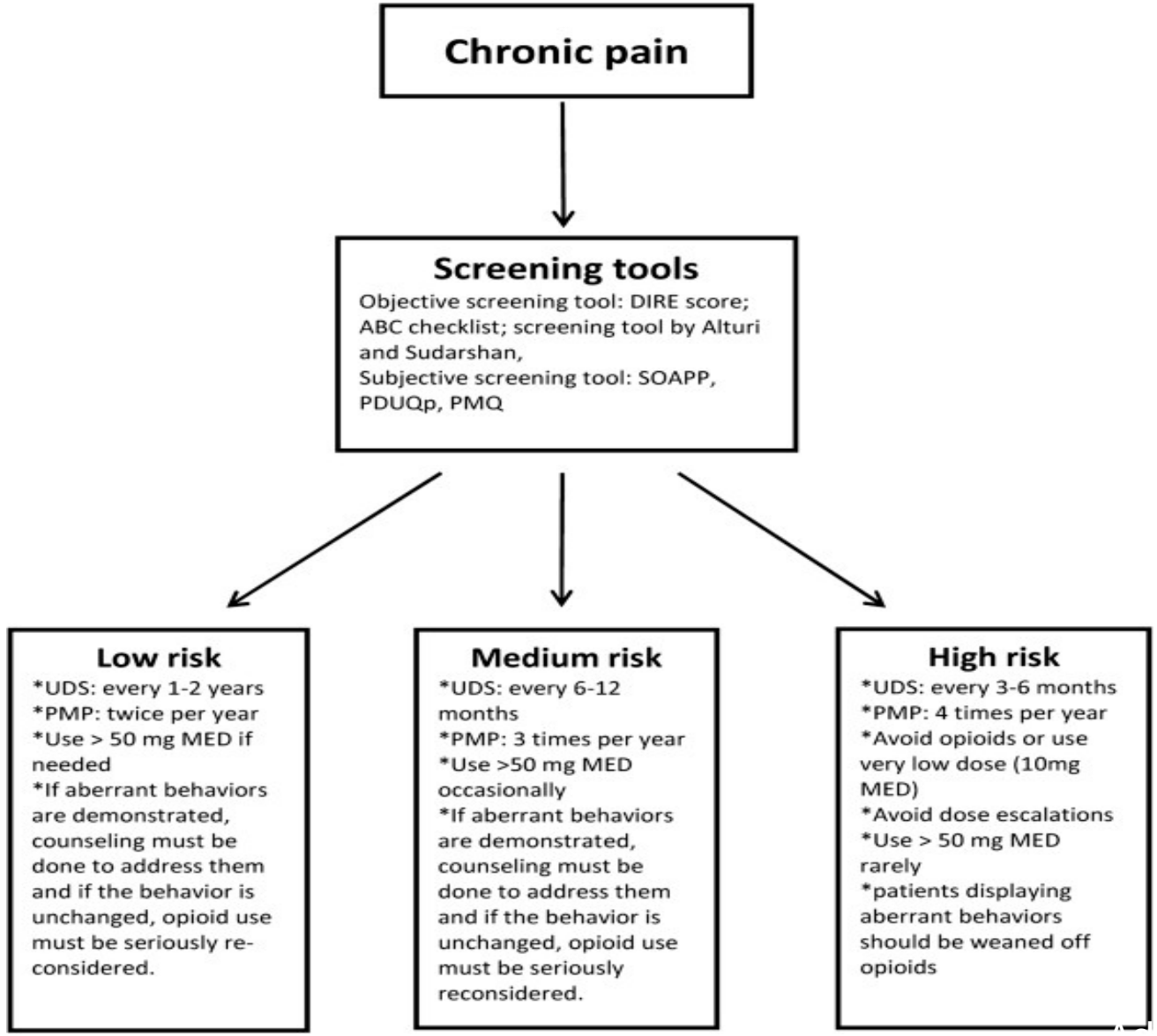
- Persons with addiction and pain have a “syndrome of pain facilitation”
  - Pain experience is worsened by consequences of addition
    - Withdrawal syndromes
    - Intoxication
    - Withdrawal-related sympathetic nervous system arousal
    - Sleep disturbances
    - Affective changes

# Risk factors

- Prior history of opioid abuse
- Pain-related functional limitations/impairments (including sleep disturbances)
- Current cigarette smoking
- A family history of substance abuse
- A history of a mood disorder (e.g. post-traumatic disorder or depression)
- History of child sexual abuse or child neglect
- Involvement in the legal system
- Significant psychosocial stressors

# Risk stratification and monitoring strategies

| | SUBJECTIVE (Patient) | OBJECTIVE (Provider) |
|---|---|---|
| RISK ASSESSMENT TOOL (Opioid naïve) | 1. Screener and Opioid Assessment for Patients with Pain (SOAPP)<br>2. SOAPP-Revised | 1. Diagnosis, Intractability, Risk, Efficacy (DIRE)<br>2. Opioid Risk Tool (ORT) |
| ONGOING ASSESSMENT & MONITORING TOOLS | 1. Pain Medication Questionnaire (PMQ)<br>2. Prescription Drug Use Questionnaire Self-Report (PDUQp) | 1. Addiction Behaviors Checklist (ABC)<br>2. Current Opioid Misuse Measure (COMM)<br>3. Prescription Drug Use Questionnaire Self-Report (PDUQ) |




Chang, Y. P., & Compton, P. (2013). Management of chronic pain with chronic opioid therapy in patients with substance use disorders. *Addiction science & clinical practice*, *8*(1), 21.

# 10 Steps of Universal Precautions[5]

1. Make a diagnosis with appropriate differential
   - Treat cause of pain
   - Treat comorbid conditions (substance abuse; mental illness)
2. Psychological assessment, including risk of addictive disorders
   - Personal & family history
   - UDS
3. Informed consent
   - Discuss proposed treatment plan, anticipated benefits and foreseeable risks
   - Patient education: dependency, tolerance, addiction

# 10 Steps of Universal Precautions[5]

4. Treatment agreement
    - Expectations and obligations of both the patient & practitioner
    - Adjuvant therapies (PT, psychology)

Informed consent & treatment agreement forms the basis of the therapeutic trial

- Explain the therapeutic trial
- Begin developing a treatment goal
    - Plan to titrate up if needed
    - What success is (duration of trial); what failure is
    - Reasons not to titrate, or to decrease/wean off (strategically)

# 10 Steps of Universal Precautions[5]

5. Pre- or post intervention assessment of pain level and function
   - The essence of Therapeutic Trial
   - PRE: Develop a goal (e.g. functional) >> TREAT >> POST:  Was goal meet?
   - RAND 36 Item Health Survey
   - Quick Dash Questionnaire
   - Modified Oswestry Low Back Pain Disability Questionnaire
6. Appropriate trial of opioid therapy +/- adjunctive medication
7. Regular reassessment of pain score & level of function
   - Every 3-4 months

# 10 Steps of Universal Precautions[5]

8. Regularly assess the "4 A's"
    - Analgesia, activity, adverse effects, and **aberrant behaviors**
    - Taking an opioid n a manner that is not prescribed
        - Lack of understanding
        - External pressures
        - Chemical coping - use of opioids to cope with emotional distress
        - Pseudoaddiction (see below)
            - Physical tolerance
            - Opioid-resistant pain
            - Opioid-induced hyperalgesia
            - Progression of their pain generator or disease
        - Addiction
        - Diversion

# 10 Steps of Universal Precautions[5]

9. Periodically review pain diagnosis and comorbid conditions, including addiction
10. Documentation
    - Important for provider & patient
    - Reduce medicolegal exposure & risk of regulatory sanction

# VA Regulations Governing Prescribing of Opioids

- A medical history & PE, to include a mental status examination, shall be performed and documented…
- Carefully consider and document reasons to exceed 50 MME/day
- Prior to exceeding 120 MME/day, the practitioner shall document reasonable justification for such doses.
- Document the rationale to continue opioid therapy every three months

# VA Regulations Governing Prescribing of Opioids

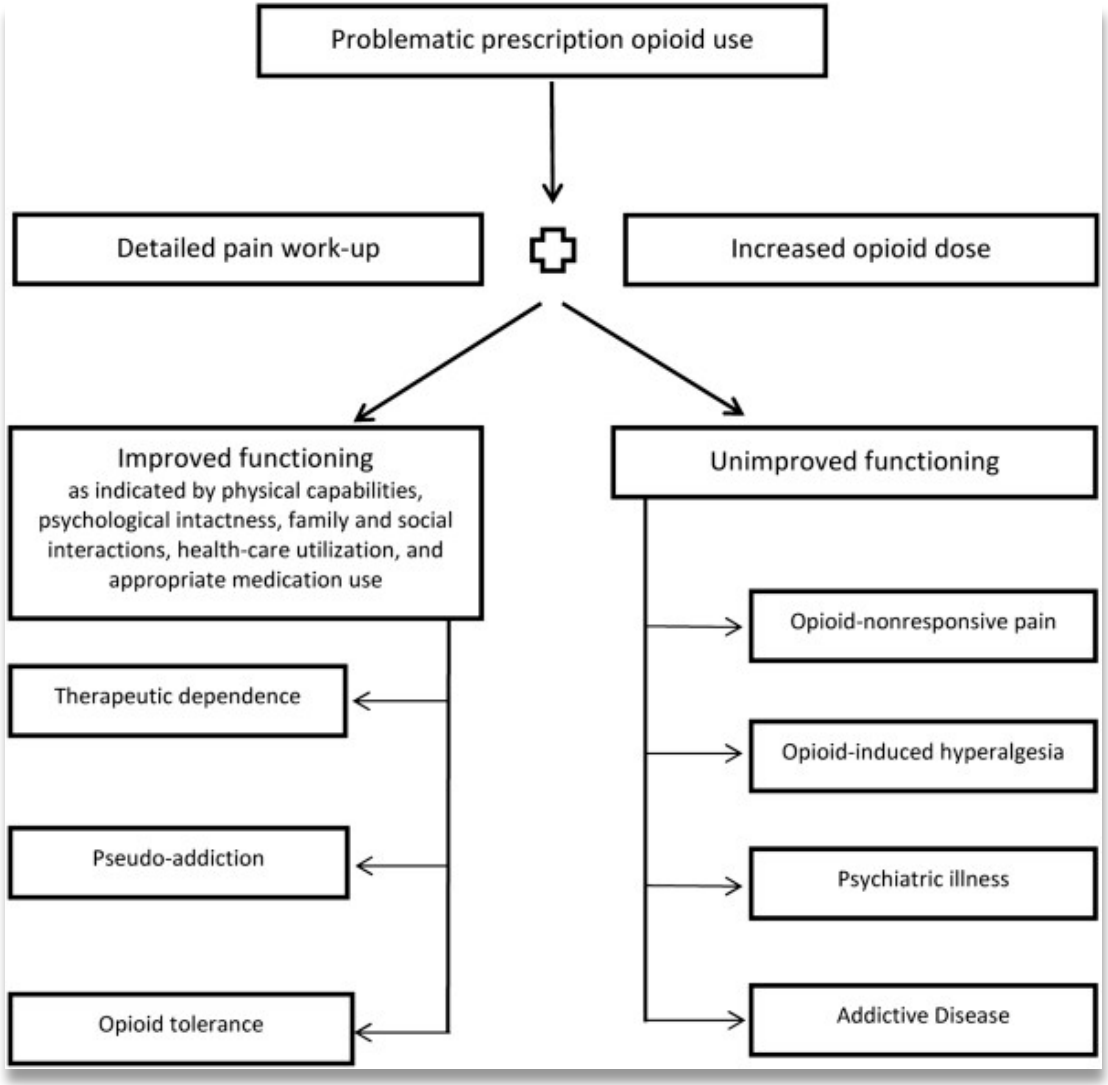
- The medical record shall include a treatment plan that states measures to be used to determine progress in treatment, including pain relief and improved physical and psychosocial function, quality of life, and daily activities.
- The prescriber shall document the presence or absence of any indicators for medication misuse, abuse, or diversion and shall take appropriate action.
- The practitioner shall document informed consent, to include risks, benefits, and alternative approaches, prior to the initiation of opioids for chronic pain.

