THIS SESSION IS BEING RECORDED

UVM Project ECHO: Chronic Pain

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Agenda

- Introductions and announcements
- Session objectives
- Didactic presentation (20-25 min)
  - Q & A
- Case presentations
  - Clarifying questions
  - Discussion
    - First, participants – then program faculty
  - Summary of recommendations
- Session parking lot items for follow up
- Closing reminders
  - Complete session evaluation (session recording info included in this email)
  - Session slides posted at www.vtahec.org
  - Submit a new case, template posted at www.vtahec.org

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Interest Disclosures:

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UVM Project ECHO Chronic Pain:
Assessing for Misuse/Addiction

Speaker: Doug Bugbee, LICSW, LADC

August 2, 2019

Objectives

- Understand the prevalence of misuse and define addiction
- Identify the signs of misuse and signs of addiction
- Build knowledge of resources and best practices for screening and assessment of risk for misuse

How prevalent is Opioid Misuse?

- Varied data- based on differences in populations and definitions of opioid misuse.
- 3-26% of patients prescribed long-term opioids meet DSM 5 criteria for OUD. 26% at sometime during past year met criteria, 3% using conservative 30 day measure.
- 2015 national survey estimates 13% prescription opioid misuse. Systematic review of incidence of opioid use disorder among patients prescribed opioids for chronic pain estimated to be 8 to 12 percent.
- Among samples of patients who were prescribed long-term opioid treatment (generally three months or greater) for chronic non-cancer pain syndromes, 16 to 78 percent had behaviors consistent with opioid misuse.
- Almost all (98%) take prescribed opioids for pain relief. 34% report addiction or dependence. 34% recreational high, 22% use as stress and coping med, 12% for relaxation, tension relief. (2016 Washington Post/Kaiser survey)
- Prevalence is increasing- those seeking SUD treatment identifying non-heroin opioids as primary substance increased from 1% to 9.3% from 1995 to 2013.

What is Addiction?

- Terms: Abuse, Dependence (Physical, Psychological), now under umbrella of Opioid Use Disorder (OUD) in DSM 5.
- Biggest predictor of OUD is long term opioid dependence.
- Pseudo-addiction: under-treatment of pain. Problem: what is adequate treatment of pain(subjective)?
- Substance use disorder vs poor coping skills (chem)

DSM 5 criteria for OUD

- Opioids are often taken in larger amounts or over a longer period than intended.
- There is a persistent desire or unsuccessful efforts to cut down or control use.
- A great deal of time is spent in activities obtaining, using, or recovering.
- Craving, a strong desire or urge to use opioids.
- Opioid use resulting in failure to fulfill major role obligations at work, school, or home.
- Continued use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids.
- Important social, occupational, or recreational activities are given up or reduced because of opioid use.
- Recurrent 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
- 2-5 sxs of above, mild, moderate, 6 or more=severe

Risk Factors for Misuse

- Substance use disorder (most consistently identified), including tobacco use disorder
- Family history of a substance use disorder
- Mental health disorder, including depression or posttraumatic stress disorder
- History of legal problems or incarceration
- White race (compared with black race), despite studies that have identified greater clinician concern and closer monitoring for black patients
- Age less than 40 to 45 years old, in most studies

SCREENING INSTRUMENT FOR SUBSTANCE ABUSE POTENTIAL (SISAP) QUESTIONNAIRE

1. If you drink, how many drinks do you have on a typical day?
    - If less than 5 for men/less than 4 for women, then ask question 2.
    - If 5 or more for men/4 or more for women, then you may stop here ..... Use caution when prescribing opioids.

2. How many drinks do you have in a typical week?
    - If less than 17 for men/less than 13 for women, then ask question 3.
    - If 17 or more for men/13 or more for women, then you may stop here ..... Use caution when prescribing opioids.

3. Have you used marijuana or hashish in the last year?
    - If no, then ask question 4.
    - If yes, then you may stop here ..... Use caution when prescribing opioids.

SISAP(cont)

4. Have you ever smoked cigarettes?
   - If no, then you may stop here ..... Probably a low opioid abuse risk.
   - If yes, then ask question 5.

