

SOAPP® Monitoring Recommendations

The following are some reasonable treatment points for clinicians that will accompany Screener and Opioid Assessment for Patients with Pain (SOAPP) scores. Pain experts may vary in their approaches to treating patients in certain SOAPP categories. Therefore, the following points are general recommendations and should be viewed as a starting place for use by providers who are not specialists in pain management. A tailored, patient-specific treatment plan by a pain specialist may be the best option in some cases.

The SOAPP is NOT intended to rule out/screen out chronic pain patients for opioid therapy. The SOAPP data, along with other clinical findings, can help the provider make a risk benefit assessment with regard to the use of opioid therapy. If opioid therapy is determined to be an option, the SOAPP can help the provider determine the level of monitoring that may be necessary to safely prescribe long-term opioid therapy for a given patient. Each provider will have a different level of comfort and/or resources dealing with higher risk patients. In addition, clinicians are recommended to have conversations with their patients about their pain management regimen and possibly review some of the answers to the SOAPP tool.

The following are general recommendations for clinicians who are caring for chronic pain patients. The recommendations are divided into three distinct categories (low, medium, and high risk). The SOAPP score along with clinical findings can help clinicians determine the most appropriate pain management regimen for a given patient. For example, an individual who scores an 8 on the SOAPP (24Q or 14Q) or 5 on the SOAPP-SF (5Q) is initially considered in the high-risk category, since the score is greater than or equal to 7 on the 14Q or 24Q SOAPP or 4 on the 5Q SOAPP. After additional evaluation, the clinician may determine the patient is more likely at moderate risk and develop a pain management regimen accordingly. However, other history and physical information may make the clinician more comfortable by assuming a higher risk potential. In that case, the treatment plan would reflect this heightened concern.

It is important to review a couple of points about the SOAPP. First, recall that the SOAPP may have false positives, so at least some patients with scores at 7 or above (on the 14Q or 24Q SOAPP) or 4 or above (on the 5Q SOAPP) will turn out to not exhibit aberrant behaviors. Secondly, the small, but present, false negative rate means that even some who score below the cutoff will later have problems. As the provider gains experience with a particular patient, the provider's view of how vulnerable the patient is to aberrant behavior will be continually revised and refined. Experience with the patient will provide the most important data that you can get.

General Considerations

Regardless of any given patient's SOAPP score, the following recommendations should be considered:

- Patients should read and sign an opioid therapy agreement that outlines the patient's responsibilities and clinic policies.
- Patients should be advised of their risks for addiction.
- The SOAPP classifies patients as either high risk or low risk for aberrant medication misuse based on how they complete the SOAPP.
- Remember, the SOAPP is NOT a lie detector. Particularly if the SOAPP score suggests low risk, the provider should be alert to inconsistencies in the patient report or with a collateral report.

What does the Cutoff Score Mean?

For the 14Q or 24Q SOAPP

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 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 high score. A cutoff score of 7 is a sensitive test. It has a sensitivity of .91, which means that it correctly classified more than 90% of the patients who actually went on to exhibit aberrant behaviors. Its specificity is only 69%. Thus, in our sample, 31% of the people, who scored a 7 or higher on the SOAPP, did **not** go on to show detectable aberrant behavior. This proportion could be improved, but only at the risk of missing those who actually did show aberrant behavior. Finally, the sensitivity and specificity of the SOAPP will change depending on the prevalence of patients in a particular setting who actually exhibit aberrant behavior.

For the 5Q SOAPP

In general, there is a trade off between the length of a questionnaire and its accuracy as a screener. Thus, to achieve a shorter form, one must live with poorer sensitivity and specificity. Naturally, the question becomes, "how much accuracy is traded for a shorter form?" In our view, while these parameters are clearly not as good as for the full 14-item scoring, the reduction in sensitivity, specificity, positive and negative predictive values and likelihood ratios suggests that the five-item version retains most of the predictive validity of the Standard SOAPP version.

