Pain Management Education Series 2014  
SCOPE of Pain: Safe and Competent Opioid Prescribing Education  
Practice & Reflection Topic 2: Assessing Opioid Misuse Risk Prior to Prescribing

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**DEBRIEF:** Observer leads the conversation/reflection over 3-4 minutes. Suggested format: 
1. Ask the provider to speak first about 1-2 things that s/he felt they did well. 
2. Ask the patient: “How did it feel to be the patient in this conversation?” 
3. Ask the provider if you can share some of your observations about the conversation. 
   a. If they agree, describe first what you observed went well. 
   b. Then offer things to consider: limit these to 1-2 specific points 
   c. Ask provider, “What do you make of this?” 
4. Discuss, doodle, and switch roles.

These cases were adapted or taken directly from the SCOPE of Pain’s online training Video Vignettes at www.scopeofpain.com.
CLINICIAN OBJECTIVES:

- Screen for unhealthy substance use
- Screen for mental illness
- Use validated questionnaire to assess for opioid misuse risk before prescribing opioids and know their limitations

CLINICIAN SKILLS:

**Discuss factors which worsen pain and limit treatment (i.e. substance abuse, mental health)**

- Administer single question alcohol screener, single question drug screener
- Ask about psychiatric history and treatment (PTSD, anxiety, etc): e.g. PHQ-2, VA Primary Care PTSD Screen
- Administer a validated questionnaire to assess for opioid misuse risk (see table for samples)
- Urine drug testing at baseline
- Obtain state prescription drug monitoring program data (i.e., CURES report)
- Review old medical records
- Talk to previous provider (if possible)
- Discuss your assessment results with your patient to explain level of concern:
  - Level of monitoring that should be implemented to minimize the risk of side effects or harms
    - E.g., “Despite being in recovery from alcoholism, you are at higher risk for developing problems with the opioid pain medication.”
  - Need for addiction or pain specialist, if available
  - Some patients may be too risky for opioid analgesics
PROVIDER HANDOUT

CLINICIAN OBJECTIVES:
• Screen for unhealthy substance use
• Screen for mental illness
• Use validated questionnaire to assess for opioid misuse risk before prescribing opioids and know their limitations

CLINICIAN SKILLS:
Discuss factors which worsen pain and limit treatment (i.e. substance abuse, mental health)
• Administer single question alcohol screener, single question drug screener
• Ask about psychiatric history and treatment (PTSD, anxiety, etc): e.g. PHQ-2, VA Primary Care PTSD Screen
• Administer a validated questionnaire to assess for opioid misuse risk (see table for samples)
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  - Need for addiction or pain specialist, if available
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ASSESSING OPIOID MISUSE RISK PRIOR TO PRESCRIBING

CASE A
Pain Management Education Series 2014
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Practice & Reflection Topic 2: Assessing Opioid Misuse Risk Prior to Prescribing

CASE A: ASSESSING OPIOID MISUSE RISK PRIOR TO PRESCRIBING
(PROVIDER ROLE: READ ALOUD)

Name: Howard Romero
Age: 42 years
Marital status: Single but in relationship with same-sex partner
Occupation: Barista in a Mission neighborhood cafe
Pain issue: Chronic right ankle and foot pain

This is the second visit to this medical provider. Howard’s primary care was transferred to this community-based clinic after his previous provider at the hospital-based clinic retired. He had been seeing his previous PCP for over 5 years and had an excellent relationship with her. She gave him a copy of his old medical records which includes a note from his surgeon at the county hospital Ortho Clinic.

The scenario:

- Two years ago, he fractured his right ankle and foot when he fell off an art sculpture he was helping to build in the desert at Burning Man. He had been eating an assortment of marijuana edibles with friends earlier in the day, and he did not realize how stoned he was when he offered to help out.
- His ankle/foot fracture required several surgeries with placement of screws and plates to restore function. His orthopedist recently told him that his ankle and foot are "well-healed" but will likely always cause him significant pain and will never be “normal.” He was told that no additional surgeries are needed at this time. The orthopedist also told him that his primary care provider should take over the treatment of his ankle and foot pain.
- He has taken multiple medications over the past year for his pain including naproxen, acetaminophen, and tramadol. All of these medications were unhelpful.
- Pain today is no better and it is interfering with his life. He has to take frequent absences from work because of the pain. He is worried about losing his job.
- He is rarely able to participate in social activities, because ankle hurts so much after a day of work. His constant pain is getting in the way of his relationship.
- Patient is interested in trying something stronger.
- CURES report was ordered at last office visit.

Interview: starts with the provider assessing the patient’s risk of opioid misuse in order to ascertain if benefits outweigh risks of a trial of opioid analgesic prescribing.
CASE A: ASSESSING OPIOID MISUSE RISK PRIOR TO PRESCRIBING
(PATIENT ROLE: READ TO SELF)

Name: Howard Romero
Age: 42 years
Marital status: Single but in relationship with same-sex partner
Occupation: Barista in a popular Mission neighborhood cafe
Pain issue: Chronic right ankle and foot pain

Pain history: Fractured right ankle and foot 2 years ago, when he fell off an art sculpture he was helping to build in the desert at Burning Man. Fractures required several surgeries. Orthopedist recently reported that ankle and foot are "well-healed" but will likely always cause him significant pain and will never be “normal.” No additional surgeries are needed at this time. Primary care provider should take over the treatment of ankle and foot pain.

