Caught between the Scylla and the Charybdis?

Integrating Risk Management into Your Practice for Chronic Pain Patients.

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Disclosures

With respect to my presentation, I do not have any financial arrangement or affiliations with any corporate organization(s) offering financial grants or support or development or sales of products to be discussed in this CME Program.
Assumptions

- You have decided that a trial of opioid therapy is warranted for your patient with chronic non-cancer pain (CNCP).
  - I will not be debating the merit of opioids in CNCP, that is a topic for an entire CME conference.
- You have performed a thorough medical evaluation and have considered or exhausted other options.
- You are interested in learning about additional methods of protecting your practice and your patients.

Objectives

- Identify the patient screening tools available to clinicians to assess the level of risk prior to initiation of opioid therapy
- Examine methods to monitor patient during opioid therapy for signs of aberrant drug behaviors
- Interpret the basic utility of urine drug testing as a risk management tool
- Apply the use of opioid treatment agreement and other methods to protect the primary care practice and patient
- Develop an “exit strategy” when opioid therapy must be discontinued
The Scylla (The Rock)

- Over 116 million people suffer from chronic pain in United States on a daily basis.
- > Heart disease, cancer and diabetes combined

- Pain costs the nation up to $635 billion each year in medical treatment and lost productivity.

- Pain research constitutes <1% of the NIH budget.

Relieving Pain In America: A Blueprint for Transforming Prevention, Care, Education and Research. Institute of Medicine, 2011.

The Charybdis (and the Hard Place)

- Prescription analgesics now kill more Americans than heroin and cocaine combined.
  - In some states overdose deaths is the leading cause of death, surpassing MVAs.

- Pennsylvania is tied with Ohio as 10\textsuperscript{th} in the country for fatal overdoses – 15.1 deaths per 100,000 people.

- Nonmedical use of prescription painkillers costs health insurers up to $72.5 billion annually in direct health care costs.

- 111% increase in ED visits due to nonmedical use of prescription opioids

- 400% increase in substance abuse treatment admissions for people abusing prescription drugs

CDC Morbidity and Mortality Report 2011;60(43);1487-1492.
www.responsibleopioprescribing.org
Assessing Risk Prior to Initiation of Opioid Trial

- All patients being considered for chronic opioid therapy should be screened for risk of substance abuse
  - This allows the clinician to stratify the patient for risk

- There are a number of tools that have demonstrated predictive value in chronic pain patients
  - ORT
  - DIRE
  - SOAPP-R
    - 5 items, less than 1 min. to administer and score
    - Provides excellent discrimination between high-risk and low-risk patients (Passik et al. Pain Medicine 2009;S2:S145-S166.)
    - Exhibits a high degree of sensitivity & specificity for determining which individuals are at high risk for opioid abuse (Webster, et al. Pain Medicine 2005;6:432-442.)
    - Patients characterized as high risk on the ORT have an increased likelihood of future abusive drug related behavior (Chou, et al. J Pain 2009;10:113-130.)
• 7 items, less than 2 minutes to administer and score


• Showed sensitivity, efficacy, specificity and high internal consistency (Belgrade at al. 2006;7:671-681.)

Ω 24 items, 5 min. to administer and score, > or =18 (identify ~81% of high risk pts)
Ω Provides excellent discrimination between high risk and low risk patients
Ω High-risk score on the SOAPP-R correlates with an increased likelihood of drug abuse
Definitions

- Addiction - A primary, chronic, neurobiologic disease, with genetic, psychosocial, and environmental factors influencing its development and manifestations.

  Characterized by behaviors that include one or more of the following:
  - Impaired control over drug use
  - Compulsive use
  - Craving
  - Continued use despite harm

Definitions (cont)

- Physical dependence – A state of adaptation that is manifested by a withdrawal syndrome that can be produced by abrupt cessation, rapid dose reduction, or administration of an antagonist.
  - Withdrawal - A syndrome that occurs due to the cessation or reduction of prolonged use of the drug. Acute opioid withdrawal is characterized by dysphoria, nausea or vomiting, muscle aches, lacrimation, rhinorrhea, pupillary dilation, diarrhea, yawning, fever, or insomnia.
Definitions (cont)

- **Abuse** – The use of a substance to modify or control mood or state of mind in a manner that is illegal or harmful to oneself or others. Examples of harmful use include accidents or injuries, blackouts, death by overdose, legal problems, and sexual behavior that increases the risk for communicable diseases.

