PAINWEEK®

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

Ted Jones, PhD, CPE

Recognized as

"distinguished comprehensive multidisciplinary pain care"

Disclosures

- Contract with Ethos Laboratories regarding an electronic version of the Brief Risk Questionnaire (BRQ)

Learning Objectives

- Describe what practice data to gather that can inform a clinician about the rates of medication aberrant behavior at their practice
- Explain some general principles about when to end opioids and when they can be continued
- List which risk assessment tools have greater or lesser sensitivity

Ain’t Misbehavin’

“I don't stay out late
Don't care to go
I'm home about eight
Just me and my radio
Ain't misbehavin'
I'm savin' my love for you”

- Fats Waller, Harry Brooks, Andy Razaf (1929)

Don't You Want…

- Patients that:
  - Take their medication exactly as prescribed
  - Inform you, at visits and not after hours, of what you need to know
  - Collaborate with you appropriately before outpatient procedures or when seeing other providers
  - Have appropriate UDT's and pill counts at every visit

You Can, Mostly

- There will always be troublesome patient behaviors to deal with.
- But you can indeed decrease problem behaviors.
- There are ways to change individual and group behavior.
- The following uses psychological principles with your patients – and you – to decrease medication aberrant behavior.

“Why me?”

- Do you know someone who says “I don’t why I always seem to attract that kind of guy/girl?”
- Yeah, it may be them. Less than consciously.
- And for problem patients it may be you – at least in part.

First, who is seeking you out?

Your Practice

Marketing


ALL WAY
PAIN
MANAGEMENT
257-9077


Public
Library
ADULTS
TEENS
362.5562
PAIN
MANAGEMENT
865-365-4675

Your Practice

- Expectations are important.
- They begin with the referral sources.
- The more you act like a reputable practice, the more you will get reputable patients.
- Work to increase referrals from neurosurgeons, specialists and primary care providers.

Self-Referrals

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

Your office environment

Look at these buildings


NORTH PALM
PAIN MANAGEMENT
FOX
29


POLICE
KNOXVILLE


Pro Relief Center
407-237-0044
2021
POLICE
POLICE


LIVE
NEWS 13
12:02
65° SANFORD
PAIN CLINIC RAIDED, 5 ARRESTED


1128
Pain Consultants
OF EAST TENNESSEE
Suite 100


Pain Consultants
Suite 100
Pain Consultants
Ted Jones, PhD
Laura Stockdale, PhD
Hours of Operation
M-F 8:00 - 4:30
No Food or Drink
Joe H. Brewster, MD, MBA
Physician
James J. Choo, MD
Physician
Susan Dalfron, FNP-BC
Nurse Practitioner
Darren McCoy, FNP-BC
Nurse Practitioner
Brandy Bledsoe, FNP-BC
Nurse Practitioner
Kendra Bellamy, FNP-BC
Nurse Practitioner
Courtney Head, FNP-BC
Nurse Practitioner
Amy Patterson-Wade, FNP-BC
Nurse Practitioner
Bonnie Norman, FNP-BC
Nurse Practitioner
Elizabeth Harding, ANP-BC
Nurse Practitioner

Take a Look at Your Office

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

The Physical Environment

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

The Welcome Letter

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

Prescribing at the First Visit

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

Not Now

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

“I only have a few pills left”

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

The Big Picture

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

Once he or she gets there

A Proper Evaluation

The Essentials of an Initial Evaluation

- Pain complaint
- Physical exam
- Scans / Studies / Labs

- Risk assessment
- UDS / UDT / OFT
- Past medical records
- PMP information

Risk Score vs Risk Assessment

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

TWO risks

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

We are not there yet

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

Rating for potential medication aberrant behavior

Risk Assessment

Risk Assessment Tools

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

For your reference

Quick Snapshots of Each Tool

SOAPP

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

PMQ

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

ORT

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

DIRE

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

SOAPP-R

- Patient-completed. 24 items. None reverse scored. Risk level is based on total score.
- Officially L-H risk rating (≥18). Manual mentions L-M-H cutoff scoring.
- http://empainline.org/practioner-resources-pdfs/SOAPP-R.pdf
- Pros: More “opaque” than SOAPP. The industry standard.
- Cons: No data on the M category (“off label use”).

