Pain Management Education Series 2014
SCOPE of Pain: Safe and Competent Opioid Prescribing Education
Practice & Reflection Topic 7: Managing or responding to aberrant behavior

OBSERVATION SHEET

TOPIC
CLINICAL SCENARIO
OBSERVATIONS MADE (Use the skills objectives/ provider tasks to evaluate the conversation)
FEEDBACK: WHAT WENT WELL
FEEDBACK: THINGS TO CONSIDER

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.

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OBSERVER HANDOUT

SKILLS OBJECTIVE
Practice and reflect on using a **risk-benefit framework** in your conversation with a patient to continue, change, or discontinue opioids.

CLINICIAN TASKS
- Continue, change or discontinue opioid therapy
- If changing opioids, educate patient about opioid rotation or breakthrough medication
- If discontinuing opioids, will you taper and if so, how? Tell your patient what you plan to do.

Possible scenarios
- If more intensive monitoring is needed, discuss with patient how this will work
- Discuss a continued lack of benefit with patient, including referral to pain specialist
- Discuss with patient when there is too much risk /harm
    - Discuss possible addiction, including referral to addiction specialist
    - Discuss possible diversion (why concerned, inability to prescribe if diversion)
- Discontinuing opioids: Discuss your "opioid exit strategy" and its rationale with patient
    - Distinguish between abandoning opioid treatment and abandoning patient
    - Determine degree of physical dependence to determine withdrawal risk and taper
    - Build up alternative pain modalities

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PROVIDER HANDOUT

SKILLS OBJECTIVE
Practice and reflect on using a **risk-benefit framework** in your conversation with a patient to continue, change, or discontinue opioids.

CLINICIAN TASKS
- Continue, change or discontinue opioid therapy
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MANAGING OR RESPONDING TO ABERRANT BEHAVIOR

CASE A

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CASE A: MANAGING OR RESPONDING TO ABERRANT BEHAVIOR
(PROVIDER ROLE: READ ALOUD)

Mr. Paul Russo is a 51 year old established patient, who presents for follow-up. He has had chronic right knee and ankle pain for the past 5 years after a motorcycle accident. He takes ibuprofen 600 mg TID, plus hydrocodone 5 mg with acetaminophen 500 mg 2 tablets TID for the past 3 years. In the last year, he has gained 20 lbs. You are concerned he eventually may need to be referred to the Orthopedic Clinic for a total knee replacement.

On routine urine drug testing his most recent urine is positive for hydrocodone and cocaine; confirmatory testing for cocaine is positive.

Pain history: Post-traumatic R knee and ankle pain status post infected distal femoral and ankle fracture 5 years ago. He has been on opioids, APAP, and NSAIDs ever since. His pain is usually always 4-5 out 10.

Other medical history: Well controlled hypertension on ACE-I and hyperlipidemia on statin.

Substance use history: Quit smoking 10 years ago. Drinks no more than 4 drinks in a day AND no more than 14 drinks/week. History of marijuana use as a younger adult, last 15+ years ago. He reports no current use. No family history of substance use disorders.

Social history: He lives with his long-term girlfriend. He is employed at a friend's store as a cashier where he is able to sit most of the day.

Physical exam: Uncomfortable with ambulation. He uses a cane. His knee is deformed with very limited range of movement.

CLINICIAN TASKS or STRATEGIES:

- Ask about unexpected UDT result in an open-ended, non-judgmental way. Example: "As you know, I send your urines to the toxicology lab periodically to monitor you for safety. The last one I sent had cocaine in it."
- Offer brief counseling for illicit drug use: e.g. could elicit pros/cons of use
- Use risk/benefit analysis to discuss cocaine use: provide information about health risks (heart attack, stroke); increased risk of misusing pain medications; how continued use may limit your ability to continue prescribing opioid analgesics
- Develop new management plan: **Continue prescribing with more intensive monitoring**
    - Discuss with patient how this will work, i.e. how more frequent UDT? Random UDT?
    - Be clear about what you will do if next urine is cocaine positive: Will you refer him to substance use counseling? Will you taper his medications? Will you fire him?
    - Make sure patient knows that the ultimate decision is his about continuing to receive opioid analgesics or continuing to use cocaine
    - When will you meet next?