- **Misuse** – The use of a substance in a manner not consistent with legal or medical guidelines, such as altering dosing or sharing medicines, which has harmful or potentially harmful consequences, exclusive of use for psychoactive purposes. Misuse can be intentional or unintentional.

- **Diversion** – Redirecting the supply of legally obtainable drugs into illegal channels or obtaining a controlled substance by an illegal method.

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## Triage Tool

<table>
<thead>
<tr>
<th>RISK LEVEL</th>
<th>CHARACTERISTICS</th>
<th>MANAGEMENT</th>
</tr>
</thead>
</table>
| Low        | • No history of substance abuse; minimal if any risk factors | • Can be managed by PCP  
• If aberrant behaviors are observed, consider increasing risk category |
| Medium     | • Past history of substance abuse; significant risk factors  
• Patient previously assigned to low risk exhibiting aberrant behaviors | • PCP co-manages with addiction and/or pain specialists  
• If aberrant behaviors are observed or persist, consider assigning to high-risk category |
| High       | • Active substance abuse problem; history of prescription opioid abuse  
• Patient previously assigned to medium risk exhibiting aberrant behaviors | • Risk of opioid prescribing by non-specialists will generally outweigh benefits  
• Refer treatment to specialists in management of patients with co-morbid pain and addictive disorders  
• Continue to manage patient’s medical care |
Prior to Prescribing an Opioid

- Explain that opioids are being started in a time-limited trial
  - Meaningful pain relief
  - Improved function
  - Little or no side effects
  - Steady doses
  - Good compliance with rules of opioid trial
Prior to Prescribing an Opioid (cont)

- Urine drug screen prior to start of opioid
- Avoid use of extended-release opioids for acute pain or opioid-naïve patients
- Limit all initial and refill prescriptions for acute pain
- Explain risk of opioids to include ongoing constipation, respiratory depression, accidental overdose, hypogonadism & other endocrine effects, sleep-disordered breathing
- Patient responsibility to keep medications in safe, locked location and not to share medication with anyone else

Patient Treatment Agreement
(The Patient’s Responsibilities)

- Only the following primary prescribing doctor will prescribe opioid medications for you: _______________________. (Identify only one pharmacy as well – especially in PA without a ePMP!)
- You agree not to ask for opioid medications from any other doctor without the knowledge and agreement of your primary prescribing doctor.
- You agree to keep all scheduled appointments, not just with your doctor, but also with recommended therapist, consultants, and psychological counselors. Three or more missed appointments or same-day cancellations may lead to tapering off of opioid medications.
- You agree to provide urine samples for drug screens, on a regular basis or upon request of your doctor. Positive tests for any illegal substances, or medications not prescribed by your physician, may result in tapering off of opioid therapy, and possibly referral elsewhere for substance abuse evaluation and management.
No prescriptions will be refilled early

No prescriptions will be refilled if you lose, destroy, or have any of your medications stolen.

Prescription refills will be authorized only during regular office hours. If you want prescriptions mailed to you, contact our office seven working days prior to the refill date. If you want to pick up the prescriptions in person, call two working days in advance of renewal date.

Successful pain management means doing more than one treatment, including regular exercise and using healthy coping strategies. Patients who continue to rely only on medications, who resist exercise, or who refuse to implement psychological strategies may have their medications discontinued and may be referred to another center for treatment.

You will secure your medications as you would cash, in a lock box or other similar device.

Make sure your medications are secured if you are going to be around children.

You will not share your medications with anyone, even if they appear to have a legitimate need, or take someone else’s medications—this is how people die of overdoses, and this is also a crime punishable by arrest and possible imprisonment.

You will tell your doctor any information that he or she needs to know to provide you the best treatment. This includes pastor present problems with drugs or alcohol, especially prescription drugs.

You will report any side effects or other problems you are having with your medication so that we can help you through them.
Patient Treatment Agreement
(Clinician’s Responsibilities)

▲ We will provide you the highest-quality pain management based on our professional judgment, or refer you elsewhere if this in your best interest.

▲ We will provide you opioid medications if that appears to be in your best interest, or provide you other pain treatments if those appear to be best for you.

▲ We will taper off and stop your opioid medications if: (1) you are not getting sufficient pain relief, (2) you are not achieving goals for improved function, (3) the dose needs to go higher and higher to achieve pain relief, or (4) you are not able to follow the rules indicated above for safe opioid treatment. This does not mean we will abandon you. You will continue to work with you to find better treatments for your pain.

