MEDICAL SCHOOL AND RESIDENCY PROGRAM
CURRICULUM RESOURCES ON DRUG ABUSE AND ADDICTION

Opioid Risk Management Objective Structured Clinical Exams (OSCE)

Boston University School of Medicine (Massachusetts Consortium)

Daniel P. Alford, M.D., M.P.H.
Angela Jackson, M.D.

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http://www.drugabuse.gov/coe

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Introduction to Opioid Risk Management OSCE

Opioid risk management refers to efforts to minimize harms and maximize benefits of opioids used in the treatment of chronic pain. Although opioid risk management education remains inadequate in medical training curricula, residents frequently manage patients who require long-term opioid analgesics for chronic pain.

Objective Structured Clinical Exams (OSCE) provide performance-based assessments of clinical skills. This opioid risk management OSCE provides opioid risk management competencies using standardized patients in realistic settings and immediate observer feedback by trained faculty assessors. There are three stations covering important phases of managing patients with chronic pain including (1) starting opioids; (2) assessing and addressing aberrant medication-taking behaviors; and (3) assessing, monitoring, and addressing the risks and benefits of long-term opioid analgesic therapy. At each station, the learner's performance is assessed by faculty assessors using rating scales in three domains (general communication, clinical assessment, and clinical management) and two global items (general organization and overall performance). The OSCE is targeted toward resident physicians in internal medicine and family medicine, but can be used to teach many levels of learners, including students, residents, or faculty.

NIDA's Center of Excellence for Physician Information offers the curriculum resource entitled, "Prescription Drug Abuse: An Introduction," which serves as an introduction and overview to prescription drug abuse. It is available online: http://www.drugabuse.gov/coe.

Key words: opioids; opioid risk management; chronic pain; drug addiction; substance abuse; prescription drug abuse

Curriculum Module Components

This curriculum resource module includes:

- Facilitator Guide
- OSCE Guide
- Sample Patient Agreement Form
- Learner Instructions for Each Station
- Standardized Patient Instructions
- Faculty – Learner Assessment Form
- Learner Self-Assessment Form
- Standardized Patient – Learner Assessment Form
- Faculty OSCE Experience Evaluation Form
- Learner OSCE Experience Evaluation Form
- Standardized Patient OSCE Experience Evaluation Form

Educational Objective

- To assess learner's opioid risk management competencies using standardized patients in realistic settings and immediate observer feedback. These competencies include:

    - Starting a trial of opioid therapy using a patient agreement form to discuss risk/benefit and monitoring strategies
    - Giving a patient feedback regarding aberrant medication-taking behaviors (e.g., escalation of dose, noncompliance with pill counts) with appropriate adjustment in opioid therapy due to worsening pain
    - Interpreting and discussing abnormal urine drug test results with a patient and discussing the need for substance abuse treatment referral
    - Discussing lack of benefit (i.e., no substantial pain relief or improved function) and increased risk (i.e., opioid induced hyperalgesia, opioid withdrawal mediated pain) in a patient with increasing pain despite increasing opioid doses and developing a treatment plan that includes opioid taper

Teaching Points

The faculty assessor can assess learners on the following skills and whether the learner performed the accompanying behaviors.

- <u>General Communication Skills / Relationship Development / Rapport Building</u>
    - Allows patient to express self: uses open-ended questions, does not interrupt, invites questions
    - Communicates in nonjudgmental fashion: no leading questions, respectful, non-patronizing
    - Exhibits empathic/supportive attitude: expresses concern, acknowledges patient's emotions/coping efforts, facilitative nonverbal behavior
    - Probes for resistance/denial: follows up on unclear statements
    - Uses language appropriate to patient's level of understanding: avoids medical jargon, explains unfamiliar medical terms
    - Strengthens treatment alliance: includes patient perspective in treatment plan