Clinically, a score of 4 or higher for SOAPP V.1-SF will identify 86% of those who actually turn out to be at high risk (compared to 91% for the 14-item version). The Negative Predictive Values for a cutoff score of 4 is .85, which means that most people who have a negative SOAPP are likely at low-risk. Finally, the positive likelihood ratio suggests that a positive SOAPP score (at a cutoff of 4) is more than two and half times (2.59 times) as likely to come from someone who is actually at high risk (compare with 2.94 for the Standard SOAPP). Note that, of these statistics, the likelihood ratio is least affected by prevalence rates. All this implies that by using a cutoff score of 4 will ensure that the provider is least likely to miss someone who is really at high risk. Remember,

this is achieved at the cost of increasing the risk (about 33%) of false positives (classifying someone as at high-risk who is not actually at high risk). This means that high score should be treated as “probable high risk,” and final treatment decisions should be made based on additional clinical findings. On the low-risk side, a score less than 4 suggests that there is a good chance that the individual is truly at low risk. Thus, the clinician can have greater confidence that low SOAPP scores are associated with people who tend not to develop problems. Thus, the SOAPP V1-SF appears to strike a reasonable balance between length and ability to detect future aberrant behavior.

Choosing Between the 24Q, 14Q, and 5Q SOAPP versions

In order to understand which version of the SOAPP to choose, it is useful to keep in mind some facts. First, while the SOAPP is the only device of which we are aware that is based on actual data, the measure itself continues to undergo further testing and development. The first version to be tested empirically was the 24Q version, of which only 14 of the 24 items were selected to comprise the SOAPP score. This version, although longer, has the advantage of being more fully tested than the other, shorter versions. Thus, the validity study utilized these 24 questions in the present order. The 24Q version is most likely to have replicable validity. The items were developed with clinician input and contain patient information of which the clinician considering long-term opioid treatment should be aware, even questions that do not directly contribute to the overall score. The 14-item version contains only the questions used in the SOAPP score calculation, removed from the context of the 24-item version. This was the initial attempt to shorten the SOAPP in response to requests from clinicians. Although the psychometrics are based on actual data, the 14-item version has not been tested directly, which means that a validity study has not been conducted on patients taking **only** the 14-item version. However, for those who need a shorter version, the 14Q version should be acceptable. Similarly, in response to further requests for an even briefer version, we went back to the original data (collected on the 24-item scale) and searched for the best combination of 5 items to produce the least decrement in predictive validity, as described above. Again, like the 14Q version, the 5Q version has not been tested directly. Remember, both the 14Q and 5Q versions leave out considerable clinical information that may be relevant for the clinician to know. However, if administration and scoring time is most critical for you, these versions (14Q and 5Q) are your best bet.

Assessing who is at Risk & Determining Appropriate Treatment

The SOAPP should only be one step in the assessment to determine which patients are high-risk. 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 at low risk.

High Risk For Opioid Misuse

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’s care because of his/her behavior, an insistence that medication will return

them to a former level of functioning and willingness to regularly not comply with physicians' orders. These patients may have misused other prescription medications in the past. It is a good idea to review the SOAPP 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 intervention prior to entering a treatment plan that includes long-acting opioids. Others may need to have psychological or psychiatric treatment prior to or concomitant with any treatment involving long-acting opioids. Patients in this category who receive opioid therapy should be required to follow a strict follow-up procedure, such as regular urine drug screens.

Additional treatment considerations for patients in this category are:

- 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 give a urine sample for a toxicology screen during every clinic visit. They should 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/chemical entities should be considered (e.g., long-acting versus short-acting opioids, transdermal versus oral preparation).
- 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.

Moderate Risk for Opioid Misuse

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 risk for misuse. Some examples of these behaviors or beliefs are an entitled attitude toward providers and an insistence on receiving only opioids, a history of legal difficulties, 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 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.

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 also need to be more regularly monitored until proven reliable by bringing extra or left over pills to visits for counting and/or having random urine drug screens.

Additional treatment considerations for patients in this category are:

- 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

Low Risk for Opioid Misuse

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. Although they should be able to handle their medication safely with minimal monitoring, they may already be using a number of modalities to manage their pain (e.g., nonopioid medications, regular physical activity, physical/aqua therapy, active cognitive coping strategies, relaxation, etc.). They are apt to drink alcohol responsibly or not drink at all, do not smoke cigarettes, and have no history of previous difficulties with alcohol, prescription drugs or illegal drugs. This patient probably reports few symptoms of affective distress, such as depression or anxiety.

As noted previously, the SOAPP is not a lie detector. The provider should be alert to inconsistencies in the patient report or with 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 are:

- Review of SOAPP questions is likely not indicated, 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.