PDUQp

- Patient-completed. 31 items. One reverse scored. Risk level is based on total score.
- ≥ 10 is more predictive of MAB
- http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2630195/pdf/nihms73559.pdf
- Pros: Validation data looks good. Developed by a leader in the field.
- Cons: Not studied in other populations. No official L-M-H categories.

BRI

- Staff interview (7-15 minutes). 12 areas of inquiry. Each area rated as to risk. Overall risk is the highest rating of any category.
- UDT and records information contributes to the rating.
- www.tedjonesresearch.com
- Pros: Shows best predictive ability of all risk tools.
- Cons: Requires staff time to ask the questions. Might require some staff training to use.

NRM

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

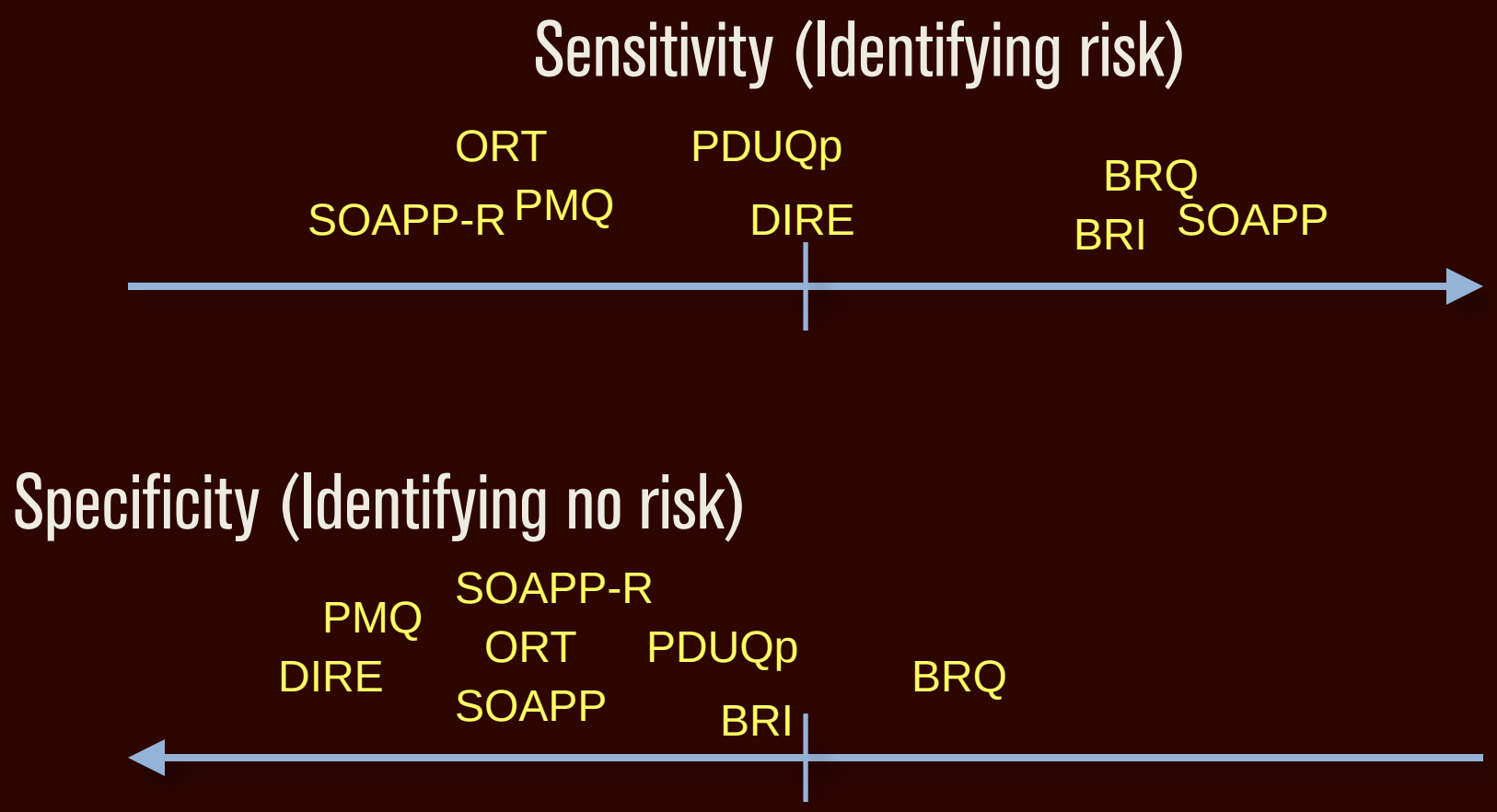
BRQ

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

SOABR

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

Risk Assessment Study Averages



Bottom Line

- Relative to other risk assessment tools the ORT and SOAPP-R miss more patients that later engage in medication aberrant behavior.
- So if you are having problems with medication aberrant behavior, it may be your risk assessment tool is not identifying risky patients well enough (is not sensitive enough).

Higher sensitivities

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

The ORT

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

Cues and Clues to Problems

How do I know if I have a problem?

- Other than a gut feeling or regulatory accusations, it is hard to know if you have a problem or need to take any of these steps.
- The following offers some empirical data to help you assess your practice.
- Here are some possible benchmarks.

UDT Numbers

	Unexpected +	Unexpected -	Illicit drugs	Total inappropriate%
Katz '03	-	-	11%	-
Kell '05	14%[1]	-	20%	-
Ives '06	26%	8%	5%	32%
Manchikanti '06	-	-	16%	-
Fleming '07	-	-	24%	-
Michna '07	15%	10%	20%	45%
Cone '08	-	-	11%	-
Fishbain "08	20%		11%	-
Schneider '08	-	-	10%	-
Jones, '10	11%	2%	4%	15%

[1] tested only oxycodone

So MAYBE expect…

	Unexpected +	Unexpected -	Illicit drugs	Total inappropriate%
	10-30%	5-20%	5-30%	15-45%

If your rate of inappropriate UDT's is higher than these rates, then it might behoove you to look deeper into your practice patterns.

Also

- At PCET we end opioid treatment on about **10%** of our patients each year ("discharge" them).