- <u>Assessment and Management of Problem (station specific content)</u>
    - Assesses for baseline opioid risk (screens for unhealthy substance (alcohol, drug, and tobacco) and consequences of substance use, asks about family history of substance abuse)
    - Discusses risks and benefits of opioids for chronic pain (risks: physical dependence, sedation, constipation, addiction, hyperalgesia ; benefits: modest improvement in pain and function; discuss concern about using friend's opioids)
    - Discusses universal monitoring strategies (opioid as a "test" not committing to long-term opioids; controlled substance agreement; urine drug testing; pill counts; includes response to aberrant medication taking behaviors – unsanctioned dose escalation, etc.; and short-term follow up arranged for pain/fct assessment and opioid monitoring)

Facilitator Guide

The Objective Structured Clinical Exam (OSCE) is a timed, multi-station exercise that requires learners to perform specific tasks in simulated clinical encounters using standardized patients. Performance is assessed at each station using predetermined rating scales by a small group of faculty assessors. The OSCE may serve as both an assessment tool and a formative exercise. The direct observation of learners "in action," in the same clinical scenario, allows for a performance-based assessment of learners' skills. The immediate feedback offered, as well as the opportunity for self-assessment, facilitates the enhancement or acquisition of knowledge and skills.

OSCEs do require dedicated blocks of time, as well as advanced planning and attention to detail for optimal execution, but are currently used widely in medical schools and residency programs. The stations described here may be easily incorporated into existing OSCEs at many institutions, or added to existing didactic sessions, seminars, academic half days, or ambulatory blocks. This OSCE includes the following components.

- **Three OSCE station cases** with 1) learner instructions [Appendix B] and 2) standardized patient instructions [Appendix C]
    - **Station 1:** Starting opioid therapy for chronic noncancer pain
    - **Station 2:** Managing a patient with aberrant medication-taking behaviors
    - **Station 3:** Discontinuing opioids due to lack of benefit and increased risks

- **Assessment of learner's performance forms**
    - Faculty assessment of learner form [Appendix D]
    - Learner self-assessment form [Appendix E]
    - Standardized patient assessment of learner form [Appendix F]

- **OSCE exercise evaluation forms**
    - Faculty assessor OSCE evaluation form [Appendix G]
    - Learner OSCE evaluation form [Appendix H]
    - Standardized patient OSCE evaluation form [Appendix I]

Faculty Training

- Three to six faculty members in internal medicine will be selected to serve as faculty assessors of learners' performance for the OSCE. The faculty assessors should have experience as clinician educators and with giving learners feedback following direct observation of clinical encounters. Faculty should have expertise in substance abuse and pain management in the ambulatory setting.
- All faculty will participate in a 20-minute small group discussion of effective feedback delivery.
- Faculty will role play each station-specific case to standardized ratings, agree on teaching points, and practice giving station-specific feedback. This 90 minute session includes the following steps:
    - The logistics of the sessions are reviewed.
    - Faculty rotate through all of the stations in groups of three. One faculty member takes on the learner's role, another faculty member assumes the faculty assessor's role, while the third serves as the observer.

- The rating forms are completed for each station and reviewed and discussed with the faculty assessors. Faculty assessors review the key components to determine when the learners have completed their tasks successfully and met the learning objectives, guided by the standardized rating forms.

Standardized Patient (SP) Selection and Training

- Some institutions have access to standardized patient programs, which provide an attractive, although sometimes costly, option for the OSCE. Other institutions recruit, from local professional acting groups, actors that are appropriate to the roles as written (e.g., age, gender), or use hospital or medical school personnel as volunteers, after first ensuring that they are not known to the learners (e.g., from different departments in the hospital).
- SPs practice with faculty assessors to standardize performance and feedback.