# VA Regulations Governing Prescribing of Opioids

- Expected outcomes shall be documented… including improvement in pain relief and function or simply in pain relief. Limitations and side effects of chronic opioid therapy shall be documented…
- Continuation of treatment with opioids shall be supported by documentation of continued benefit from such prescribing

# Identification of addiction in the chronic pain patient receiving COT

Decision tree for interpreting aberrant prescription opioid use behavior






Chang, Y. P., & Compton, P. (2013). Management of chronic pain with chronic opioid therapy in patients with substance use disorders. *Addiction science & clinical practice*, *8*(1), 21.

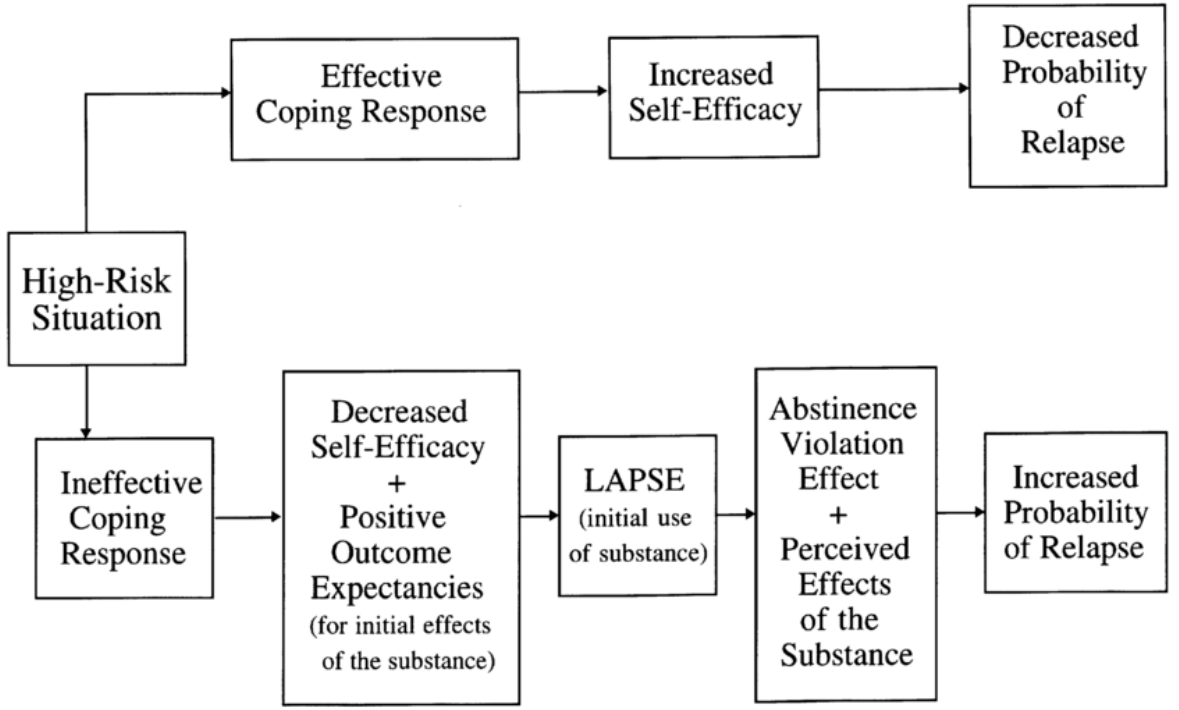
# Treating chronic pain in SUD patients receiving COT

- Patients with chronic pain and active addiction are not candidates for COT
- Patients with addiction in remission: focus on relapse prevention

# The cognitive – behavioral model of the relapse process

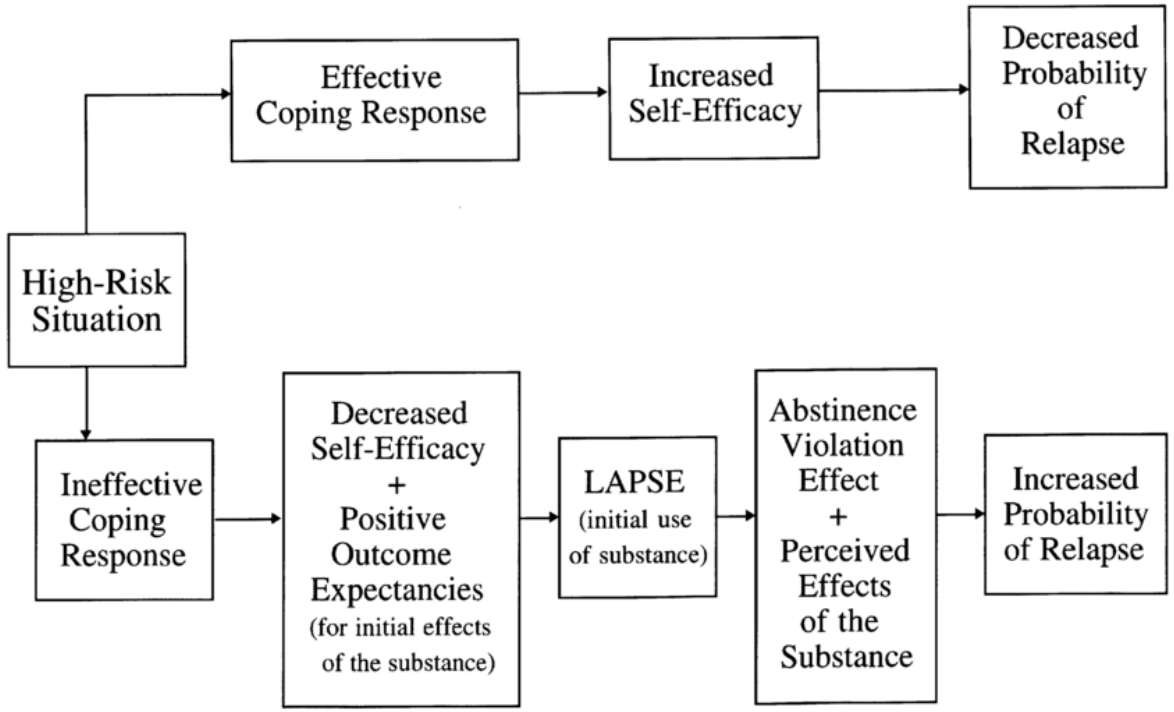
Management of chronic pain with chronic opioid therapy in patients with substance use disorders Addiction Science and Clinical Practice 2013; 8(1): 2

Relapse prevention. An overview of Marlatt's cognitive-behavioral model. Alcohol Research & Health. 1999; 23(2): 151 – 60.



Coping response – response to high-risk situation

Self-efficacy – personal perception of the level of mastery over the specific high-risk situation

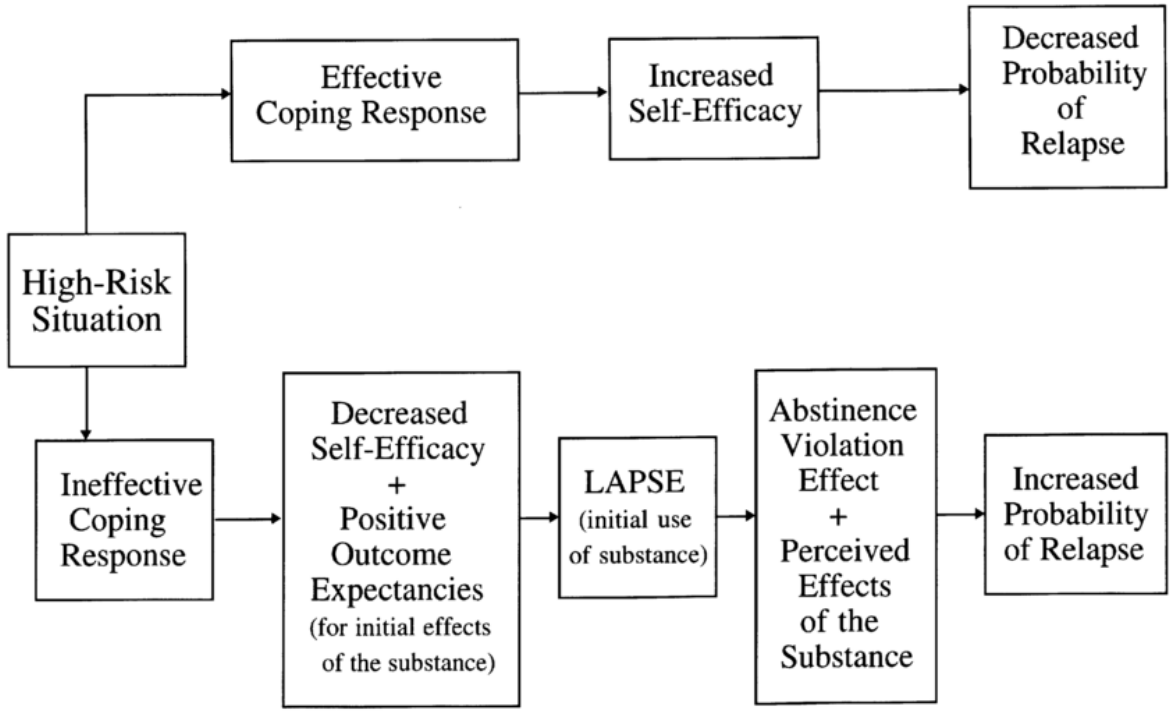



Management of chronic pain with chronic opioid therapy in patients with substance use disorders Addiction Science and Clinical Practice 2013; 8(1): 2

Relapse prevention. An overview of Marlatt's cognitive-behavioral model. Alcohol Research & Health. 1999; 23(2): 151 – 60.