- If your rate of ending opioids – or your "discharge" rate – is significantly higher than this, it might be that you are prescribing opioids to an overly risky population of patients,
- And changes may be in order.

More comparative data

Your Risk Assessment Tool

Risk Tools' Results

	Webster '05	Butler '09	Jones '12	Jones '13	Jones '15	Jones '15
Low, Low-Medium	10%	34% & 35%	40%	37%	51%	40%
Medium	66%	-	31%	33%	40%	60%
Medium-High, High, Very High	24%	66% & 65%	30%	30%	9%	

So MAYBE expect…

Low	15-45%
Medium	30-50%
High	10-30%

If you are having a significant rate of medication aberrant behaviors and your Low risk assessment % is higher than this, your risk tool may not be sensitive enough.

And Finally, Which Behaviors

	Jones ' 15	Jones '15
Short pill count. theft, lost medication	36%[1]	49%
UDT + for non-prescribed opioids	32%	28%
UDT + for illicit drugs or alcohol	11%	9%
UDT – for prescribed opioids	16%	3%
Non-UDT data about use of opioids form other sources	5%	1%
Inappropriate behavior	3%	1%
Non-UDT data about use of alcohol / illicit drugs	0%	0%

[1] % of total medication aberrant behavior

If you are having a significant rate of medication aberrant behaviors, you might compare your numbers to these to see what sorts of problems you are having.

It can be hard to do

Saying NO to Opioids

Prescribing Opioids

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

And

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

Everyone on the same page

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

Create a practice protocol

RISK:	LOW	MEDIUM	HIGH
Hydrocodone 5, 7.5, 10 mg	Y	Y	Y (60)
Oxycodone 5, 7.5, 10 mg	Y	Y	N
Oxycodone 15, 30 mg	Y	N	N
Rapid onset opioids	Y	N	N
Qid dosing SA	Y	Y	N
More than qid dosing SA	Y	N	N
carisoprodol	N	N	N
benzodiazepines	N	N	N
UDT's	2x a year	4X a year	Every visit
PMP check	1x a year	4X a year	Every visit
Pill count	Every other visit	Every visit	Every visit
Visit frequency	Every Other Month	Monthly	Weekly
Review/re-eval. Point(s)	120 MED dose		

The neglected tool

The Treatment Agreement and Patient Education

Treatment Agreement

- I find it odd that some state guidelines recommend the use of a treatment agreement only at a certain dose.
- In my view a treatment agreement is indicated for every patient being prescribed opioids.
- How else are they going to know what to expect from you and what they are supposed to do?