▲ We will treat you with respect and dignity.

Patient Treatment Agreement
(Possible Side Effects of Opioid Medications)

▲ Opioids may cause drowsiness that can be worsened with alcohol, benzodiazepines (Ativan and similar medications), and other sedating medications. Use care when driving or operating machinery.

▲ Taking more than prescribed, or taking your medication in combination with other non-prescribed medications or alcohol, can cause severe side effects, even death.

▲ Other common, usually temporary, side effects include nausea, itching, and sweating. Psychological depression may also occur. Sleep apnea, if present, may be worsened by opioids. If you snore or have trouble breathing at night, or if you are too sleepy during the day, tell your doctor. Constipation commonly occurs, and often does not improve with time. It is impossible to predict opioid side effects in any individual patient. Having side effects on one opioid does not necessarily mean that there will be side effects on another opioid.
Patient Treatment Agreement  
(Possible Side Effects of Opioid Medications)

- You must take opioids only as directed. Tampering with the dosage, such as cutting or crushing it when you’re not supposed to, is dangerous and potentially fatal.

- Physical dependence will develop with regular use. This means that if you stop the medication suddenly you will feel sick for a few days (withdrawal syndrome). Important: This does not by itself indicate addiction. You need to plan ahead to not run out of your medications.

- Tolerance may develop to the pain relieving effects of opioids; this means that the pain relief may be decrease over time. If this happens, tell your doctor.

Patient Treatment Agreement  
(Exiting Opioid Therapy)

- Not everybody benefits from opioid therapy.

- Patients on opioid therapy who do not look like they are going to benefit, should come off opioids.

- The usual signs that the patient will not benefit from opioid therapy are:
  - Problems with side effects at the lowest doses that relieve pain
  - Escalating doses without pain relief in sight
  - Trouble following the rules of opioid therapy
  - Deterioration in physical or mental function while an opioid therapy
  - Persistent severe pain despite high doses

- If you fall into one or more of the above categories, we will slowly taper you off opioid medications while trying other types of pain treatments.
Signs of Opioid Abuse

- Deterioration of personal appearance and hygiene
- Appearing intoxicated or sedated or confused
- Increasingly negative moods and mood swings
- Overreactions to criticism or complements
- Increasing complaints about coworkers, family, or friends
- Carelessness; making frequent mistakes and showing poor judgment
- Involvement in a car accident (3.6 times more likely to have an accident at work and 9 times more likely to have a car accident or accident at home)

Signs of Opioid Abuse

- Frequent and recurring financial problems
- Frequent tardiness at work
- Requests for early dismissal (2.2 times more often)
- Frequent use of sick time (3 times more often)
- Frequent filing of worker compensation claims (5 times more likely)
- Purposeful oversedation
- Use of pain medication in response to stress
- Use of more medication than prescribed
Signs of Opioid Abuse

- Reporting lost/stolen prescriptions
- Requesting frequent early renewal/running out a medications early
- Attempting to obtain prescriptions from other doctors
- Buying medication on the streets
- Alteration of dosage formulations
- Legal problems: arrest; driving under the influence; domestic violence
- Contact with substance abusers

Urine Drug Testing: Why, Who and How to Test?
Background

▲ Urine
  ➢ Preferred biologic specimen for detecting the presence or absence of drugs

▲ Other methods
  ➢ Blood, saliva, hair, sweat

▲ Useful for monitoring opioid use
  ➢ Controversies regarding clinical value
  ➢ Current methods were designed for forensic or workplace deterrent-based testing

Background (cont.)

▲ Accurate interpretation is the key
  ➢ Data suggests most clinicians lack essential knowledge regarding proper collection / validation, interpretation and confirmation¹-³

▲ Understand the limits

▲ Should be used in combination with history and physical assessment, functional assessment, and behavioral observations

Terms to Understand

Limits of Detection (LOD)
- Lowest amount of drug that a laboratory can reliably identify in a specimen

Cut-off Values
- The drug concentration above which an assay reports a positive result and below which, the result is negative

High LOD and cut-off values can lead to false-negative results and misinterpretation

Goals of Urinary Drug Monitoring

- Monitor for illegal or non-prescribed drugs
- Monitor compliance with prescribed medications
- Identify diversion
- Support assessment & diagnosis
- Strengthen the physician-patient relationship
Why use UDM?