Project ECHO®
Virginia Commonwealth University

# Positive outcome expectancies – anticipate only the immediate + effects of use




Management of chronic pain with chronic opioid therapy in patients with substance use disorders Addiction Science and Clinical Practice 2013; 8(1): 2

Relapse prevention. An overview of Marlatt's cognitive-behavioral model. Alcohol Research & Health. 1999; 23(2): 151 – 60.

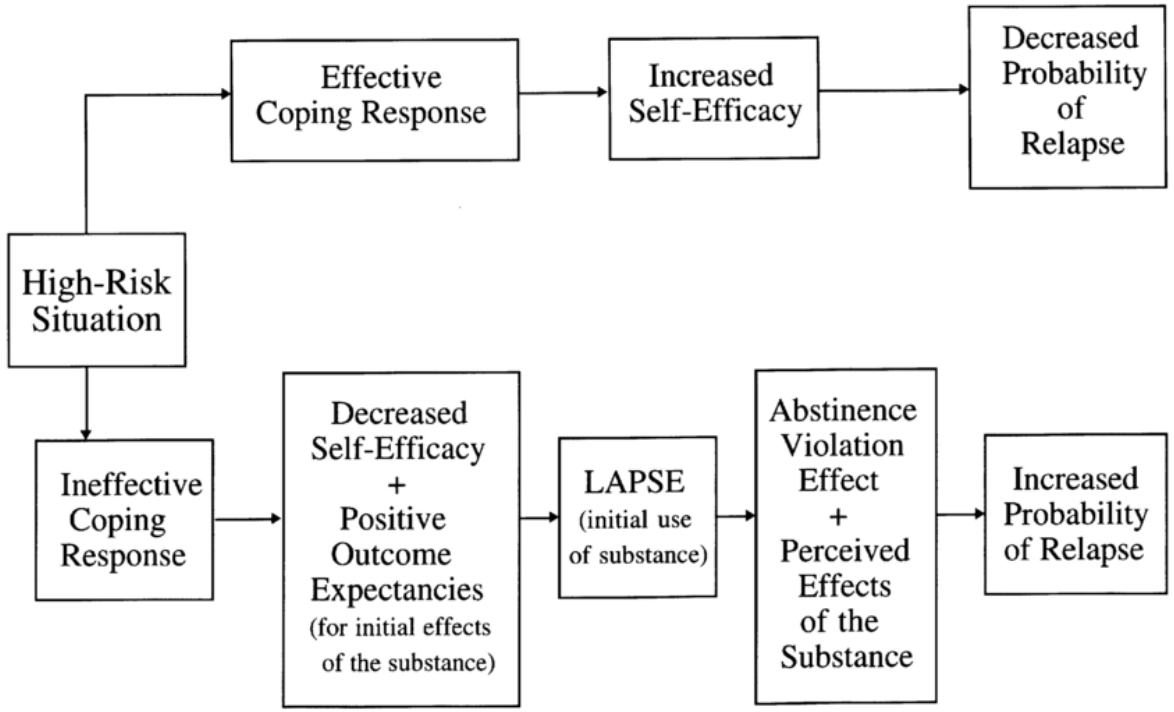
VCU

Project ECHO
Virginia Commonwealth University

## Abstinence violation reaction -

Focuses on emotions (guilt; failure)

Lack of willpower vs poor coping response





Management of chronic pain with chronic opioid therapy in patients with substance use disorders Addiction Science and Clinical Practice 2013; 8(1): 2

Relapse prevention. An overview of Marlatt's cognitive-behavioral model. Alcohol Research & Health. 1999; 23(2): 151 – 60.


VCU

# Successful relapse prevention

1. Specific intervention techniques: enhance self-efficacy
   - Talk openly about relapse
   - Improve coping response – IDENTIFY HIGH-RISK SITUATIONS
   - Decrease positive outcome expectancy
   - Educate patient about Abstinence Violation Effect.

2. Global self-control approaches designed to reduce relapse risk by promoting positive lifestyle changes
   - Stress-reduction activities into their daily life, such as exercise or meditation

# Management of lapse/relapse

- Informed consent & treatment plan
- Lapse vs relapse (7)
  - Lapse: a brief episode of opioid use
  - Relapse: the resumption of more extended and excessive opioid use involving the return of symptoms meeting diagnostic criteria for a substance use disorder
- Addiction: continuum marked by 3 broad zones of action & experience
  - 1) A stage of excessive, compulsive, and problematic opioid use
  - 2) A stage of recovery stability, and
  - 3) A transitional stage in which people pass back and forth between addiction and recovery

# Management of lapse/relapse

- Following a lapse, a careful review of the lapse episode can be helpful
- Simply discharging patient from treatment is problematic
- VA regulations: The practitioner shall regularly evaluate for opioid use disorder and shall initiate specific treatment for opioid use disorder, consult with an appropriate health care provider, or refer the patient for evaluation for treatment if indicated
- Maintain high levels of controls over opioid access
- Opioid detoxification should be gradual
- Initiate SUD treatment, or refer out

# Management of lapse/relapse

- Informed consent & treatment plan
- Lapse vs relapse (7)
  - Lapse: a brief episode of opioid use
  - Relapse: the resumption of more extended and excessive opioid use involving the return of symptoms meeting diagnostic criteria for a substance use disorder
- Discharging the patient from pain treatment without providing addiction intervention is premature and is not patient-centered.
- VA regulations:The practitioner shall regularly evaluate for opioid use disorder and shall initiate specific treatment for opioid use disorder, consult with an appropriate health care provider, or refer the patient for evaluation for treatment if indicated.
- Maintain high levels of controls over opioid access
- Opioid detoxification should be gradual

# References


1. Risks for Possible and Probable Opioid Misuse Among Recipients of Chronic Opioid Therapy in Commercial and Medicaid Insurance Plans: the TROUP Study. Pain. 2010 Aug; 150 (2): 332 -9
2. Risk factors for drug dependence among out-patients on opioid therapy in a large US health-care system. Addiction. 2010 Oct; 105 (10): 1776 - 82
3. Management of chronic pain with chronic opioid therapy in patients with substance use disorders. Addition Science & Clinical Practice. 2013; 8(1): 21
4. Acute pain management for patients receiving maintenance methadone or buprenorphine therapy. Annals of Internal Medicine. 2006 Jan 17; 144 (2): 127 – 134.
5. Universal Precautions in Pain Medicine: A Rational Approach to the Treatment of Chronic Pain. Pain Medicine 2005. 6(2). 2005.
6. Relapse prevention. An overview of Marlatt's cognitive-behavioral model. Alcohol Research & Health. 1999; 23(2): 151 – 60.
7. Lapse and relapse: Is it time for a new language. www.facesandvoicesofrecovery.org.

Project ECHO®
Virginia Commonwealth University

# Questions?

VCU

# Case Presentation #1

- 12:35pm-12:55pm [20 min]
  - 5 min: Presentation
  - 2 min: Clarifying questions- Spokes (participants)
  - 2 min: Clarifying questions – Hub
  - 2 min:  Recommendations – Spokes (participants)
  - 2 min:  Recommendations – Hub
  - 5 min:  Summary - Hub

# Case Presentation #1

Presenter: Dr. Van Zee

Requesting assistance with (check all that apply):

☒ Other

If Other please explain:

case example of buprenorphine in pain treatment

Please state your MAIN QUESTION for this patient case:

this case is presented to illustrate that buprenorphine, in selective clinical situations, can be an effective & compassionate tool for patients with history of opioid use disorder now living with severe chronic pain

**Patient Case - Demographic Information**

Age:

48

Sex:

⊗ Male

Current Living Situation

lives with family

# Case Presentation #1

Presenter: Dr. Van Zee

Employed

⊗ Yes

Education/Literacy:

⊗ High School Degree/GED

Does patient have social support or any significant social history?

⊗ Yes

If Yes please explain:

has immediate family plus girl friend

Patient Strengths/Protective Factors

has prior history of opioid use  disorder, IVDA, HCV, morbid obesity, DM-type II, and lumbar radiculopathy.---had disabling severe pain related to his lumbar radiculopathy.  gabapentin helped his leg pain to modest extent, but continued severe disabling back pain.  he adamantly did not want any pain pill exposure as he knew he would relapse.

Potential Barriers to Treatment

financial barriers. was initially not working when he came into treatment.---was able to get the Gap Medicaid insurance.

Any cultural factors that may have an impact on this patient's situation?

⊗ Yes

If Yes please explain:

---lives in region of widespread prescription opioid misuse

# Case Presentation #1

Presenter: Dr. Van Zee

Any Substance Use history?

⊗ Yes

If Yes please explain:

Opioid use disorder, remote Hx IVDA, + HCV

Have any Behavioral Interventions been tried?

⊗ Yes

If Yes please explain:

relapse prevention & management of chronic pain discussion

Medication History

--initially tried on Suboxone films->> severe nausea & vomiting. changed to bup/naloxone tablets--->> severe N/V
--given in office trial of Bunavail-->> nausea, but not severe, no vomiting, and able to tolerate
---has been maintained on Bunavail 4.2/0.7--2 films daily since that time with good analgesic response,, with pain level decreasing from 8-9 level to a 1-2 level if sedentary, a 4-5 level if active. --multiple UDS before & after start of Bunavail---negative for illicit drug use

Any comorbidities?

⊗ Yes

If Yes please explain:

--as above, morbid obesity (419#, BMI =55.6), DM, type II, + HCV, hypertension

Any Medications Tried for Relapse Prevention?

⊗ Yes

If Yes please explain (Specify):

Bunavail

# Case Presentation #1

Presenter: Dr. Van Zee

Any Labs (including urine) ?

⊗ Yes

If Yes please explain (as indicated):

negative for illicit drug use. A1C much better control. HCV + RNA

Is the patient involved in any Prescription Monitoring Program?

⊗ Yes

If Yes please explain pertinent findings:

Virginia PMP

Proposed Diagnoses

#1--opioid use disorder #2--Lumbar radiculopathy with severe chronic pain #3--Hx IVDA #4--Hep C
#5--DM, type II #6--Hypertension #7--Morbid obesity

Any Substance Abuse Treatment history?

⊗ Yes

If Yes please explain:

as above

# Case Presentation #1

Presenter: Dr. Van Zee

Does the patient have goals for treatment?