Patient Education

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

The Two

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

How Do You Do It Now?

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

I'm Not a Fan of Pamphlets

- Do you really read the information about airplane safety in your seat back cushion?
- When was the last time you looked at it?

- Do you fly Delta?
- Did you watch the safety information video they did?
- They have seven versions, and all are entertaining.

So

- I do not think:
  - a brief conversation with the prescriber,
  - A brief conversation with the pharmacist,
  - A signature that the patient has been educated, or
  - A pretty pamphlet about safe storage and disposal of medication
- are adequate or sufficient to educate patients and change behavior.
- So what happens at our practice?

Medication Class?

- We require that all patients attend a 75 minute "medication class" – a class on "How to be a proper patient on opioids."
- We review such topics as:
  - Why the medication agreement is SO important
  - What to do if you get hurt or have surgery
  - How to carry your medications around legally
  - Storage of medication

Medication Class? (cont'd)

- We review such topics as:
  - THC & alcohol use
  - Visit expectations
  - Calling the practice
  - The primary goal of treatment: function, not pain
  - Expectations for pain relief ("takes the edge off" is all)

E.g., proper storage

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

Dealing with medication aberrant behavior

Ten Questions to Ask When Facing Medication Aberrant Behavior

When to End Opioids?

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

The Ten Questions to Ask

1. **Is the (UDT) finding correct and truly inconsistent with what has been prescribed?**
   - Be sure it really is unexpected.
2. **Does the finding reflect a medically dangerous behavior?**
   - The more medically dangerous or risky the behavior, the more quickly the clinician should discontinue opioid treatment.

3. Does the finding reflect illegal behavior?

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

4. **Did (or should) the patient know better, based on the education provided?**
   - Consider how well the patient has been educated about the treatment agreement.
5. **Does the finding reflect a patient taking a substance for pain, or for some other reason?**
   - To the extent possible, the clinician should determine why the patient did what he or she did

6. **At what risk level has the patient been assessed?**
   - Higher risk patients get fewer chances
7. **Is the patient being honest about what happened?**
   - Patients who are not forthcoming about their medication aberrant behavior offer more risk for continued treatment.

8. Based on the above, how should the treatment plan change?

- Some change in treatment is called for when facing medication aberrant behavior. Never ignore it.

9. **Has the patient made changes as requested to decrease the chances of a given behavior happening again?**
   - If a recommended change is not implemented by a patient in a reasonable amount of time, then it is more likely that opioid treatment should be discontinued.

10. Has there been documentation of the finding, the clinician's thought process, and communication to the patient?

—If you don't, you ignored the whole thing, and that's not good.

Ask for Help

- I recommend that you ask for help in making these decisions.
- Ask other providers for input.
- Set up a system for input – in person or in email or with a form that several staff review.
- We all have our blind spots and favorite patients. Ask for help, and consider others' input.

Wrapping it up

In Summary

- Work to decrease your self-referral %.
- Create a parking lot & waiting room environment that represents a good medical practice.
- Have a welcome letter that outlines expectations
- Create a practice process in which opioids are rarely prescribed at the first visit.

- Look at your overall failed UDT rate and your discharge rate, and compare yourself.
- Look at your assessed % of low risk patients and compare yourself.
- Look at what kinds of medication aberrant behaviors you are having, and compare yourself.

- Be able to say “no” or “stop” to opioid prescribing.
- Have a practice protocol that brings all providers to a general consensus on when, how and what opioids to prescribe.
- Put significant effort into informed consent and educating your patients about what is expected of them.

- Do not necessarily stop opioids if any medication aberrant behavior is found.
- Ask yourself ten questions when you are faced with medication aberrant behavior, and address the situation using clinical judgment.
- Ask for help and advice on any of these issues.

Questions?

“Ain’t Misbehavin’: Decreasing and Managing Medication Aberrant Behavior”

Thank you!