1/5 patients treated in pain clinics may be misusing or abusing the controlled substances you are prescribing\(^1\)

The prevalence of drug abuse / addiction among chronic pain patients ranges from 3.2% - 18.9\(^{\text{2}}\)

- May be lower or higher based on patient population

Numerous studies have proven the unreliability of patient self-report\(^3\text{-}5\)


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Why use UDM?

The patient self-report of illegal and non-prescribed drug use is often unreliable

<table>
<thead>
<tr>
<th>UDS Results</th>
<th>Aberrant Behaviors</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Positive</td>
<td>8%</td>
<td>21%</td>
</tr>
<tr>
<td>Negative</td>
<td>14%</td>
<td>57%</td>
</tr>
<tr>
<td>Total</td>
<td>22%</td>
<td>78%</td>
</tr>
</tbody>
</table>

Primary UDM Testing Methods

- Immunoassay
- Gas Chromatography / Mass Spectrometry (GC / MS)
- Liquid Chromatography-Mass Spectrometry/Mass Spectrometry (LC-MS/MS)

Immunooassay

- Most common, least expensive, rapid
- Can be done in the office = Point of Care (POC)
- Low levels of sensitivity and specificity
- May test only for a “class” of drugs
  - Amphetamines, Cocaine, Opiates, PCP, THC
- Low levels may be reported as “negative”
- Subject to cross-reactivity
  - Typically only detects natural opiates
Opioids by Type

- **Natural**
  - Morphine
  - Codeine

- **Semisynthetic**
  - Heroin
  - Hydrocodone
  - Hydromorphone
  - Oxycodone
  - Oxymorphone
  - Buprenorphine

- **Synthetic**
  - Fentanyl
  - Meperidine
  - Methadone
  - Propoxyphene

Example – Case 1
GC / MS

- “Gold-standard” for confirmation testing
- Highly sensitive and specific
- Used initially or as a follow up test to immunoassay to identify a specific drug or its metabolite
- Provides exact concentrations = quantitative results
- Tests for natural, synthetic and semisynthetic opioids

LC-MS/MS

- Most advanced and sensitive analytical method for detecting prescription pain medications
- Tandem mass spectrometry allows simultaneous quantification of multiple drugs and metabolites
  - More time-efficient method compared to GC/MS
- Not available in all laboratories and more expensive than other methods
Who to Test?

- Standardized approach is recommended
- Present as a precondition for all for opioid therapy
- Avoid “singling out” particular patients based on appearance, dress, etc
- Consider testing at every visit if practical
- New patients already receiving a controlled substance
- Patients starting a controlled substance
- Patients who request a specific drug
- Patients who display aberrant behaviors
- Multiple requests for dose increases
- Support decision to refer

Before Ordering UDM

- Let the laboratory know what you are looking for in your monitoring
  - Strong lines of communication with lab personnel is crucial
- Take a thorough history of prescribed, OTC, and herbal drugs
  - Last dose and quantity
- Ask about drug abuse / addiction history
- Controlled substance treatment agreements and informed consent
How to Test: Specimen collection

- Random collection is preferred
- Unobserved is typically acceptable
- No running water allowed
- Blue pigment added to toilet water

Laboratory Testing Process

- Typically a 2-Step Process
  - **STEP I: Immunoassay screening**
    - Laboratory-based or Point-of-Care
    - Classify as either present or absent
  - **STEP II: Confirmation (GC/MS, LC-MS/MS)**
    - Laboratory-based
    - Identify or confirm specific drugs or metabolites and quantities
Interpreting Results

Background

- Immunoassays are the most commonly used methods of UDM
  - Only specific for a class of drugs
  - Qualitative results (positive or negative)
  - Cut-off values may vary
  - Cross reactivity can occur with other substances, leading to false-positives

- Misunderstandings can lead to inappropriate discharges
- Monitoring should be used to improve patient care
- Requires the clinician to understand the science behind the test
### Interpretation of Urine Drug Monitoring Results

<table>
<thead>
<tr>
<th>Patient has taken the drug</th>
<th>Patient has NOT taken the drug</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Positive test result</strong></td>
<td><strong>True positive</strong></td>
</tr>
<tr>
<td><strong>Negative test result</strong></td>
<td><strong>False negative</strong></td>
</tr>
</tbody>
</table>

False-negatives are typically related to the cut-off levels or limits of detection (LOD):
- Typical THC cut-off conc. = 50 - 100 ng/mL
- Typical opiate cut-off conc. = 200- 2000 ng/mL
- Typical amphetamine cut-off conc. = 1000 ng/mL

False-positives are related to cross-reactivity or interference by other substances.