5. What is your age?
   - If under 40 years of age, then you may stop here ..... Use caution when prescribing opioids.
   - If 40 years of age or older, then you may stop here ..... Probably a low opioid abuse risk.

NOTE: Use caution when prescribing opioids to these patients:

a. Men who drink more than 4 alcoholic beverages per day or 16 per week

b. Women who drink more than 3 alcoholic beverages per day or 12 per week

c. Persons who admit to recreational use of marijuana or hashish in the previous year

d. Persons who are younger than 40 years of age and smoke

Timeframe for Full Substance Assessment

- Risk factors present: before prescribing opioids
- No or few risk factors: 90 days if pt wants continued opioids
- Decision of therapy for pain with substance use disorder, no different if substance use disorder is treated.
- The risk profile that emerges from assessment should help to inform decisions about whether to prescribe or continue prescribing controlled substances, and, if the clinician chooses to prescribe them, will help to inform the intensity of monitoring and determine which additional treatments are indicated.
- Window of tolerance

Screening Tools

- General Substance Abuse:
  DAST(10), AUDIT(AUDIT-C), CAGE
- Considering L-T Opioid Tx:
  SOAPP-R, SISAP, DIRE
- Once Opioid Tx initiated:
  COMM, ABC (Addiction Behaviors Checklist), PDUQ, PADT
- Assessing withdrawal: COWS

https://www.affirmhealth.com/blog/identifying-and-assessing-patient-risk-a-must-for-opioid-prescribers

AUDIT-C

Please circle the answer that is correct for you.

1. How often do you have a drink containing alcohol?					**SCORE**
Never (0)	Monthly or less (1)	Two to four times a month (2)	Two to three times per week (3)	Four or more times a week (4)	_____
2. How many drinks containing alcohol do you have on a typical day when you are drinking?					
1 or 2 (0)	3 or 4 (1)	5 or 6 (2)	7 to 9 (3)	10 or more (4)	_____
3. How often do you have six or more drinks on one occasion?					
Never (0)	Less than Monthly (1)	Monthly (2)	Two to three times per week (3)	Four or more times a week (4)	_____
TOTAL SCORE Add the number for each question to get your total score.					_____

Scoring: The AUDIT-C is scored on a scale of 0-12. Each AUDIT-C question has 5 answer choices. Points allotted are:

- a = 0 points, b = 1 point, c = 2 points, d = 3 points, e = 4 points
- In men, a score of $\geq$ 4 is considered positive, optimal for identifying hazardous drinking or active alcohol use disorders. In women, a score of $\geq$ 3 is considered positive (same as above).
- However, when the points are all from Question #1 alone (#2 & #3 are zero), it can be assumed that the patient is drinking below recommended limits and it is suggested that the provider review the patient's alcohol intake over the past few months to confirm accuracy.

Signs of Misuse

- Multiple lost or stolen prescriptions
- Running out of medication early
- Aggressive complaints about need for additional prescriptions
- Drug hoarding during periods of reduced sxs
- Urgent calls, unscheduled visits
- Injecting or snorting prescribed opioids
- Using meds for euphoric effect
- Use of prescribed opioid to self-medicate another problem, e.g. insomnia

Signs of Misuse (cont)

- Frequently missing appts unless it is for opioid renewal
- Unwillingness to try non-opioid treatments
- Visible withdrawal at appts
- Concurrent alcohol or illicit drug use
- Sedation, declining activity, sleep disturbances, irritability unexplained by pain or other co-occurring conditions
- Deterioration of occupational or social functioning
- Forging or selling prescriptions
- Obtaining opioids from multiple medical sources

Addiction Behaviors Checklist

Addiction behaviors—since last visit

1. Patient used illicit drugs or evidences problem drinking* Yes No Not Assessed

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 Checklist(cont)

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

Addiction Behaviors Checklist(cont)

- 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

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.