Learner Introduction to Opioid Risk Management OSCE

- Learners participate in the OSCE after attending teaching sessions on prescription drug abuse and receiving an overview of pain management. NIDA's Center of Excellence for Physician Information offers the curriculum resource entitled, "Prescription Drug Abuse: An Introduction. This resource includes a 60-minute prescription drug abuse case-based lecture and a 90-minute interactive discussion on management of chronic pain in the ambulatory setting. It provides an overview of prescription drug abuse, framed within the common clinical scenario of chronic pain management in the outpatient settings. It is available online: http://www.drugabuse.gov/coe.
- Additional curriculum resources on prescription drug abuse are also available from NIDA. These resources, including can be found here: http://www.drugabuse.gov/coe/topic.htm#pda.
- For additional information on prescription drug abuse, please go to the National Institute on Drug Abuse's NIDAMED Web site:
  http://www.drugabuse.gov/nidamed/
  http://www.drugabuse.gov/drugpages/prescription.html
  http://www.drugabuse.gov/researchreports/prescription/prescription.html
- Learners attend a 20-minute OSCE introduction session outlining learning objectives and logistics of each station (as described below).

Administration of the Opioid Risk Management OSCE

- Learners rotate through all three stations; each station experience takes **25 minutes.**
  - Learners have **2 minutes** before each station to read the station-specific learner instruction sheet posted outside of each station's exam room and the specific tasks to be accomplished.
  - Learners have **10 minutes** to assess and manage the particular case while a faculty assessor completes a rating form.
  - At the end of each encounter, learners self-assess their performance in **2 minutes** and the standardized patient gives a brief assessment in **1 minute**. The faculty assessor then provides **10 minutes** of direct feedback based on predetermined teaching points.

- The learner, standardized patient, and faculty assessor will complete the learner assessment forms.

OSCE Evaluation

- Faculty assessors, learners, and standardized patients complete an evaluation of the OSCE experience, focusing on process, logistics, and learning opportunities.
- Learners and faculty assessors participate in a 20-minute group debriefing session to discuss the pros and cons of the OSCE experience and any improvements that can be made to the content and/or process.

OSCE Guide

2 min Read case [visit scenario and specifics tasks (3 tasks per station)]

10 min Patient interview (**1 min** warning to "wrap things up")

1 min Learners self evaluate
"What was the most challenging part of this interview?"

1 min Standardized patient to evaluate
"How did the interaction feel to you?"

5 min Faculty observer to give feedback
- ***Communication skills***
- ***Assessment and management of the problem***

1 min Complete assessment forms
Learners move to the next station

Faculty role

- Keep things on schedule
- Give corrective and reinforcing feedback to learner
- Complete learner assessment form after each session and hand in at end of OSCE
- Collect assessment forms from SP and hand in at the end of the OSCE
- Give standardized patient some feedback between sessions
- Complete OSCE evaluation form (remember this is a pilot project)

OSCE Overhead Announcements

0:00 / 20:00	"Next Station, Read Case"
1:00	"1 Minute More for Case"
1:30	"30 Seconds More for Case"
2:00	"Stop Reading Case, Enter Room, Start Interview Now"
11:00	"Wrap Up Interview, 1 Minute"
12:00	"Stop Interview, Start Feedback Now"
18:00	"Wrap Up Feedback, 1 Minute"
19:00	"Stop Feedback, Complete Forms"

Selected Bibliography

This bibliography provides additional resources to faculty who are interested in reading more about addiction medicine and learning more on the background of some of the concepts taught here.

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Pilot Information

TEACHING OPIOID RISK MANAGEMENT (ORM) SKILLS TO RESIDENTS

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STATEMENT OF PROBLEM: Chronic pain is a leading complaint for which adults seek medical care, and opioid analgesics are increasingly being prescribed. The rate of prescription opioid misuse, including addiction, unintentional overdoses, and diversion, is increasing. Inadequate medical education about opioid risk management for patients with chronic pain could be contributing to this problem.

OBJECTIVES OF THE PROGRAM: To increase internal medicine residents' knowledge and skills in opioid risk management (ORM).

DESCRIPTION OF THE PROGRAM: We developed a two-part ORM education program.

Part A–Didactic: 1-hour lecture covered assessment of pain, function, addiction risk and potential opioid benefit/risk; monitoring for opioid benefit/risk; developing exit strategies for lack of benefit/increased risk; and developing effective communication skills on these topics.