Cut-off: the drug concentration above which an assay will test positive and below which, will test negative.

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Interpreting Negative Results

Negative UDM: 5 different circumstances:

- **No drug in the specimen**
  - Diversion vs noncompliance vs bingeing vs dose/metabolism
- Drug in the specimen, but at a concentration below the detection threshold
- Drug in the specimen at a concentration above the threshold, but the assay reacts only weakly with that drug
- Interference with the assay created unintentionally, by other medications; or intentionally, by the administration of adulterants
- Laboratory error


Understanding False-Positive Results

Misinterpretation of positive results related to illegal or non-prescribed agents can have negative consequences:

- Unjustified discontinuation of opioid therapy
- Damaged physician-patient relationship
- Unnecessary opioid withdrawal
- Compromised reputation
- Unnecessary involvement of law enforcement

Ingestion of **poppy seed** muffins or bread can cause a false positive UDS for **opioids**?

**TRUE**
Opioids

- Compounds causing false-positives:
  - Poppy seeds (even with GC/MS)
  - Rifampin
  - Fluoroquinolone antibiotics (e.g., levofloxacin)

- Immunoassays typically only detect natural opioids
  - Morphine, codeine
  - Other opioids may yield false-negative result


Opioids: Metabolism Considerations

- Codeine is metabolized to morphine
  - A small amount is also metabolized to hydrocodone

- Hydrocodone is metabolized to hydromorphone

- Heroin is metabolized to morphine
  - Parent compound may only be detected 1-2 hrs

- Morphine may be metabolized to small amounts of hydromorphone

- Oxycodone is metabolized to oxymorphone

- Any contamination is possible, especially with generic formulations

Example – Case 2

How to Diagnose Heroin Use?

- codeine
- morphine
- 6-MAM
- heroin

- hydrocodone
- hydromorphone
Methadone

- Compounds causing **false-positives**
  - None

- Methadone will not show a positive result by most opiate immunoassays
  - Synthetic agent

Amphetamines

- Compounds causing **false-positives**\(^1\)
  - Pseudoephedrine, l-ephedrine
  - Fenfluramine, phentermine
  - Vicks\(^\circledR\) nasal inhaler
  - Propanolol
  - Trazadone
  - Buproprion
  - Selegiline

*Cutoff values typically do not detect use from OTC products*

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True or False?

Ingestion / administration of Novocain can cause a false-positive UDS for cocaine?

False
Cocaine

- Compounds causing false positives
  - None

- Immunoassays test for the metabolite benzoylecgonine

- There is no structural similarity between other topical anesthetics that end in "caine" (e.g. Novocain, lidocaine)

- Prescribed cocaine may be used in certain trauma, dental, ophthalmic and otolaryngologic procedures
  - The metabolite may be present for 2-3 days following a procedure

Marijuana

- Compounds causing false-positives
  - Proton-pump inhibitors (not by GC/MS)
  - Efavirenz (unlikely with GC/MS)

- Synthetic THC (Marinol®) will result in a positive UDS for THC

- Passive inhalation (i.e., second hand smoke) does not produce THC values above the standard cut-offs and will not yield a positive result

Retention Times

<table>
<thead>
<tr>
<th>Drug</th>
<th>Approx. Detection Time in Urine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opiates</td>
<td>1 - 3 days</td>
</tr>
<tr>
<td>Cocaine (metabolite)</td>
<td>2 - 4 days</td>
</tr>
<tr>
<td>Methadone</td>
<td>3 days (highly variable)</td>
</tr>
<tr>
<td>Marijuana</td>
<td>5 days (moderate smoker)</td>
</tr>
<tr>
<td></td>
<td>10 – 30 days (heavy smoker)</td>
</tr>
<tr>
<td>Amphetamines</td>
<td>2 - 5 days</td>
</tr>
<tr>
<td>PCP</td>
<td>3 - 8 days (≥30 days in chronic users)</td>
</tr>
</tbody>
</table>

Detection times may vary based on dose, frequency, individual metabolism, and methodology.