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CASE A: MANAGING OR RESPONDING TO ABERRANT BEHAVIOR
(PATIENT ROLE: READ TO SELF)

Your initial response: "That can't be right. Someone must have made a mistake at the lab, because I wouldn't be using cocaine."

If the provider's approach feels **non-judgmental**, please feel free to disclose as appropriate:

- "OK, you caught me but it's not an everyday thing." You snort a little cocaine once in a while with your friends on the weekends when you get together at parties.
- You have been using it a little more frequently in the last couple of months. You do notice that when you use cocaine that your pain is less distracting.
- You don't like the way it makes your heart race and sometimes your chest feels tight.
- You don't like that it's illegal and can be expensive.
- But you don't think it's a problem: "It's not like I am addicted or anything. I can stop anytime."

If your provider indicates that your continued use of cocaine will mean that s/he will have to stop prescribing your pain medication:

- Reassure the provider that it will be no problem for you to stop cocaine.

If the provider asks you if you will have a challenge quitting cocaine use or changing your behavior:

- Keep saying that it won't be a problem. "I can quit it anytime." You want the opioids for your pain to continue and you aren't willing to sacrifice them.

Only if you feel that the provider is speaking to you in a **judgmental** way, then respond defensively:

- Continue to deny cocaine use, show your emotions
- You've been around people using cocaine, so maybe it somehow got into your bloodstream.
- If provider accuses you of having a cocaine problem and that you are in denial, feel free to rage: "After all, it's none of your goddamn business what I do with my free time."
- My friends' docs don't do all this urine testing. They don't have a problem prescribing them with the painkillers they need.
- "I might have to find a new provider."

MANAGING OR RESPONDING TO ABERRANT BEHAVIOR

CASE B

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CASE B: MANAGING OR RESPONDING TO ABERRANT BEHAVIOR
(PROVIDER ROLE: READ ALOUD)

Name: Lindsey Beecher
Age: 43 year
Marital status: Married, 1 son age 22 and 1 granddaughter age 2
Occupation: Elementary school teacher
Pain issue: Chronic painful diabetic neuropathy

This is an early follow-up visit scheduled after the patient was seen in an outside emergency room over the weekend for worsening foot pain. The ER discharge summary comments that the patient appeared oversedated, distressed, and accompanied by a 2 year old granddaughter. If the patient's son had not arrived, they would not have discharged them home.

The Scenario: The patient's pain is in both feet and is burning and sharp all the time and worse at night when the sheets touch her feet. She is considering going on disability due to her severe foot pain. She describes her pain as "9-10" out of 10 all the time. You recently increased her methadone dose from 15 mg to 20 mg TID. Previously, her former PCP had tried sustained release morphine and then fentanyl patch without improvement in her pain. She is reluctant to increase her gabapentin above 300 TID, because it makes her feel dizzy.

She has an up-to-date controlled substance treatment agreement that describes the potential benefits and harms of opioid medications, the importance of routine safety monitoring, taking her methadone only as prescribed, and a condition of one prescriber/one pharmacy.

She went to an emergency room on Saturday night because she ran out of her methadone after doubling her dose for several days when her pain felt unbearable. Review of CURES data confirm that she was prescribed an additional 30 tablets of methadone 10 mg by the ED. UDT done in the ED is positive for methadone only.

The interview starts with a conversation about her recent emergency room visit

- Discuss the lack of apparent benefit (9-10 our of 10 pain) and increased risk (oversedation) of methadone
- Discuss the need for tapering her methadone and treating her pain with non-opioids and non-pharmacotherapy
- Practice using risk-benefit framework in your conversation with patient to continue, or change opioids
- Develop new management plan: continue, change or discontinue opioid therapy
  - If more intensive monitoring needed, discuss with patient how this will work
  - If changing opioids, educate patient about opioid rotation or breakthrough medication
  - If discontinuing opioids, will you taper and if so, how? Tell you patient what you plan to do.

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CASE B: MANAGING OR RESPONDING TO ABERRANT BEHAVIOR
(PATIENT ROLE: READ TO SELF)

Name: Lindsey Beecher
Age: 43 year
Marital status: Married, 1 son age 22 and 1 granddaughter age 2
Occupation: Elementary school teacher
Pain issue: Chronic painful diabetic neuropathy

The Scenario: Both feet burning and sharp all the time and worse at night when the sheets touch your feet. Considering going on disability due to this severe foot pain; pain is "9-10" out of 10 all the time. Methadone dose was recently increased from 15 mg to 20 mg TID but helped only a little. Past trials of sustained release morphine and then fentanyl patch without improvement pain or function. Anything above gabapentin 300 TID makes you feel dizzy.