⊗ Yes

If Yes please explain:

(1) attain adequate analgesia so he can have better functioning and continue to work ( he was able to go to work driving a coal truck after Bunavail started and had better pain control)

Proposed Treatment Plan

(1) maintain Bunavail for treatment of severe chronic pain & opioid use disorder
(2) complete treatment for Hepatitis C---started through the UVA Telemed treatment project

**REMINDER: Please ensure that NO patient specific identifiable information (PHI) is included in this submission. Please read, sign, and click SUBMIT when completed.**

By signing below, you have acknowledged that Project ECHO case consultations DO NOT create or otherwise establish a provider-patient relationship between any ECHO clinician and any patient whose case is being presented in a teleECHO clinic.

# Case Presentation #2

- 12:55pm-1:25pm [20 min]
  - 5 min: Presentation
  - 2 min: Clarifying questions- Spokes
  - 2 min: Clarifying questions – Hub
  - 2 min:  Recommendations – Spokes
  - 2 min:  Recommendations – Hub
  - 5 min:  Summary - Hub

# Case Presentation #2

Presenter: Dr. Lipato

Requesting assistance with (check all that apply):

☒ Other

If Other please explain:

Management of significant opioid dependency

Please state your MAIN QUESTION for this patient case:

Is there is a safe way to manage this patient with sickle cell disease and chronic pain secondary to avascular necrosis on opioids?

Patient has a diagnosis (sickle cell disease and avascular necrosis) for which opioids are an integral part of the treatment. He has been on HIGH dose chronic opioid therapy for many years (more than 7; total daily MME of 660). Over the years his UDS has been negative for opioids, making use concerned for diversion; however we now suspect overuse of his chronic opioids after taking him and his wife. Both admit to him running out early; over-sedation; and even what appear to be apneic episodes at night.

**Patient Case - Demographic Information**

Age:

44

Sex:

⊗ Male

Current Living Situation

Lives with wife

# Case Presentation #2

Presenter: Dr. Lipato

Employed

⊗ Yes

Education/Literacy:

⊗ High School Degree/GED

Does patient have social support or any significant social history?

⊗ Yes

If Yes please explain:

He is married

Patient Strengths/Protective Factors

He is married and his wife is very supportive. She tries to manage his opioids but holding them for him.

Any cultural factors that may have an impact on this patient's situation?

⊗ No

Current Substance Use

Intermittent cocaine use
Smokes tobacco

Any Substance Use history?

⊗ Yes

If Yes please explain:

intermittent use of cocaine (7/2011; 9/2011; 12/2014; 03/2015; 10/2018)
one documented used of heroin (3/2015)

# Case Presentation #2

Presenter: Dr. Lipato

Have any Behavioral Interventions been tried?

⊗ No

Medication History

1.Oxycodone 30mg, 240 tabs / day
2. Methadone 10mg, 300 tabs/ day. This is a decrease from 360 tabs/ day that he used to get dating back to 2011.
3. Used to be on a benzodiazepine. Not anymore.
4. Allergy to Gabapentin
5. Stopped using Tylenol and NSAIDS years ago.

Any comorbidities?

⊗ Yes

If Yes please explain:

Sickle cell disease; Hb SC disease

Avascular necrosis in hips and shoulder, s/p bilateral hip replacement and a unilateral shoulder replacement

Any Medications Tried for Relapse Prevention?

⊗ No

Any Labs (including urine) ?

⊗ Yes

If Yes please explain (as indicated):

UDS positive for cocaine -7/2011; 9/2011; 12/2014; 03/2015; 10/2018
UDS positive for heroin - 3/2015
Over the past years UDS has been negative and positive for oxycodone and methadone.

# Case Presentation #2

Presenter: Dr. Lipato

Is the patient involved in any Prescription Monitoring Program?

⊗ Yes

If Yes please explain pertinent findings:

No recent history of multiple providers.

Proposed Diagnoses

1. Opioid dependency
2. Chronic pain from AVN
3. Opioid use disorder vs pseudoaddiction
4. Cocaine abuse

Any Substance Abuse Treatment history?

⊗ No

Does the patient have goals for treatment?

⊗ Yes

If Yes please explain:

1.Decrease pain so he can be more functional, but functional goals not set yet.
2. Has enough opioids so he won't has withdrawal.

Proposed Treatment Plan

1. Have him formally evaluated for an opioid use disorder.
2. Engage is some form of behavioral therapy, such as CBT for chronic pain, but also to address his cocaine use.
3. More frequent visit (every 2 weeks), more frequent UDS
4. Develop specific functional goals.

Not being proposed, but maybe should - wean off opioids and treat with an opioid replacement therapy (daily dose of methadone; suboxone)

**REMINDER: Please ensure that NO patient specific identifiable information (PHI) is included in this submission. Please read, sign, and click SUBMIT when completed.**

# Case Studies and Feedback

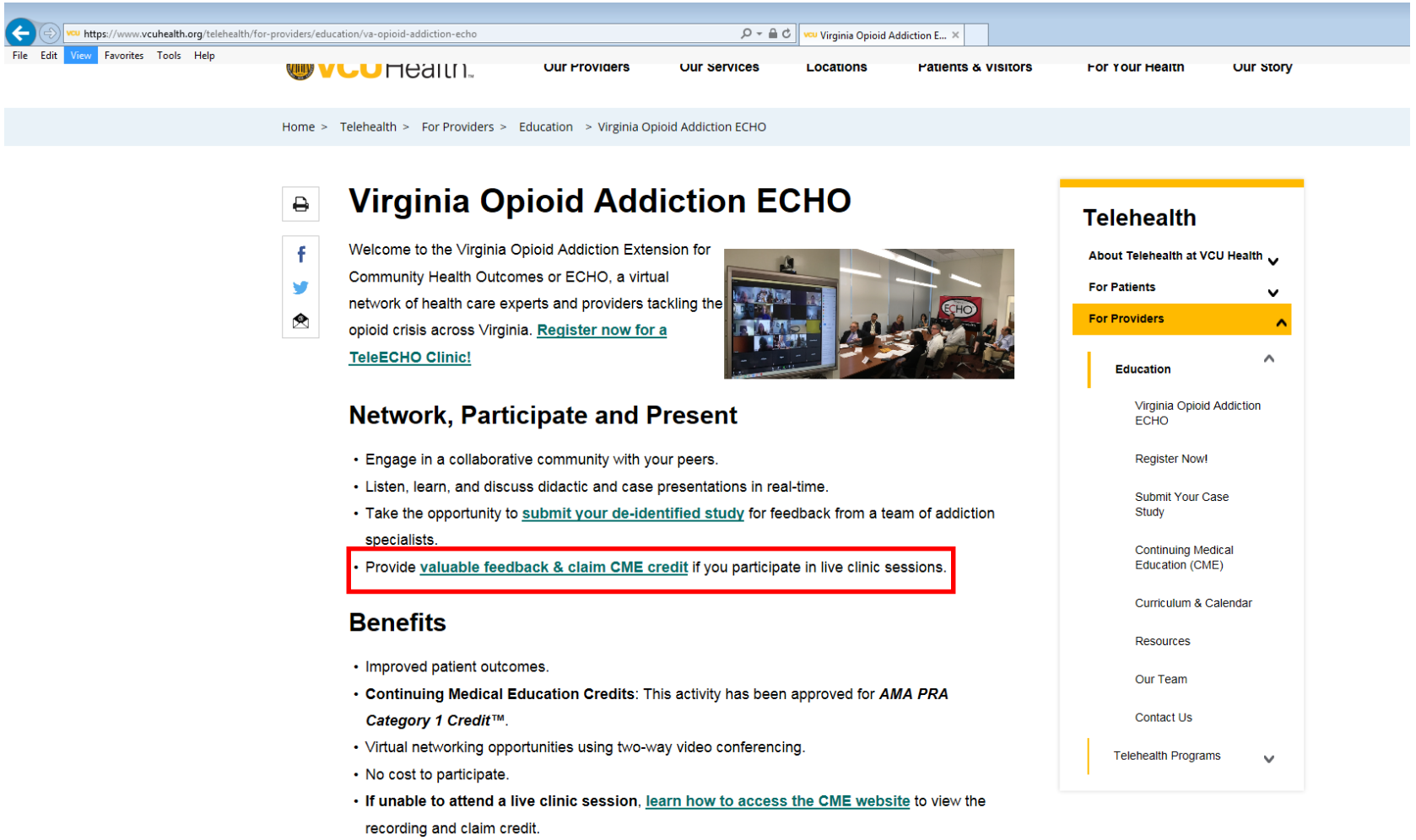
- Case studies
  - Submit: www.vcuhealth.org/echo
  - Receive feedback from participants and content experts
- Opportunity to formally submit feedback
  - Survey: www.vcuhealth.org/echo
  - Overall feedback related to session content and flow?
  - Ideas for guest speakers?