Clinical Opioid Withdrawal Scale (COWS)

- COWS may be used in both inpatient and outpatient settings:
  - During Detox: for the general monitoring of opiate withdrawal during opioid detoxification.
  - During Pain Treatment: for patients receiving opiates for the treatment of acute or chronic pain who may show subtle signs of opiate withdrawal.
  - In the ED & More: for patients requesting methadone for opiate withdrawal symptoms and their enrollment in methadone maintenance treatment has not been verified.
- COWS is most commonly used in buprenorphine induction, and is recommended specifically for this use.

COWS Clinical Opiate Withdrawal Scale

Wesson & Ling, J Psychoactive Drugs. 2003 Apr-Jun;35(2):253-9.

Resting Pulse Rate: _____beats/minute *Measured after patient is sitting or lying for one minute* 0 Pulse rate 80 or below 1 Pulse rate 81-100 2 Pulse rate 101-120 4 Pulse rate greater than 120	GI Upset: *over last 1/2 hour* 0 No GI symptoms 1 Stomach cramps 2 Nausea or loose stool 3 Vomiting or diarrhea 5 Multiple episodes of diarrhea or vomiting
Sweating: *over past 1/2 hour not accounted for by room temperature or patient activity.* 0 No report of chills or flushing 1 Subjective report of chills or flushing 2 Flushed or observable moistness on face 3 Beads of sweat *on* brow or face 4 Sweat streaming off face	Tremor *observation of outstretched hands* 0 No tremor 1 Tremor can be felt, but not observed 2 Slight tremor observable 4 Gross tremor or muscle twitching
Restlessness *Observation during assessment* 0 Able to sit still 1 Reports difficulty sifting still, but is able to do so 3 Frequent shifting or extraneous movements of legs/arms 5 Unable to sit still for more than a few seconds	Yawning *Observation during assessment* 0 No yawning 1 Yawning once or twice during assessment 2 Yawning three or more times during assessment 4 Yawning several times/minute
Pupil size 0 Pupils pinned or normal size for room light 1 Pupils possibly larger than normal for room light 2 Pupils moderately dilated 5 Pupils so dilated that only the rim of the iris is visible	Anxiety or irritability 0 None 1 Patient reports increasing irritability or anxiousness 2 Patient obviously irritable anxious 4 Patient so irritable or anxious that participation in the assessment is difficult
Bone or Joint aches *If patient was having pain previously, only the additional component attributed to opiates withdrawal is scored* 0 Not present 1 Mild diffuse discomfort 2 Patient reports severe diffuse aching of joints/ muscles 4 Patient is rubbing joints or muscles and is unable to sit still because of discomfort	Gooseflesh skin 0 Skin is smooth 3 Piloerrection of skin can be felt or hairs standing up on arms 5 Prominent piloerrection
Runny nose or tearing *Not accounted for by cold symptoms or allergies* 0 Not present 1 Nasal stuffiness or unusually moist eyes 2 Nose running or tearing 4 Nose constantly running or tears streaming down cheeks	Total Score _____ The total score is the sum of all 11 items Initials of person completing Assessment:_____

Score: 5-12 mild; 13-24 moderate; 25-36 moderately severe; more than 36 = severe withdrawal

Resources

- https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3200070/
- https://www.uptodate.com/contents/opioid-use-disorder-epidemiology-pharmacology-clinical-manifestations-course-screening-assessment-and-diagnosis
- https://www.affirmhealth.com/blog/identifying-and-assessing-patient-risk-a-must-for-opioid-prescribers

Cases/HIPAA

<u>DO NOT INCLUDE:</u>

- Names
- Address
- DOB
- Phone/Fax #
- Email address
- Social Security #
- Medical Record #

The discussion and materials included in this conference are confidential and privileged pursuant to 26VSA Section 1441-1443. This material is intended for use in improving patient care. It is privileged and strictly confidential and is to be used only for the evaluation and improvement of patient care.

- STOP RECORDING

Reminders

- Volunteers to present cases (key to the Project ECHO)
- Use the case template form posted at www.vtahec.org
  - Return completed case forms to: Mark.Pasanen@uvmhealth.org
- Please complete evaluation survey after each session
- Claim your CME at www.highmarksce.com/uvmmed
- Please contact us with any questions, concerns, or suggestions
  - Mark.Pasanen@uvmhealth.org
  - Elizabeth.Cote@uvm.edu
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