- You have been working with this provider now for 6 months. You are just getting to know the provider and do not know if s/he understands your pain.
- Your pain has been so bad in the last month, that you have not been able to sleep. You know that the methadone helps you get to sleep, so you've been taking more than prescribed at night.
- If provider asks more about your insomnia and you feel you can trust them by the tone of his/her voice, feel free to disclose that you've been having nightmares again. This month is the anniversary of when you were raped 23 years ago.
- You have tried medications for depression and anxiety in the past. They either made your mouth dry or caused weight gain. For some reason, the methadone doesn't do that. If there were some newer medications available that didn't have those side effects and that might even help your neuropathy, then you'd be eager to try them.
- You know that you should not have brought your granddaughter with you to the ED, but you had promised to babysit and didn't want to let your son down. He doesn't ask you that often to help him out, because he knows how much discomfort you have.
- You still have some of the methadone tablets left that the ED gave you. You are hoping to store them away for emergency situations. You would be reluctant to turn them in at the clinic, if your provider asked you to do this. After all, they are yours.
- You would like your provider to prescribe you a few extra methadone tablets each month, so that you don't have to end up going to the ED for them.
- You would miss your students and colleagues greatly, if you had to go on disability.

MANAGING OR RESPONDING TO ABERRANT BEHAVIOR

CASE C

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CASE C: MANAGING OR RESPONDING TO ABERRANT BEHAVIOR
(PROVIDER ROLE: READ ALOUD)

Lisa Andrews is a 26 year old new patient, who is transferring her care to this primary care physician because she did not like her previous physician. She states that she is prescribed oxycodone 20 mg 5 times per day for chronic shoulder pain. She presents without medical records and states that she has run out of oxycodone this morning.

Upon review of the CURES Report, the patient has filled multiple prescriptions for oxycodone from multiple prescribers at multiple pharmacies over the past 3 months.

Pain history: Her pain started after a rotator cuff injury while playing softball 12 months ago. She had surgery and has been on opioids ever since. Her orthopedic surgeon prescribed opioids for the first 3 months but then stopped.

Other medical history: None. Uses condoms for birth control.

Substance use history: Smokes only e-cigarettes now.

Social history: Lives with friends in an apartment. Has a subsidy that helps pays for rent, if she stays in school. She is worried about her performance in school, losing tuition subsidy, and then being unable to pay her rent.

Physical exam: She appears anxious; pupils are dilated. No significant findings on exam.

The interview starts with a conversation about her softball injury and how the pain medications made her feel.

CLINICIAN TASKS or STRATEGIES:

- Assess the cause of patient's aberrant behavior (going to several different providers and clinics to get oxycodone) using a non-judgmental, open-ended, complete differential diagnostic approach
- Discuss possible addiction/including referral to an addiction specialist
- Develop new management plan: refill, change or discontinue opioid therapy
  - Should you offer a taper and if so, how?
  - Will you be able to offer this patient treatment for what may be an opioid use disorder?
  - Tell your patient what you plan to do. Check for her understanding.

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CASE C: MANAGING OR RESPONDING TO ABERRANT BEHAVIOR

(PATIENT ROLE: READ TO SELF)

- "Oxys helped with my pain after the surgery, so I was and able to do things; go to work and do things with friends. Then I guess I started taking them more because they made me feel good and gave me energy."
- "Then the surgeon just stopped giving them to me and I got sick. I was throwing up and felt crappy. I went to my old doctor, and she gave some pills and I felt better."

- You actually find yourself spending a lot of time trying to get these pills; actually more time than you spend taking care of your pain. They are less available on the streets and the prices have gone up.
- You are feeling like this situation is out of control. You are at the end of your rope.
- But you don't think you have an addiction. Your brother is the addict in the family. He would steal from family members, got kicked out of school, uses needles and has Hep C.
- You don't want to end up turning to heroin like your brother.
- What does this provider know that makes him/her think that I have an addiction problem?
- If they convince you that you have a problem, then how can they help you?