# Access Your Evaluation and Claim Your CME

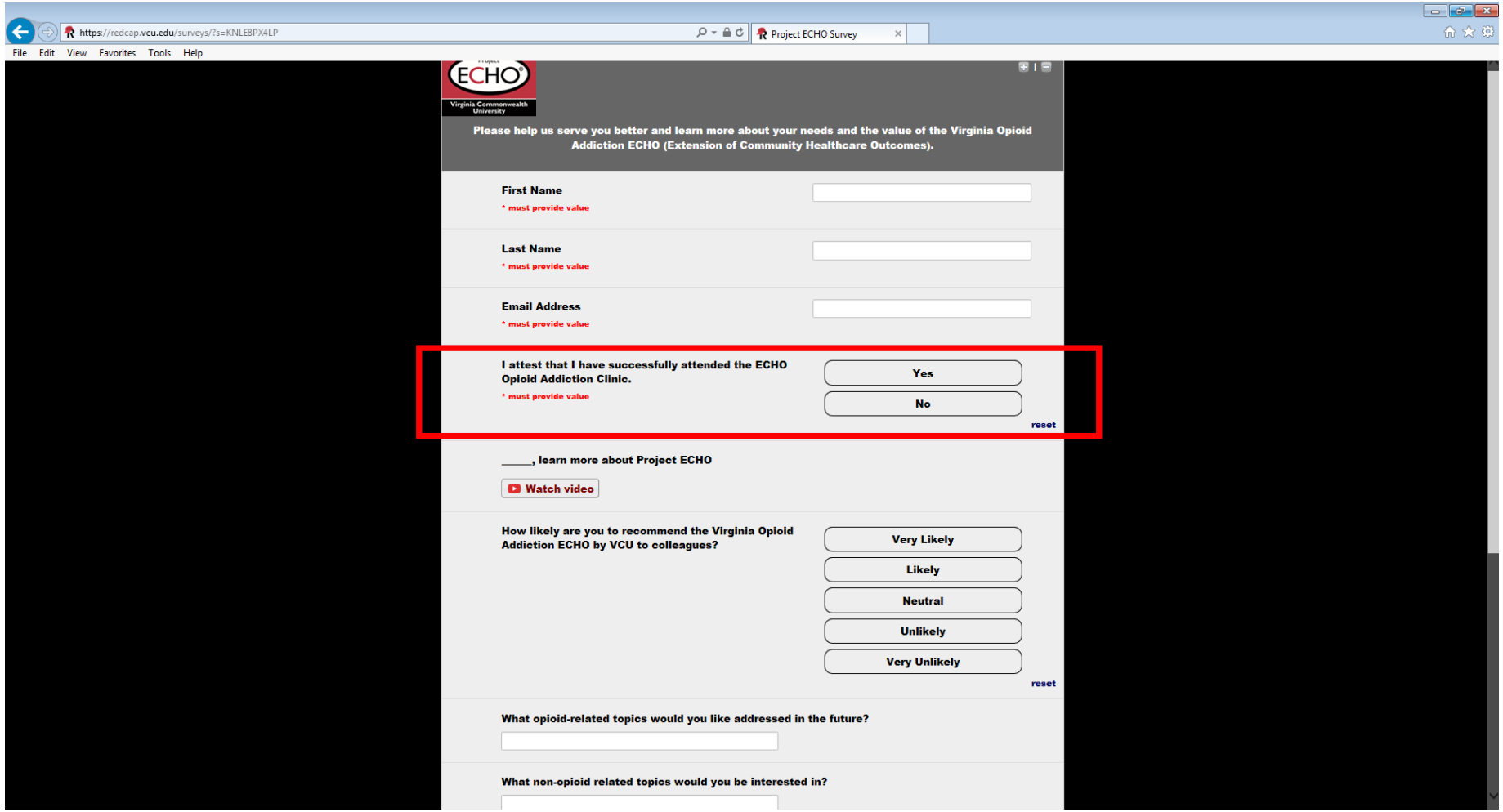
- www.vcuhealth.org/echo

  - To claim CME credit for today's session

# Access Your Evaluation and Claim Your CME



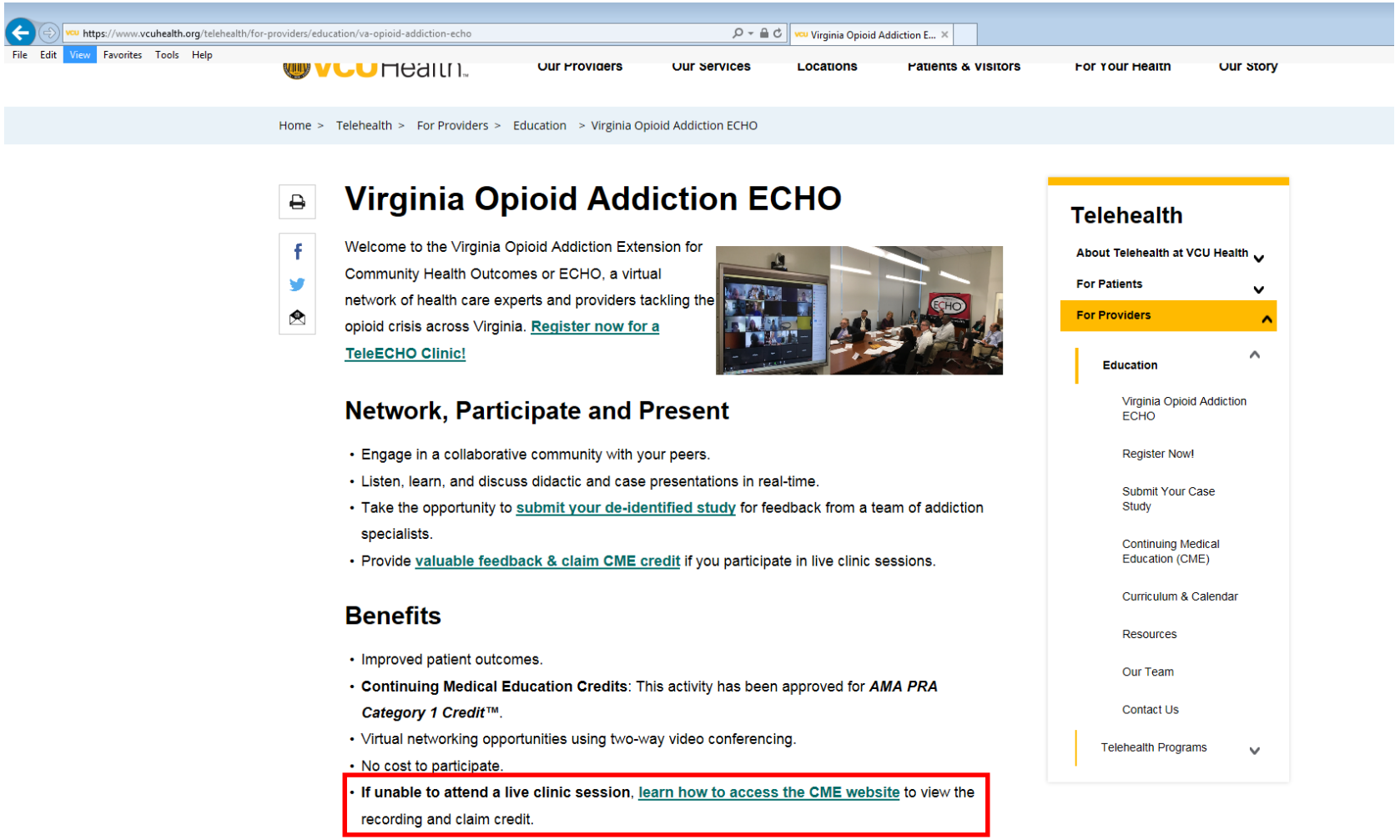
# Access Your Evaluation and Claim Your CME



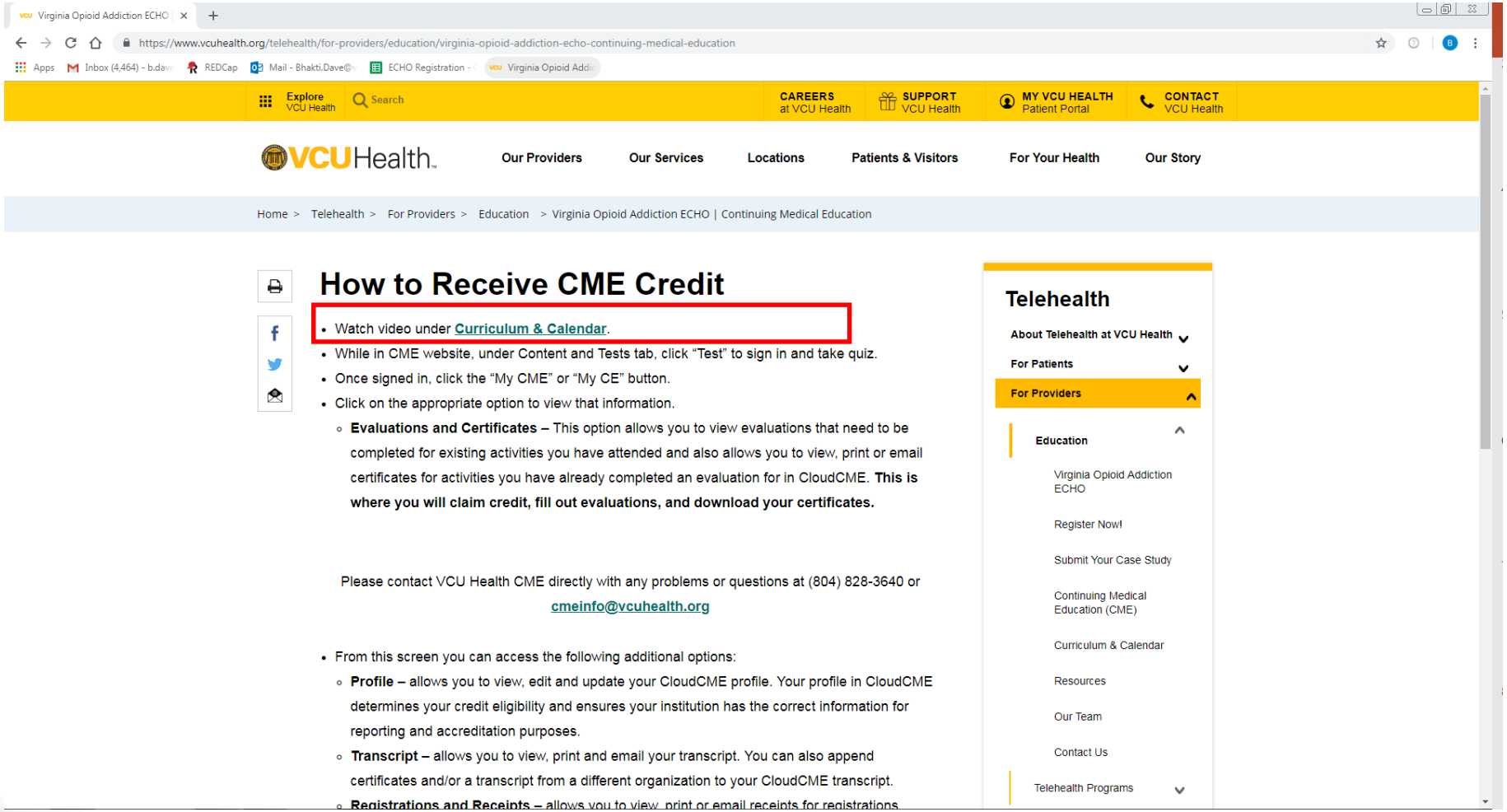
# Access Your Evaluation and Claim Your CME

- www.vcuhealth.org/echo
  - To view previously recorded clinics and claim credit

# Access Your Evaluation and Claim Your CME



# Access Your Evaluation and Claim Your CME



VCU Virginia Opioid Addiction TeleECHO Clinics

Bi-Weekly Fridays - 12-1:30 pm

## Mark Your Calendar --- Upcoming Sessions

| | | |
|---|---|---|
| 11/30 | Office Based Opioid Treatment using the DMAS model | Ke'Shawn Harper, MIS |
| 12/07 | Pharmacotherapy for AUD | Megan Lemay, MD |
| 01/04 | Trauma Informed Care and Treating Those Experiencing Opioid Addiction | Courtney Holmes, PhD |
| 01/18 | Syringe Exchange | Mishka Terplan, MD |

