tipSC | Timely Information for Providers in South Carolina

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OPIOID ADDICTION ISN'T A CHOICE

An outreach service for Medicaid providers to help identify and prevent potential gaps in evidence-based care, as well as detect fraud, abuse, overuse or inappropriate use.

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PICK UP QUICK TIPS ON...identifying patients with or at risk for Opioid Use Disorder (OUD)

Screen patients being prescribed opioids, at baseline and ongoing, to help identify those with or at risk for OUD and to help guide management strategies, including need for referral.

QUICK tip SC

OUD is a manageable chronic disease, just like hypertension and diabetes

QUICK FACTS TO CONSIDER

- **As many as 1 in 4 patients** on chronic opioid therapy for pain may begin to **use opioids inappropriately.**
- **Buprenorphine and methadone** (opioid-agonist therapy) **and naltrexone** (non-opioid) **are all FDA-approved** treatment options **for OUD.**
- **Physical dependence is not the same thing as addiction;** everyone who takes opioids for an extended period will become physically dependent.
- Only **1 in 5 individuals** with an opioid use disorder **receives treatment.**

CLINICAL PEARLS

The odds are high you have at least one patient who is at risk for or has OUD and could benefit from management/treatment. **Baseline and ongoing monitoring in all patients is important since no one is at zero risk for OUD** (or diversion) and risk or benefit can change at any time.

Monitoring patients for potential OUD is multi-faceted and includes: patient observation; family feedback; quantitative information, such as urine drug screens and prescription drug monitoring (SCRIPTS or DHEC) reports; and self-report and physician assessment tools. Ideally, it **starts before ever prescribing**. It is also important to screen for mental health concerns that often co-occur with OUD, including depression, bipolar disorder, anxiety and poly-drug abuse.

Besides assessing for OUD, ongoing monitoring helps recognize and document when benefits exceed risks in patients who do not show warning signs of abuse or diversion and are benefiting from opioids as part of their chronic pain management.

Guidelines agree we need to start somewhere and generally include monitoring recommendations based on relatively weak or indirect evidence due to the pressing need to address opioid-related adverse outcomes.

SELECTED SCREENING TOOLS FOR MONITORING AND DOCUMENTATION[1]

Patient self-assessment tools validated for use in primary care

Tool	Baseline	Ongoing	Number of Questions	Time to Completion
Risks of Opioid Therapy				
ORT	√		10	≤ 1 minute
SOAPP-R	√		24	5 minutes
COMM		√	17	≤ 10 minutes
Benefits of Opioid Therapy				
PEG	√	√	3	< 1 minute
Co-Morbid Health Concerns				
PHQ-9 (Depression)	√	√	10	4 minutes
GAD-7 (Anxiety)	√	√	7	2 – 5 minutes
Single-Item Screen (Polysubstance)[2]	√	√	1 (alcohol)[3] 1 (drug)[4]	< 1 minute

[1] This does not preclude screening tools you use in your practice or your clinical judgement. [2] Self-assessment demonstrated as valid approach in primary care to detect unhealthy alcohol/drug use. [3] How many times in the past year have you had 5 (male) / 4 (female) or more drinks in a day? (> 0 positive) [4] How many times in the past year have you used an illegal drug or prescription medication for non-medical reasons (for example, because of the experience or feeling it caused)? (> 0 positive).

KEY: COMM Common Opioid Misuse Measure; **GAD-7** Generalized Anxiety Disorder 7-item Scale; **ORT** Opioid Risk Tool; **PEG** Three item scale of pain (P), enjoyment of life (E), general activity (G); **PHQ-9** Patient Health Questionnaire 9-item depression scale; **SOAPP-R** Screener and Opioid Assessment for Patients with Pain - Revised

ASSESSING FUTURE OPIOID RISK

The Opioid Risk Tool© (ORT) is one brief, validated patient self-assessment used in primary care **prior to prescribing** that **may help determine how closely to monitor a patient when initiating a trial of opioids.** The CDC notes the inconsistency of ORT results and the paucity of quality evidence to support *any* tool that predicts the relative risk of opioid misuse and abuse. While the ORT has had mixed results, the individual questions are crafted around components that place patients at risk for opioid misuse and abuse. **At a minimum, the ORT opens the door that it is okay to talk about these things.**

OPIOID RISK TOOL©

Patient Name: _____ Female ___ / Male ___ Date: _____

Relative risk of individual questions varies by gender

		Female	Male	Score
1. Family His	❑ Alcohol	1	3	_____
	❑ Illegal Drugs	2	3	_____
	❑ Prescription Drugs	4	4	_____
2. Personal History of Substance Abuse	❑ Alcohol	3	3	_____
	❑ Illegal Drugs	4	4	_____
	❑ Prescription Drugs	5	5	_____
3. Age	❑ 16 – 45	1	1	_____
4. History of Preadolescent Sexual Abuse	❑ Yes	3	0	_____
5. Psycholog	❑ Attention Deficit Disorder Obsessive Compulsive Disorder Bipolar Schizophrenia	2	2	_____
	❑ Depression	1	1	_____
			TOTAL	_____

The ORT provides one data point to help assess risk of future opioid use.