Part B–Objective Structured Clinical Exams (OSCE): Three 20-minute stations using standardized patients in realistic settings and immediate faculty observer feedback. The stations covered ORM skills, including starting opioid therapy, giving patients feedback regarding aberrant medication-taking behaviors, and discussing opioid taper due to lack of benefit/increased risk.

The educational program was evaluated by comparing three groups of residents selected by convenience sampling: **Group 1** (n=20) participated in the didactic session only, **Group 2** (n=9) participated in both the didactic and OSCE sessions, and **Group 3** (n=10), a control group, did not participate in either session. All three groups completed a baseline survey composed of three components: knowledge, clinical confidence,* and practice. Groups 1 and 2 completed a post-didactic survey to detect changes in knowledge from baseline. Group 2 completed a post-OSCE survey assessing clinical confidence to detect changes from baseline. Group 2 also completed an evaluation of the OSCE experience. All three groups are scheduled to complete 4- and 8-month follow-up surveys (identical to the baseline survey) asking about ORM knowledge, clinical confidence, and practice.

FINDINGS TO DATE/EVALUATION: The total resident sample (n=39) was 51 percent female, 38 percent PGY1, 36 percent PGY2, and 26 percent PGY3. At baseline:

- 31 percent reported no previous training in the use of opioids for managing chronic pain;
- 74 percent reported that their prior ORM training was not enough; and
- 23 percent reported starting patients on long-term opioids in the past three months.

* The information about clinical confidence was obtained using the evaluation tools—self-report, surveys—used to assess the earlier intervention, which was an OSCE for residents.

Baseline differences in ORM clinical confidence/practice were not significant between the three study groups.

Post-didactic ORM knowledge scores (max score = 4) increased for Group 1 (didactic only) from 2.7 to 3.3 (p=.05), while Group 2 (didactic + OSCE) changed from 3.2 to 3.7, a non-significant change. For Group 2, the pilot's post-OSCE mean clinical confidence (8 ORM skills using 5-point Likert scale) increased from 2.8 to 3.8 (p=.002). Group 2 all reported that the OSCE "helped me identify my strengths and weaknesses," "taught me something new," and "was a valuable learning tool."

KEY LESSONS LEARNED: Internal medicine residents are not very confident about initiating and managing long-term opioid pain therapy in patients with chronic pain. A didactic session on the topic can increase knowledge. A related OSCE provides additional valuable experience in developing skills needed to communicate effectively with patients suffering from chronic pain on long-term opioids.

Appendix A. Sample Patient Agreement Form

Patient Name:
Medical Record Number: **Addressograph Stamp:**

AGREEMENT FOR LONG TERM CONTROLLED SUBSTANCE PRESCRIPTIONS

The use of _____ (print names of medication(s)) may cause addiction and is only one part of the treatment for:_____ (print name condition—e.g., pain, anxiety, etc.).

The goals of this medicine are:

☐ to improve my ability to work and function at home.

☐ to help my _____ (print name of condition—e.g., pain, anxiety, etc.) as much as possible without causing dangerous side effects.

I have been told that:

1. If I drink alcohol or use street drugs, I may not be able to think clearly and I could become sleepy and risk personal injury.
2. I may get addicted to this medicine.
3. If I or anyone in my family has a history of drug or alcohol problems, there is a higher chance of addiction.
4. If I need to stop this medicine, I must do it slowly or I may get very sick.

I agree to the following:

- I am responsible for my medicines. I will not share, sell or trade my medicine. I will not take anyone else's medicine.
- I will not increase my medicine until I speak with my doctor or nurse.
- My medicine may not be replaced if it is lost, stolen, or used-up sooner than prescribed.
- I will keep all appointments set up by my doctor. (Primary Care, physical therapy, mental health, substance abuse treatment, pain management, etc.)
- I will bring the pill bottles with any remaining pills of this medicine to each clinic visit.
- I agree to give a blood or urine sample, if asked, to test for drug use.

Refills

Refills will be made only during regular office hours—Monday through Friday, 8:00AM-4:30 PM. No refills on nights, holidays or weekends. I must call at least three (3) working days ahead (M-F) to ask for a refill of my medicine. **No exceptions will be made**. I will not come to Primary Care for my refill until I am called by the nurse.