- He has taken multiple medications over the past year for his pain. Provider recently had you try ibuprofen and acetaminophef. All of these medications were unhelpful.

Substance use history:

- Former tobacco smoker: “Nope, I haven’t had a cigarette in 10 years. I used to smoke a pack a day. I quit with the help of Dr. Green, by last provider.”
- Drinks below safe limits: “A couple times a week” but never exceeds 4 drinks per day. “Three’s usually my limit.”
- Does not use illicit substances: “I don’t use drugs. I did marijuana back in the day.”
- When asked about his injury at Burning Man, you report: that you used to smoke marijuana regularly as a young adult. You did not appreciate how potent edibles were, and were “pretty stoned” at the time of his injury. You no longer smoke or eat pot, because it reminds you of the incident and that you don’t want anything like that to happen to him again.
- You do not consider taking your friend’s left over pain medications as a problem. They were offered out of compassion to you.

Social history:

- No history or mental illness or symptoms of depression or anxiety or PTSD.
  - PHQ-2 = 0, PTSD screen = 0
- Mother had some mild depression.
- Boyfriend is in AA (long term remission from alcohol and crystal meth)
ASSESSING OPIOID MISUSE RISK PRIOR TO PRESCRIBING

CASE B
**CASE B: ASSESSING OPIOID MISUSE RISK PRIOR TO PRESCRIBING**

**PROVIDER ROLE: READ ALoud**

**Name:** Mary Williams  
**Age:** 44 years  
**Marital status:** Married with children ages 6, 12, 15 years. Husband manages hardware store.  
**Occupation:** Part-time receptionist in law office  
**Pain issue:** Chronic painful diabetic neuropathy and chronic low back pain

**Scenario:** Mary Williams is visiting you for the first time. Her previous provider moved out of state. For the past year, she’s been on a medication regimen that includes metformin, lisinopril, hydrochlorothiazide, and aspirin. For her chronic back and neuropathic pain for the past year, she’s been taking oxycodone 5 mg with acetaminophen 325 mg, 1-2 tablets q 4-6 h. Her previous PCP prescribed only 150 tablets per month, b/c she was afraid she would get addicted to them. She’s also prescribed gabapentin 300 mg TID.

To manage her pain, she had previously tried NSAIDs (upset stomach), acetaminophen, tricyclic antidepressants, tramadol (dry mouth), and acetaminophen with codeine; none of which offered adequate pain relief, and some had intolerable side effects.

She hopes to get enough medication to consistently take 8 tablets per day, which allows her to go to work. She is very careful not to run out early, gets anxious if supply runs out early in month. She has enough medication to last one week. She experiences nausea, vomiting and diarrhea upon running out.

**Other medical history:** Obesity, type 2 DM x 8 years, painful diabetic neuropathy x 2 years, hypertension, chronic low back pain, tobacco use disorder, alcohol use disorder in remission x 10 yrs.

**Physical exam:** Weight 220 lbs (BMI 32 = obese). No acute distress, normal cardiopulmonary exam, spine normal alignment, negative straight leg test, no Achilles tendon reflex bilaterally. Diabetic foot exam: No lesions/ulcerations, palpable pulses, monofilament testing bilaterally 4/5.

**Family history:** Mother died of alcoholic cirrhosis.

**Interview:** starts with the provider assessing the patient’s risk of opioid misuse in order to ascertain if benefits outweigh risks of continuing opioid analgesic prescribing.
CASE B: ASSESSING OPIOID MISUSE RISK PRIOR TO PRESCRIBING
(PATIENT ROLE: READ TO SELF)

Name: Mary Williams
Age: 44 years
Marital status: Married with children ages 6, 12, 15 years. Husband manages hardware store.
Occupation: Part-time receptionist in law office
Pain issue: Chronic painful diabetic neuropathy and chronic low back pain

- You screen negative for unhealthy substance use
- You screen negative for depression, anxiety, PTSD
- On the ORT tool, you score as a “moderate” risk (4-7 points):
  - Family h/o substance use = 1
  - Personal h/o substance use = 3
  - Age between 16-45 = 1
- You will agree to provide a urine drug test, if asked
- You agree to return to clinic in one week

Review of your CURES record will show:
- Prescriptions written only by her PCP

Review of your medical records will show:
- Progress notes, medication lists are reconciled
- Radiology reports: Lumbar degenerative joint disease, Mild spinal stenosis
- No evidence of misuse of her opioid prescriptions
- Lack of adequate documentation about pain and functional benefits in her old record

These cases were adapted or taken directly from the SCOPE of Pain’s online training Video Vignettes at www.scopeofpain.com.
ASSESSING OPIOID MISUSE RISK PRIOR TO PRESCRIBING