SCORING:
≤ 3: Low risk
4 – 7: Moderate risk
≥ 8: High risk

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

ASSESSING CURRENT/ONGOING OPIOID RISK

A good clinical interview along with good eye contact may uncover symptoms/behaviors of OUD in your patient. OUD symptoms may become more apparent when tapering an opioid to a reduced dose or discontinuation.

OUD (i.e., opioid addiction) is a maladaptive pattern of opioid use leading to impairment or distress manifested by at least 2 of the 11 diagnostic criteria listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) occurring within a 12-month period. Severity of OUD is determined by the number of symptoms present (i.e., mild: 2 – 3 symptoms, moderate: 4 – 5 symptoms, severe: 6 or more symptoms).

DECLINE IN FUNCTIONING

- Failure to fulfill major role obligations at work, school or home
- Important social, occupational or recreational activities are reduced or given up
- Tolerance (*e.g., needing to take more and more to achieve same effect*)*
- Withdrawal (*e.g., feeling sick if opioid is not taken on time*)*

*Not applicable if taking opioid under medical supervision

LOSS OF CONTROL

- Taking larger amounts or over a longer time period than was intended (*e.g., repeated requests for early refills, multiple office contacts regarding opioids*)
- Persistent desire or unable to cut down or control use
- Trying to obtain/use/recover from opioids consumes a lot of time
- Craving or a strong desire or urge to use opioids

CONTINUED USE DESPITE NEGATIVE CONSEQUENCES

- Ongoing use despite persistent or recurrent social or interpersonal problems related to the effects of opioids (*e.g., spouse or family member worried or critical about use*)
- Continued use despite ongoing physical or psychological problems caused by opioids
- Recurrent use in situations in which it is physically hazardous (*e.g., driving under influence repeatedly*)

The Current Opioid Misuse Measure (COMM)® is an example of a brief, validated patient self-report useful in the ongoing monitoring of pain patients currently on chronic opioid therapy **to help identify possible OUD and related aberrant behaviors.**

Current Opioid Misuse Measure (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 problem	0	0	0	0	0
2. In the past 30 days, how often do people com doing things that need to be done, such as going to	0	0	0	0	0
3. In the past 30 days, how often have you had t o get sufficient pain relief from medications? (i.e., a rces)	0	0	0	0	0
4. In the past 30 days, how often have you taken your medications differently from how they are prescribed?	0	0	0	0	0
5. In the past 30 days, how often have you seriou	0	0	0	0	0
6. In the past 30 days, how much of your time w ugh, taking them, dosing schedule, etc.)?	0	0	0	0	0
7. In the past 30 days, how often have you been	0	0	0	0	0
8. In the past 30 days, how often have you had trouble controlling your anger (e.g., road rage, screaming, etc.)?	0	0	0	0	0
9. In the past 30 days, how often have you neede	0	0	0	0	0
10. In the past 30 days, how often have you been	0	0	0	0	0
11. In the past 30 days, how often have others bee s?	0	0	0	0	0
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?	0	0	0	0	0
13. In th ?	0	0	0	0	0
14. In medication than prescribed?	0	0	0	0	0
15. In rom someone else?	0	0	0	0	0
16. In or symptoms other than for pain (e.g., to help you sleep, improve your mood, or relieve stress)?	0	0	0	0	0
17. In the past 30 days, how often have you had to visit the Emergency Room?	0	0	0	0	0

COMM SCORING:
Sum total rating (0 – 4) of all questions
≥ 9: Positive
< 9: Negative

The intentional low cut-off score of ≥ 9 over-identifies misuse to better detect those actually misusing as well as those with a possibility of misuse.

The COMM helps document decisions about the planned level of monitoring and/or need for referral.

The COMM, like all other screening tools, helps objectify the decision-making process, provides consistency and reduces stigma when given to every patient.

 The Current Opioid Misuse Measure (COMM)® was developed with a grant from the National Institutes of Health and an educational grant from Endo Pharmaceuticals.

PATIENTS WITH OPIOID ADDICTION NEED TREATMENT – NOT STIGMA

- AMA Task Force 2015

There is good evidence that patients with OUD, including patients with chronic pain, can be well managed with medication assisted treatment (MAT) that includes agonist medication for addiction treatment (e.g., buprenorphine/naloxone, methadone), and experience lower rates of relapse. In addition to medication, MAT includes frequent drug use monitoring and counseling/behavioral therapies.

Conversations about OUD/treatment can be difficult.

- **Express concern and provide feedback** *"I am concerned about your health and safety. This is the third time you have run out of pain medications early."*
- **Validate pain and set boundaries** *"I believe you are suffering/in pain, and I cannot safely prescribe you this opioid at this time."*
- **Provide education and support** *"I want you to know that there is excellent medication for opioid addiction that can help with pain and prevent withdrawal."*

If you are interested in learning more or providing MAT at your practice, please visit http://scmataccess.com and/or contact Rachel Grater at grater@musc.edu or 843.792.5380

To find substance abuse treatment services in your area visit: https://www.findtreatment.samhsa.gov

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This information is intended to assist primary care providers in the management of pain in adults in a primary care setting. This information is advisory only and is not intended to replace sound clinical judgment nor should it be regarded as a substitute for individualized diagnosis and treatment. Special considerations are needed when treating some populations with certain conditions (such as respiratory/sleep disorders; cardiac; liver/renal impairment; addiction; debility; elderly; and pregnancy/breast-feeding).