Specimen Tampering

- Dilution
- Adulteration
- Substitution
Dilution

Adulteration
## Substitution

![Image of The Urinator](image1.png)

### Example – Case 3

<table>
<thead>
<tr>
<th>Test Ordered (ng/mL)</th>
<th>Lab Result</th>
<th>Cutoff</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMPHETAMINES/MET</td>
<td>SUB</td>
<td>1000</td>
</tr>
<tr>
<td>BARBITURATES</td>
<td>SUB</td>
<td>300</td>
</tr>
<tr>
<td>BENZODIAZEPINES</td>
<td>SUB</td>
<td>100</td>
</tr>
<tr>
<td>CANNABINOIDS (THC)</td>
<td>SUB</td>
<td>30</td>
</tr>
<tr>
<td>COCAINE</td>
<td>SUB</td>
<td>200</td>
</tr>
<tr>
<td>METHADONE</td>
<td>SUB</td>
<td>150</td>
</tr>
<tr>
<td>OPIATES</td>
<td>SUB</td>
<td>50</td>
</tr>
<tr>
<td>PHENCYCLIDINE</td>
<td>SUB</td>
<td>25</td>
</tr>
<tr>
<td>PROPOXYPHENE</td>
<td>SUB</td>
<td>200</td>
</tr>
<tr>
<td>Other:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urine Creatinine (mg/dL)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specific Gravity (gr/ml)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>pH</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- SUB: The specimen is not consistent with human urine.
- NT: Not tested.
- Lab comments: ANALYSIS CANCELLED SPECIMEN SUBSTITUTED. NOT CONSISTENT WITH NORMAL HUMAN URINE.
Improving Reliability

Urine Characteristics
- Color
- Temperature 90-100 F (within 4 minutes)
- pH 4.5 – 8.0
- Specific gravity
- Creatinine > 20 mg/dL
  - < 5 mg/dL is not consistent with human urine

Carefully label and handle the sample (Avoid the Ryan Braun situation)

Avoid Pitfalls of UDM

Carefully review a patients medications prior to collecting the sample
- Collect in the office if possible

When the result is positive, confirm with GC/MS or LC-MS/MS to determine the exact substance
- Confirmatory tests are rarely associated with false-positives or false-negatives
Avoid Pitfalls of UDM (cont.)

- Know the laboratory specifics
  - Cut-off values
  - Specific drugs for which test conducted (especially with immunoassay)
  - Consult with laboratory when discrepancies arise

- Discuss unexpected / abnormal results with the patient in a supportive fashion

Clinical Correlation

- No reliable correlation exists between measured levels and ingested dose
  - Following trends in levels over time can be predictable
  - Understand expected levels related to parent drug vs. metabolite

- Use a comprehensive approach, keeping in mind the limitations of UDM
Summary of UDM

- UDM should only be used with appropriate knowledge of capabilities and limitations
- Unexpected results should be confirmed with appropriate testing
  - Consultation with laboratory personnel may be helpful
- UDM is recommended as one component of a comprehensive treatment program

Current Opioid Misuse Measure (COMM™)
- 17 items, < 10 minutes to administer & score
- Excellent internal consistency, Sensitivity and test-retest reliability
Scoring the COMM
• Add the rating of all questions
• > or = 9 is positive for probable misuse
• The Negative Predictive Values for cutoff score of 9 is .95 – most are not misusing

Exit Strategy

- Determine if the risk–benefit of opioid therapy in a patient is not your continued use using the following criteria:
  - Intolerable side effects at the minimum dose that produces effective analgesia
  - Reasonable attempts at opioid rotation unsuccessful
  - Persistent noncompliance with patient care agreement
  - Rational dose escalation without adequate analgesia
  - Deterioration in physical, emotional, or social functioning attributed to opioid therapy
Establish collaborative relationship with patient around need for discontinuation of opioid therapy.
✓ Review exit criteria agreed upon inpatient care agreement.
✓ Clarify that exit is for patient’s (not doctor’s) benefit.
✓ Clarify that exiting opioid therapy is not synonymous with abandoning pain management or abandoning the patient.


Resources

- OpioidRisk – Skills to Minimize the Risk of Prescription Opioid Misuse
  [www.opiodrisk.com](http://www.opiodrisk.com)
- Tufts Health Care Institute Program on Opioid Risk Management
  [www.thci.org/opioid](http://www.thci.org/opioid)
- Physicians for Responsible Opioid Prescribing
  [http://www.responsibleopioidprescribing.org/index.html](http://www.responsibleopioidprescribing.org/index.html)
- PainEDU.org
  [www.painedu.org](http://www.painedu.org)
Thank You – Any Questions?