CASE C
CASE C: ASSESSING OPIOID MISUSE RISK PRIOR TO PRESCRIBING
(PROVIDER ROLE: READ ALOUD)

Name: Brenda King
Age: 51 years
Marital status: Married twice, divorced once.
Occupation: Unemployed on SSI

Pain issue: Chronic painful burning feet for years; for which she has obtained the most relief with ibuprofen, high dose gabapentin 1200 mg TID, and methadone 40 mg TID. She has tried tricyclic antidepressants, venlafaxine, pregabalin, lamotrigine, duloxetine, topiramate in the past without effective relief or with unbearable side effects. Methadone for pain was discontinued at time of crack cocaine relapse, but she was continued on methadone maintenance.

Pt drops into your clinic today. She has just been accepted into 90-day residential drug treatment program. She would like to restart methadone pills for chronic pain management in addition to continuing ibuprofen and gabapentin. Pain is an 11/10 severity; having trouble walking and sleeping because of pain. (PEG score 11/6/9)

Medical history: Well controlled HIV disease x 10 yrs (on DOT ART); chronic hepatitis C (untreated); chronic bronchitis, anal dysplasia. Admitted last year to ICU for skull fracture and traumatic brain injury after assaulted by unknown assailant at the bus stop. Discharged this week to residential treatment program from hospital for another admission you have few details about.

Social history: Born and raised in California. Parents divorced. Mom dealt drugs in their suburban community. Married her high school sweet heart and divorced after she got involved in heroin. Married second husband who also has HIV and she met at methadone clinic. Their 6-yr old daughter is HIV-negative and living with family friends.

Family history: Breast cancer in two 1st degree relatives. Mother with history of substance use disorder.

Physical exam: Thin, alert, well groomed, rapid speech. Lungs: Coarse expiratory wheezes. Neuro exam: Reduced/absent ankle jerks; decreased pinprick and vibratory sense, feet/toes; preserved motor strength and proprioception. Normal gait.

Interview: starts with the provider assessing the patient’s risk of opioid misuse in order to ascertain if benefits outweigh risks of resuming opioid analgesic prescribing.

- Review recent medical records (ask patient for this interim medical history)
- Discuss your assessment results with your patient to explain level of concern:
  - Level of monitoring that should be implemented to minimize the risk of side effects or harms
  - Need for addiction or pain specialist, if available
  - Some patients may be too risky for opioid analgesic treatment at this time

These cases were adapted or taken directly from the SCOPE of Pain’s online training Video Vignettes at www.scopeofpain.com.
CASE C: ASSESSING OPIOID MISUSE RISK PRIOR TO PRESCRIBING

[PATIENT READ TO YOURSELF]

Name: Brenda King
Age: 51 years
Marital status: Married twice, divorced once.
Occupation: Unemployed on SSI
Pain issue: Chronic painful burning feet for years; for which she has obtained the most relief with ibuprofen, high dose gabapentin 1200 mg TID, and methadone 40 mg TID. She has tried tricyclic antidepressants, venlafaxine, pregabalin, lamotrigine, duloxetine, topiramate in the past without effective relief or with unbearable side effects. Methadone for pain was discontinued at time of crack cocaine relapse, but she was continued on methadone maintenance at a higher dose.

You have dropped into primary care clinic today. You were just accepted into 90-day residential drug treatment program. You would like to restart methadone pills for chronic pain management in addition to continuing ibuprofen and gabapentin. Your pain is an 11/10 severity; having trouble walking and sleeping because of pain. (PEG score 11/6/9)

When your provider brings up the topic of assessing your risk for opioid misuse, you are not surprised that that your provider does not trust you. You feel stigmatized by the entire health care system as someone who uses drugs AND as someone who has HIV. You feel like you will never get a “fair hearing” in life.

Substance use history: Smoking half to one ppd of cigarettes. You avoid alcohol because of hep C. On methadone maintenance 140 mg/d for opioid dependence. Crack cocaine and methamphetamine relapse began, when husband was released from prison last year.

If you are asked, interim medical history: Just discharged from hospital for methadone overdose, requiring naloxone drip and ICU stay. “When you “cut me off” from my methadone pills, I had to buy them on the street. Someone must have sold me something else. I don’t remember very much; just waking up in the hospital with a tube down my throat.”

“If you don’t prescribe the methadone to me, you are going to make me go back out on the street to get it.”

Additional social history: Diagnosed with depression (on sertraline), borderline personality disorder. Stabbed in the neck by a former boyfriend. Had to obtain a restraining order against current husband and father of 6-year old daughter, but let it drop after a year because they decided to live together.

If asked, answer YES to #2, 3, 4: In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, in the past month, you:
1. Have had nightmares about it or thought about it when you did not want to?
2. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?
3. Were constantly on guard, watchful, or easily startled?
4. Felt numb or detached from others, activities, or your surroundings?
You’ve been referred to and completed Seeking Safety program three times. You’d like to do it again.

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