**Please refer and register at vcuhealth.org/echo**

Project ECHO®
Virginia Commonwealth University

# THANK YOU!

VCU

## D.I.R.E. Score: Patient Selection for Chronic Opioid Analgesia

For each factor, rate the patient's score from 1-3 based on the explanations in the right hand column.

| Score | Factor | Explanation |
|---|---|---|
| | Diagnosis | 1 = Benign chronic condition with minimal objective findings or no definite medical diagnosis. Examples: fibromyalgia, migraine headaches, nonspecific back pain.<br>2 = Slowly progressive condition concordant with moderate pain, or fixed condition with moderate objective findings. Examples: failed back surgery syndrome, back pain with moderate degenerative changes, neuropathic pain.<br>3 = Advanced condition concordant with severe pain with objective findings. Examples: severe ischemic vascular disease, advanced neuropathy, severe spinal stenosis. |
| | Intractability | 1 = Few therapies have been tried and the patient takes a passive role in his/her pain management process.<br>2 = Most customary treatments have been tried but the patient is not fully engaged in the pain management process, or barriers prevent (insurance, transportation, medical illness).<br>3 = Patient fully engaged in a spectrum of appropriate treatments but with inadequate response. |
| | Risk | (R = Total of P + C + R + S below) |
| | Psychological: | 1 = Serious personality dysfunction or mental illness interfering with care. Example: personality disorder, severe affective disorder, significant personality issues.<br>2 = Personality or mental health interferes moderately. Example: depression or anxiety disorder.<br>3 = Good communication with clinic. No significant personality dysfunction or mental illness. |
| | Chemical Health: | 1 = Active or very recent use of illicit drugs, excessive alcohol, or prescription drug abuse.<br>2 = Chemical coper (uses medications to cope with stress) or history of CD in remission.<br>3 = No CD history. Not drug-focused or chemically reliant. |
| | Reliability: | 1 = History of numerous problems: medication misuse, missed appointments, rarely follows through.<br>2 = Occasional difficulties with compliance, but generally reliable.<br>3 = Highly reliable patient with meds, appointments & treatment. |
| | Social Support: | 1 = Life in chaos. Little family support and few close relationships. Loss of most normal life roles.<br>2 = Reduction in some relationships and life roles.<br>3 = Supportive family/close relationships. Involved in work or school and no social isolation. |
| | Efficacy score | 1 = Poor function or minimal pain relief despite moderate to high doses.<br>2 = Moderate benefit with function improved in a number of ways (or insufficient info – hasn't tried opioid yet or very low doses or too short of a trial).<br>3 = Good improvement in pain and function and quality of life with stable doses over time. |

___ Total score = D + I + R + E

Score 7-13: Not a suitable candidate for long-term opioid analgesia
Score 14-21: May be a candidate for long-term opioid analgesia

# Addiction Behaviors Checklist (ABC)

Designed to track behaviors characteristic of addiction related to prescription opioid medications in chronic pain patients. Items are focused on observable behaviors noted both during and between visits. ABC is focused on longitudinal assessment and tracking of problematic behaviors.

## Addiction Behaviors Checklist

***Instructions*: Code only for patients prescribed opioid or sedative analgesics on behaviors exhibited ''since last visit'' and ''within the current visit'' (NA = not assessed)**

**Addiction behaviors—since last visit**

| | | | |
|---|---|---|---|
| 1. Patient used illicit drugs or evidences problem drinking* | Y | N | NA |
| 2. Patient has hoarded meds | Y | N | NA |
| 3. Patient used more narcotic than prescribed | Y | N | NA |
| 4. Patient ran out of meds early | Y | N | NA |
| 5. Patient has increased use of narcotics | Y | N | NA |
| 6. Patient used analgesics PRN when prescription is for time contingent use | Y | N | NA |
| 7. Patient received narcotics from more than one provider | Y | N | NA |
| 8. Patient bought meds on the streets | Y | N | NA |

**Addiction behaviors—within current visit**

| | | | |
|---|---|---|---|
| 1. Patient appears sedated or confused (e.g., slurred speech, unresponsive) | Y | N | NA |
| 2. Patient expresses worries about addiction | Y | N | NA |
| 3. Patient expressed a strong preference for a specific type of analgesic or a specific route of administration | Y | N | NA |
| 4. Patient expresses concern about future availability of narcotic | Y | N | NA |
| 5. Patient reports worsened relationships with family | Y | N | NA |
| 6. Patient misrepresented analgesic prescription or use | Y | N | NA |
| 7. Patient indicated she or he ''needs'' or ''must have'' analgesic meds | Y | N | NA |
| 8. Discussion of analgesic meds was the predominant issue of visit | Y | N | NA |
| 9. Patient exhibited lack of interest in rehab or self-management | Y | N | NA |
| 10. Patient reports minimal/inadequate relief from narcotic analgesic | Y | N | NA |
| 11. Patient indicated difficulty with using medication agreement | Y | N | NA |

**Other**

| | | | |
|---|---|---|---|
| 1. Significant others express concern over patient's use of analgesics | Y | N | NA |

*Item 1 original phrasing: (''Patient used ETOH or illicit drugs''), had a low correlation with global clinical judgment. This is possibly associated with difficulty in content interpretation, in that if a patient endorsed highly infrequent alcohol use, he or she would receive a positive rating on this item, but not be considered as using the prescription opioid medications inappropriately. Therefore, we include in this version of the ABC a suggested wording change for this item that specifies problem drinking as the criterion for alcohol use.

## ABC Score: _____

Score of ≥3 indicates possible inappropriate opioid use and should flag for further examination of specific signs of misuse and more careful patient monitoring (i.e., urine screening, pill counts, removal of opioid).

Checklist developed by Bruce D. Naliboff, Ph.D. with support from VA Health Services Research and Development. Used with permission.

Published in: Wu SM, Compton P, Bolus R, et al. The addiction behaviors checklist: validation of a new clinician-based measure of inappropriate opioid use in chronic pain. *J Pain Symptom Manage*. 2006;32(4):342-351.

# Opioid Risk Tool

## Introduction

**The Opioid Risk Tool (ORT) is a brief, self-report screening tool designed for use with adult patients in primary care settings to assess risk for opioid abuse among individuals prescribed opioids for treatment of chronic pain. Patients categorized as high-risk are at increased likelihood of future abusive drug-related behavior. The ORT can be administered and scored in less than 1 minute and has been validated in both male and female patients, but not in non-pain populations.**

# Opioid Risk Tool

This tool should be administered to patients upon an initial visit prior to beginning opioid therapy for pain management. A score of 3 or lower indicates low risk for future opioid abuse, a score of 4 to 7 indicates moderate risk for opioid abuse, and a score of 8 or higher indicates a high risk for opioid abuse.

| Mark each box that applies | Female | Male |
|---|---|---|
| **Family history of substance abuse** | | |
| Alcohol | 1 | 3 |
| Illegal drugs | 2 | 3 |
| Rx drugs | 4 | 4 |
| **Personal history of substance abuse** | | |
| Alcohol | 3 | 3 |
| Illegal drugs | 4 | 4 |
| Rx drugs | 5 | 5 |
| **Age between 16—45 years** | 1 | 1 |
| **History of preadolescent sexual abuse** | 3 | 0 |
| **Psychological disease** | | |
| ADD, OCD, bipolar, schizophrenia | 2 | 2 |
| Depression | 1 | 1 |
| **Scoring totals** | | |

Questionnaire developed by Lynn R. Webster, MD to asses risk of opioid addiction.

Webster LR, Webster R. Predicting aberrant behaviors in Opioid-treated patients: preliminary validation of the Opioid risk too. Pain Med. 2005; 6 (6) : 432

# Current Opioid Misuse Measure (COMM)™

The Current Opioid Misuse Measure (COMM)™ is a brief patient self-assessment to monitor chronic pain patients on opioid therapy. The COMM™ was developed with guidance from a group of pain and addiction experts and input from pain management clinicians in the field. Experts and providers identified six key issues to determine if patients already on long-term opioid treatment are exhibiting aberrant medication-related behaviors:

- *Signs & Symptoms of Intoxication*
- *Emotional Volatility*
- *Evidence of Poor Response to Medications*
- *Addiction*
- *Healthcare Use Patterns*
- *Problematic Medication Behavior*

The COMM™ will help clinicians identify whether a patient, currently on long-term opioid therapy, may be exhibiting aberrant behaviors associated with misuse of opioid medications. In contrast, the Screener and Opioid Assessment for Patients with Pain (SOAPP®) is intended to predict which patients, being considered for long-term opioid therapy, may exhibit aberrant medications behaviors in the future. Since the COMM™ examines concurrent misuse, it is ideal for helping clinicians monitor patients' aberrant medication-related behaviors over the course of treatment. The COMM™ is:

- A quick and easy to administer patient-self assessment
- 17 items
- Simple to score
- Completed in less than 10 minutes
- Validated with a group of approximately 500 chronic pain patients on opioid therapy
- Ideal for documenting decisions about the level of monitoring planned for a particular patient or justifying referrals to specialty pain clinic.
- The COMM™ is for clinician use only. The tool is not meant for commercial distribution.
- The COMM™ is **NOT** a lie detector. Patients determined to misrepresent themselves will still do so. Other clinical information should be used with COMM™ scores to decide if and when modifications to particular patient's treatment plan is needed.
- It is important to remember that all chronic pain patients deserve treatment of their pain. Providers who are not comfortable treating certain patients should refer those patients to a specialist.

 The COMM™ was developed with a grant from the National Institutes of Health and an educational grant from Endo Pharmaceuticals.

PainEDU.org
IMPROVING PAIN TREATMENT THROUGH EDUCATION

**COMM™**

Please answer each question as honestly as possible. Keep in mind that we are only asking about the **past 30 days**. There are no right or wrong answers. If you are unsure about how to answer the question, please give the best answer you can.

| **Please answer the questions using the following scale:** | **Never** | **Seldom** | **Sometimes** | **Often** | **Very Often** |
|---|---|---|---|---|---|
| | 0 | 1 | 2 | 3 | 4 |
| 1. In the past 30 days, how often have you had trouble with thinking clearly or had memory problems? | O | O | O | O | O |
| 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) | O | O | O | O | O |
| 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) | O | O | O | O | O |
| 4. In the past 30 days, how often have you taken your medications differently from how they are prescribed? | O | O | O | O | O |
| 5. In the past 30 days, how often have you seriously thought about hurting yourself? | O | O | O | O | O |
| 6. In the past 30 days, how much of your time was spent thinking about opioid medications (having enough, taking them, dosing schedule, etc.)? | O | O | O | O | O |

 The COMM™ was developed with a grant from the National Institutes of Health and an educational grant from Endo Pharmaceuticals.