I must keep track of my medications. No early or emergency refills may be made.

Pharmacy

I will only use one pharmacy to get my medicine. My doctor may talk with the pharmacist about my medicines.
The name of my pharmacy is_____.

Prescriptions from Other Doctors

If I see another doctor who gives me a controlled substance medicine (for example, a dentist, a doctor from the Emergency Room or another hospital, etc.) I must bring this medicine to Primary Care in the original bottle, even if there are no pills left.

Privacy

While I am taking this medicine, my doctor may need to contact other doctors or family members to get information about my care and/or use of this medicine. I will be asked to sign a release at that time.

Termination of Agreement

If I break any of the rules, or if my doctor decides that this medicine is hurting me more than helping me, this medicine may be stopped by my doctor in a safe way.

I have talked about this agreement with my doctor and I understand the above rules.

Provider Responsibilities

As your doctor, I agree to perform regular checks to see how well the medicine is working.

I agree to provide primary care for you even if you are no longer getting controlled medicines from me.

_____ _____

Patient's signature Date

_____

Resident Physician's signature

_____

Attending Physician's signature

☐ This document has been discussed with and signed by the physician and patient. (A signed copy stamped with patient's card should be sent to the medical records department and a copy given to the patient.)

Appendix B: Learner Instructions for Each Station

Station #1: Robert Jones

Patient information:

Name:	**Mr. Robert Jones**
Age:	**50**
Marital status:	**Married**
Children:	**2 children; ages 13 and 17**
Occupation:	**Mechanic**
Pain issue:	**Chronic right ankle pain**

Setting: **This is the second visit for this patient. The interview starts with you having a conversation about how Mr. Jones' pain is on the ibuprofen and acetaminophen you prescribed at the last visit 1 month ago.**

Scenario:
Mr. Jones is a 50-year-old mechanic with chronic right ankle pain. He transferred his primary care to you because his previous primary care physician moved out of state. When he presented last month (his first visit), he gave you a copy of his old medical records.

Two years ago after falling off a ladder, he fractured his right ankle. Several surgeries were required to restore his ankle to relatively normal function. His current orthopedist's notes document a "well-healed" ankle with indwelling hardware, and a near normal range of motion. He was told by his orthopedist that his primary care physician should manage his pain.

Pain assessment: Good days 6 out of 10 – with use of the ibuprofen and acetaminophen you prescribed last time.
Bad days 15 out of 10 – only gets relief with "Oxys" (OxyContin 10 mg) obtained from a friend.

Functional assessment: He recently started working again as a mechanic, and his ankle pain has increased significantly. It is important to him to work full-time to support his family because his wife is not working.

Over the past year, he has tried multiple prescribed medications for his pain, including Naprosyn, Tylenol with codeine, and Ultram. He states that all of these medications were ineffective and often made him "sick to his stomach."

His exam is normal except for multiple well-healed scars and bony deformities on his right ankle and small areas of numbness and hyperalgesia on his right forefoot.

==========

Your tasks:

- **Start the encounter by summarizing the above pain and functional assessment and asking Mr. Jones if there is anything he would like to add. Then:**
    - **Assess his baseline risk for opioid analgesics**
    - **Discuss the potential risks and benefits of opioid analgesics for chronic pain**
    - **Discuss the monitoring strategies that will be required**

Appendix B: Learner Instructions for Each Station

Station #2: Mary Tempo

Patient information:

Name:	**Ms. Mary Tempo**
Age:	**33**
Marital status:	**Divorced and single**
Children:	**None**
Occupation:	**Registered nurse on disability**
Pain complaint:	**Chronic low back pain**

Setting: **This is a regularly scheduled follow-up visit for this patient who you have been seeing for the past 9 months. The patient is eager to hear the results of her recent back MRI.**

Scenario:
Ms. Tempo is a 33-year-old nurse in recovery from benzodiazepine addiction who arrives for a follow-up visit. She has an 8-year history of chronic low back pain and is on disability because of this back pain. You have been seeing her for the past 9 months. Because of her increasing back pain you ordered an MRI of her L-S spine that showed mild–moderate degenerative changes at multiple lumbar levels and mild spinal stenosis, which was unchanged from an MRI done 2 years ago.