PainEDU.org
IMPROVING PAIN TREATMENT THROUGH EDUCATION

| Please answer the questions using the following scale: | Never | Seldom | Sometimes | Often | Very Often |
|---|---|---|---|---|---|
| | 0 | 1 | 2 | 3 | 4 |
| 7. In the past 30 days, how often have you been in an argument? | O | O | O | O | O |
| 8. In the past 30 days, how often have you had trouble controlling your anger (e.g., road rage, screaming, etc.)? | O | O | O | O | O |
| 9. In the past 30 days, how often have you needed to take pain medications belonging to someone else? | O | O | O | O | O |
| 10. In the past 30 days, how often have you been worried about how you're handling your medications? | O | O | O | O | O |
| 11. In the past 30 days, how often have others been worried about how you're handling your medications? | O | O | O | O | O |
| 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? | O | O | O | O | O |
| 13. In the past 30 days, how often have you gotten angry with people? | O | O | O | O | O |
| 14. In the past 30 days, how often have you had to take more of your medication than prescribed? | O | O | O | O | O |
| 15. In the past 30 days, how often have you borrowed pain medication from someone else? | O | O | O | O | O |
| 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)? | O | O | O | O | O |



| Please answer the questions using the following scale: | Never | Seldom | Sometimes | Often | Very Often |
|---|---|---|---|---|---|
| | 0 | 1 | 2 | 3 | 4 |
| 17. In the past 30 days, how often have you had to visit the Emergency Room? | O | O | O | O | O |

 The COMM™ was developed with a grant from the National Institutes of Health and an educational grant from Endo Pharmaceuticals.

# Scoring Instructions for the COMM™

To score the COMM™, simply add the rating of all the questions. A score of 9 or higher is considered a positive

| Sum of Questions | COMM Indication |
|---|---|
| **> or = 9** | **+** |
| **< 9** | **-** |

As for any scale, the results depend on what cutoff score is chosen. A score that is sensitive in detecting patients who are abusing or misusing their opioid medication will necessarily include a number of patients that are not really abusing or misusing their medication. The COMM™ was intended to over-identify misuse, rather than to mislabel someone as responsible when they are not. This is why a low cut-off score was accepted. We believe that it is more important to identify patients who have only a possibility of misusing their medications than to fail to identify those who are actually abusing their medication. Thus, it is possible that the COMM™ will result in false positives – patients identified as misusing their medication when they were not.

The table below presents several statistics that describe how effective the COMM™ is at different cutoff values. These values suggest that the COMM™ is a sensitive test. This confirms that the COMM™ is better at identifying who is misusing their medication than identifying who is not misusing. Clinically, a score of 9 or higher will identify 77% of those who actually turn out to be at high risk. The Negative Predictive Values for a cutoff score of 9 is .95, which means that most people who have a negative COMM™ are likely not misusing their medication. Finally, the Positive likelihood ratio suggests that a positive COMM™ score (at a cutoff of 9) is nearly 3 times (3.48 times) as likely to come from someone who is actually misusing their medication (note that, of these statistics, the likelihood ratio is least affected by prevalence rates). All this implies that by using a cutoff score of 9 will ensure that the provider is least likely to miss someone who is really misusing their prescription opioids. However, one should remember that a low COMM™ score suggests the patient is really at low-risk, while a high COMM™ score will contain a larger percentage of false positives (about 34%), while at the same time retaining a large percentage of true positives. This could be improved, so that a positive score has a lower false positive rate, but only at the risk of missing more of those who actually do show aberrant behavior.

| COMM™ Cutoff Score | Sensitivity | Specificity | Positive Predictive Value | Negative Predictive Value | Positive Likelihood Ratio | Negative Likelihood Ration |
|---|---|---|---|---|---|---|
| Score 9 or above | .77 | .66 | .66 | .95 | 3.48 | .08 |

 The COMM™ was developed with a grant from the National Institutes of Health and an educational grant from Endo Pharmaceuticals.

PainEDU.org
IMPROVING PAIN TREATMENT THROUGH EDUCATION

# Screener and Opioid Assessment for Patients with Pain- Revised (SOAPP®-R)

The Screener and Opioid Assessment for Patients with Pain- Revised (SOAPP®-R) is a tool for clinicians to help determine how much monitoring a patient on long-term opioid therapy might require. This is an updated and revised version of SOAPP V.1 released in 2003.

Physicians remain reluctant to prescribe opioid medication because of concerns about addiction, misuse, and other aberrant medication-related behaviors, as well as liability and censure concerns. Despite recent findings suggesting that most patients are able to successfully remain on long-term opioid therapy without significant problems, physicians often express a lack of confidence in their ability to distinguish patients likely to have few problems on long-term opioid therapy from those requiring more monitoring.

SOAPP-R is a quick and easy-to-use questionnaire designed to help providers evaluate the patients' relative risk for developing problems when placed on long-term opioid therapy. SOAPP-R is:

- A brief paper and pencil questionnaire
- Developed based on expert consensus regarding important concepts likely to predict which patients will require more or less monitoring on long-term opioid therapy (content and face valid)
- Validated with 500 chronic pain patients
- Simple to score
- 24 items
- <10 minutes to complete
- Ideal for documenting decisions about the level of monitoring planned for a particular patient or justifying referrals to specialty pain clinic.
- The SOAPP-R is for clinician use only. The tool is not meant for commercial distribution.
- The SOAPP-R is **NOT** a lie detector. Patients determined to misrepresent themselves will still do so. Other clinical information should be used with SOAPP-R scores to decide on a particular patient's treatment.
- The SOAPP-R is **NOT** intended for all patients. The SOAPP-R should be completed by chronic pain patients being considered for opioid therapy.
- It is important to remember that all chronic pain patients deserve treatment of their pain. Providers who are not comfortable treating certain patients should refer those patients to a specialist.

**SOAPP®-R**

The following are some questions given to patients who are on or being considered for medication for their pain. Please answer each question as honestly as possible. There are no right or wrong answers.

| | Never | Seldom | Sometimes | Often | Very Often |
|---|---|---|---|---|---|
| | 0 | 1 | 2 | 3 | 4 |
| 1. How often do you have mood swings? | ○ | ○ | ○ | ○ | ○ |
| 2. How often have you felt a need for higher doses of medication to treat your pain? | ○ | ○ | ○ | ○ | ○ |
| 3. How often have you felt impatient with your doctors? | ○ | ○ | ○ | ○ | ○ |
| 4. How often have you felt that things are just too overwhelming that you can't handle them? | ○ | ○ | ○ | ○ | ○ |
| 5. How often is there tension in the home? | ○ | ○ | ○ | ○ | ○ |
| 6. How often have you counted pain pills to see how many are remaining? | ○ | ○ | ○ | ○ | ○ |
| 7. How often have you been concerned that people will judge you for taking pain medication? | ○ | ○ | ○ | ○ | ○ |
| 8. How often do you feel bored? | ○ | ○ | ○ | ○ | ○ |
| 9. How often have you taken more pain medication than you were supposed to? | ○ | ○ | ○ | ○ | ○ |
| 10. How often have you worried about being left alone? | ○ | ○ | ○ | ○ | ○ |
| 11. How often have you felt a craving for medication? | ○ | ○ | ○ | ○ | ○ |
| 12. How often have others expressed concern over your use of medication? | ○ | ○ | ○ | ○ | ○ |

| | Never | Seldom | Sometimes | Often | Very Often |
|---|---|---|---|---|---|
| | 0 | 1 | 2 | 3 | 4 |
| 13. How often have any of your close friends had a problem with alcohol or drugs? | ○ | ○ | ○ | ○ | ○ |
| 14. How often have others told you that you had a bad temper? | ○ | ○ | ○ | ○ | ○ |
| 15. How often have you felt consumed by the need to get pain medication? | ○ | ○ | ○ | ○ | ○ |
| 16. How often have you run out of pain medication early? | ○ | ○ | ○ | ○ | ○ |
| 17. How often have others kept you from getting what you deserve? | ○ | ○ | ○ | ○ | ○ |
| 18. How often, in your lifetime, have you had legal problems or been arrested? | ○ | ○ | ○ | ○ | ○ |
| 19. How often have you attended an AA or NA meeting? | ○ | ○ | ○ | ○ | ○ |
| 20. How often have you been in an argument that was so out of control that someone got hurt? | ○ | ○ | ○ | ○ | ○ |
| 21. How often have you been sexually abused? | ○ | ○ | ○ | ○ | ○ |
| 22. How often have others suggested that you have a drug or alcohol problem? | ○ | ○ | ○ | ○ | ○ |
| 23. How often have you had to borrow pain medications from your family or friends? | ○ | ○ | ○ | ○ | ○ |
| 24. How often have you been treated for an alcohol or drug problem? | ○ | ○ | ○ | ○ | ○ |

*Please include any additional information you wish about the above answers.*
*Thank you.*

# Scoring Instructions for the SOAPP®-R®

All 24 questions contained in the SOAPP®-R have been empirically identified as predicting aberrant medication-related behavior six months after initial testing.

To score the SOAPP, add the ratings of all the questions. A score of 18 or higher is considered positive.

| Sum of Questions | SOAPP-R Indication |
|---|---|
| **> or = 18** | **+** |
| **< 18** | **-** |

***What does the Cutoff Score Mean?***

For any screening test, the results depend on what cutoff score is chosen. A score that is good at detecting patients at-risk will necessarily include a number of patients that are not really at risk. A score that is good at identifying those at low risk will, in turn, miss a number of patients at risk. A screening measure like the SOAPP-R generally endeavors to minimize the chances of missing high-risk patients. This means that patients who are truly at low risk may still get a score above the cutoff. The table below presents several statistics that describe how effective the SOAPP-R is at different cutoff values. These values suggest that the SOAPP-R is a sensitive test. This confirms that the SOAPP-R is better at identifying who is at high risk than identifying who is at low risk. Clinically, a score of 18 or higher will identify 81% of those who actually turn out to be at high risk. The Negative Predictive Values for a cutoff score of 18 is .87, which means that most people who have a negative SOAPP-R are likely at low-risk. Finally, the Positive likelihood ratio suggests that a positive SOAPP-R score (at a cutoff of 18) is 2.5 times (2.53 times) as likely to come from someone who is actually at high risk (note that, of these statistics, the likelihood ratio is least affected by prevalence rates). All this implies that by using a cutoff score of 18 will ensure that the provider is least likely to miss someone who is really at high risk. However, one should remember that a low SOAPP-R score suggests the patient is very likely at low-risk, while a high SOAPP-R score will contain a larger percentage of false positives (about 30%); at the same time retaining a large percentage of true positives. This could be improved, so that a positive score has a lower false positive rate, but only at the risk of missing more of those who actually do show aberrant behavior.

| SOAPP-R Cutoff Score | Sensitivity | Specificity | Positive Predictive Value | Negative Predictive Value | Positive Likelihood Ratio | Negative Likelihood Ration |
|---|---|---|---|---|---|---|
| Score 17 or above | .83 | .65 | .56 | .88 | 2.38 | .26 |
| Score 18 or above | .81 | .68 | .57 | .87 | 2.53 | .29 |
| Score 19 or above | .77 | .75 | .62 | .86 | 3.03 | .31 |

***How does the SOAPP-R help determine appropriate treatment?***
The SOAPP-R should only be one step in the assessment process to determine which patients are high-risk for opioid misuse. The following discussion examines the assessment and treatment options for chronic pain patients who are at risk (high risk or medium risk) and those who are likely not at risk.

***Who is at a high risk for opioid misuse? (SOAPP-R score = 22 or greater*)***

Patients in this category are judged to be at a high risk for opioid misuse. These patients have indicated a history of behaviors or beliefs that are thought to place them at a higher risk for opioid misuse. Some examples of these behaviors or beliefs include a current or recent history of alcohol or drug abuse, being discharged from another physician' care because of his/her behavior, and regular noncompliance with physicians' orders. These patients may have misused other prescription medications in the past. It is a good idea to review the SOAPP-R questions with the patient, especially those items the patient endorsed. This will help flesh out the clinical picture, so the provider can be in the best position to design an effective, workable treatment plan.

Careful and thoughtful planning will be necessary for patients in this category. Some patients in this category are probably best suited for other therapies or need to exhaust other interventions prior to entering a treatment plan that includes chronic opioid therapy. Others may need to have psychological or psychiatric treatment prior to or concomitant with any treatment involving opioids. Patients in this category who receive opioid therapy should be required to follow a strict protocol, such as regular urine drug screens, opioid compliance checklists, and counseling.

Specific treatment considerations for patients in this high-risk category:

- Past medical records should be obtained and contact with previous and current providers should be maintained.
- Patients should also be told that they would be expected to initially give a urine sample for a toxicology screen during every clinic visit. They should also initially be given medication for limited periods of time (e.g., every 2-weeks).
- Ideally, family members should be interviewed and involvement with an addiction medicine specialist and/or mental health professional should be sought.
- Less abusable formulations should be considered (e.g., long-acting versus short-acting opioids, transdermal versus oral preparation, tamper-resistant medications).
- Early signs of aberrant behavior and a violation of the opioid agreement should result in a change in treatment plan. Depending on the degree of violation, one might consider more restricted monitoring, or, if resources are limited, referring the patient to a program where opioids can be prescribed under stricter conditions. If violations or aberrant behaviors persist, it may be necessary to discontinue opioid therapy.

** Note these are general ranges. Clinicians should also complement SOAPP scores with other clinical data such as urine screens and psychological evaluations.*

***Who is at a moderate risk for opioid misuse? (SOAPP-R score = 10 to 21*)***

Patients in this category are judged to be at a medium or moderate risk for opioid misuse. These patients have indicated a history of behaviors or beliefs that are thought to place them at some risk for misuse. Some examples of these behaviors or beliefs are family history of drug abuse, history of psychological issues such as depression or anxiety, a strong belief that medications are the only treatments that will reduce pain and a history of noncompliance with other prescription medications. It is a good idea to review the SOAPP-R items the patient endorsed with the patient present.

Some of these patients are probably best treated by concomitant psychological interventions in which they can learn to increase their pain-coping skills, decrease depression and anxiety, and have more frequent monitoring of their compliance. They may need to be closely monitored until proven reliable by not running out of their medications early and having appropriate urine drug screens.

Additional treatment considerations for patients in this category:

- Periodic urine screens are recommended.
- After a period in which no signs of aberrant behavior are observed, less frequent clinic visits may be indicated. If there are any violations of the opioid agreement, then regular urine screens and frequent clinic visits would be recommended.
- After two or more violations of the opioid agreement, an assessment by an addiction medicine specialist and/or mental health professional should be mandated.
- After repeat violations referral to a substance abuse program would be recommended. A recurrent history of violations would also be grounds for tapering and discontinuing opioid therapy

** Note these are general ranges. Clinicians should also complement SOAPP scores with other clinical data such as urine screens and psychological evaluations.*

***Who is at a low risk for opioid misuse? (SOAPP-R score < 9*)***

Patients in this category are judged to be at a low risk for opioid misuse. These patients have likely tried and been compliant with many other types of therapies. They should be able to handle their medication safely with minimal monitoring. They are apt to be responsible in their use of alcohol, not smoke cigarettes, and have no history of previous difficulties with alcohol, prescription drugs, or illegal substances. This patient probably reports few symptoms of affective distress, such as depression or anxiety.

As noted previously, the SOAPP-R is not a lie detector. The provider should be alert to inconsistencies in the patient report or a collateral report. Any sense that the patient's story "doesn't add up" should lead the provider to take a more cautious approach until experience suggests that the person is reliable.

Patients in this category would be likely to have no violations of the opioid treatment agreement. These patients are least likely to develop a substance abuse disorder. Additionally, they may not require special monitoring or concomitant psychological treatment.

Additional treatment considerations for patients in this category:

- Review of SOAPP-R questions is not necessary, unless the provider is aware of inconsistencies or other anomaly in patient history/report.
- Frequent urine screens are not indicated.
- Less worry is needed about the type of opioid to be prescribed and the frequency of clinic visits.
- Efficacy of opioid therapy should be re-assessed every six months, and urine toxicology screens and update of the opioid therapy agreement would be recommended annually.

11:50:30 From Jessica Gillispie : Jessica Gillispie, PA-C New Horizons Healthcare Roanoke VA

11:50:47 From VCU Health Support : Welcome!

11:54:19 From Health Quality Innovators - Michelle White : Michelle White, MSW - Health Quality Innovators

11:55:15 From Heather Scott : Heather Scott-Walnut Hill Pharmacy

11:55:43 From Kimberly Albero : Kimberly Albero, University of Virginia

11:58:21 From ostephe : Orlando Stephenson, Horizon Behavioral Health

12:02:19 From VCU Health Support : Can you also please make sure your Zoom site/screen name has the name of the institution you represent?

12:03:51 From nicole hill : Nicole Hill with Crossroads in Farmville, VA

12:15:19 From sahsan : do we have audio! I can not hear

12:15:50 From Vimal : welcome everyone

12:17:18 From Yusuf Khan, MD : Hello Everyone! Yusuf Khan, MD from Ashburn Family Medicine in Ashburn, VA.

12:19:05 From Vimal : Dr. Lipato is our guest speaker today. He is an addiction and sickle cell specialist at VCU.

12:24:44 From Vimal : Feel free to send your questions via chat

12:26:05 From VCU Health Support : Please list your name/site in the chat if youhaven't done it yet

12:27:18 From Vimal : Todays talk - Chronic Opioid Therapy in Patients with Substance Use Disorders

12:41:58 From Vimal : Prevalence of SUDs in chronic pain patients

12:42:22 From Vimal : Possible misuse at 24% of COT recipients in the commercially insured sample and 20% in the Medicaid sample[1]

12:42:49 From Vimal : A random sample of 705 chronic pain patients receiving COT in primary care and specialty pain treatment
26% of those reported a current opioid use disorder and 36% had a life-time[2]

12:44:46 From Vimal : Chronic Opioid Therapy in Patients with Substance Use Disorders - Dr. Lipato recommends following 10 Steps of Universal Precautions.

12:55:10 From Vimal : Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act that removes the originating site geographic requirements and adds the home of an individual as a permissible originating site for telehealth services furnished for purposes of treatment of a substance use disorder or a co-occurring mental health disorder for services furnished on or after July 1, 2019.

12:55:19 From Vimal : https://www.cms.gov/newsroom/fact-sheets/final-policy-payment-and-quality-provisions-changes-medicare-physician-fee-schedule-calendar-year

13:00:57 From Vimal : https://www.hhs.gov/opioids/sites/default/files/2018-09/hhs-telemedicine-hhs-statement-final-508compliant.pdf

13:15:20 From Vimal : Dr. Lipto - Thank you for the summary and reommendations.

13:17:58 From Vimal : Thanks Dr. Van Zee for case presentation!!

13:23:07 From Rosie Lewis : Do you or anyone screen or at any point condct genetic testing for receptors, metabolism etc?

13:27:35 From Rosie Lewis : IS it bc of cost? or just what to do with it?

13:28:57 From Rosie Lewis : It should be interpretated using Interprofessional collaboration with pharmacy and other genetics specialist. It is as you say a guide.

13:34:44 From VCU Health Support : Please remember unmuting your site when you speak and mute (!) back when you don't

13:41:06 From Vimal : https://www.vcuhealth.org/services/telehealth/for-providers/telehealth-education

13:41:07 From VCU Health Support : vcuhealth.org/echo

**Case Study #1 – Recommendations**

**Presented by Al Van Zee, MD**

48 YO Male
Relapse prevention and management of chronic pain

- History of substance abuse
- Chronic back pain, occupation as truck driver
- Tried antiflammatory medication
- Has seen orthopedic
- Wants pain management, but reluctant to use traditional opioids
- Treated with combo of Buphonophrine and Naloxone, not traditional, but gave enough pain relief so that he could be functional

**Spoke recommendations:**

- None stated

**Hub recommendations:**

- Don't think of these drugs as traditional pain medications, but they do have analgesic effect
- Balbucca: New drug which is Morphine + Naloxone: Marketed for pain management. Abuse deterrent. Likely to see more of these medications introduced.
- Important for patients to understand the medication
- Important for patients that it is provided for 2 reasons: To treat pain, and for relapse prevention

---

**Case Study #2 – Recommendations**

**Presented by Thoko Lipato, MD**

44 YO Male
Sickle cell patient

- Never formally diagnosed with SUD
    - High dose opioids, exhibiting aberrant behavior
    - However, has had several documented uses of cocaine and heroine
    - Intermittently positive and negative on opioid
        - Concern that patient might be diverting medications
- Is there a safe way to manage this patient with sickle cell disease, chronic pain, and significant opioid dependency
- Does he have OUD? Or pseudo-addiction?

**Spoke recommendations:**

- Failure of opioid therapy?
    - Consider genetic testing
- Change opioid regimen
    - Consider a pain pump
    - Change opioid rotation
- Tighter monitoring
    - Put on regimen of weekly toxicology screens
- Adjuvant therapy
    - Consider any psychiatric conditions not being addressed
- Other
    - Consider having spouse control medicines
    - Any role for an anti-depressant
    - Consider giving patient a purpose, and have him serve in his role as barber, to provide some emotional fulfillment

**Hub recommendations:**

- Discussed genetic testing and challenge of knowing what to do with results