In the past, her pain has been treated with NSAIDs, tramadol, gabapentin, tricyclic antidepressants, steroid injections, acupuncture, heat and ice treatments, cognitive behavior therapy, and physical therapy. Opioids, which she has been taking for more than 5 years, are the only treatment that consistently helps her pain.

Current medications: Sustained-release morphine (MSContin) 30 mg BID; Oxycodone 5 mg every 8 hours as needed for breakthrough pain (maximum of 3 tablets per day); Atenolol for her hypertension; Prozac for her depression

Pain and functional assessment: She has been on stable doses of opioids for years, and her pain has been well controlled, ranging from 4 to 6 out of 10. She spends most of her time at home watching TV but has recently started babysitting for her neighbor's 15-month-old son.

She has an up-to-date controlled substances agreement that outlines the need for compliance and close monitoring, including urine drug tests, pill counts, and taking the morphine and oxycodone as prescribed. For the first 7 months of treatment, she was completely compliant. Then she came in 2 months in a row asking for early refills of her morphine and oxycodone prescriptions. She has recently been noncompliant with monitoring—not leaving urine drug tests and not bringing in her pills for pill counts.

==========

Your tasks:

- **Start the encounter by briefly discussing the results of Ms. Tempo's MRI scan. Then:**
  - **Assess and try to diagnose the cause of patient's aberrant medication-taking behaviors (early refill requests, non-adherence with monitoring)**
  - **Give feedback and discuss your concerns about aberrant medication-taking behaviors**
  - **Discuss strategies for addressing her aberrant behaviors, including a revised treatment plan with intensified monitoring**

Appendix B. Learner Instructions for Each Station

Station #3: Lindsey Beecher

Patient information:

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

Setting: **This is an early follow-up visit scheduled after the patient was seen in the emergency room over the weekend for worsening foot pain. You have been following this patient for the past 6 months.**

Scenario:
Mrs. Beecher is 43-year-old elementary school teacher with type 2 diabetes mellitus and bilateral lower leg painful diabetic neuropathy. She presents for a follow-up visit. Her pain is burning all the time and worse at night when the sheets touch her feet (allodynia). She denies current tobacco or alcohol use. She is considering going on disability because of her severe foot pain. She describes her pain as 10 out of 10 all the time.

You have been seeing Mrs. Beecher for the past 6 months and recently increased her methadone dose from 15 mg to 20 mg TID. She is also on gabapentin 600 mg TID and amitriptyline 10 mg at night. In addition, her diabetes is being treated with Glucophage and Glyburide, and she is taking Lisinopril for her hypertension and Simvistatin for her hypercholesterolemia.

She has an up-to-date controlled substances agreement that outlines the need for compliance and close monitoring, including urine drug tests, pill counts, and taking her methadone as prescribed.

You notice since her last visit that she was seen in the emergency room over the weekend because she ran out of her methadone. The emergency room physician gave her a 15 day supply of methadone, did a urine drug test, and scheduled a follow-up visit with you in 10 days. She was instructed to bring her pill bottle in for a pill count at her next visit with you. She presents without her pill bottle. Her urine drug test sent from the emergency room was positive for methadone and cocaine.

==========

Your tasks:

- **Start the encounter by asking Mrs. Beecher about her emergency room visit over the weekend. Then:**
    - **Discuss her abnormal urine drug test result and aberrant medication taking behaviors**
    - **Discuss the lack of apparent benefit and increased risk of continued use of methadone to treat her pain**
    - **Discuss the need for tapering her methadone and the need for a referral to substance abuse treatment**

Appendix C. Standardized Patient Instructions

Station #1: Robert Jones

Patient information:

Name:	**Mr. Robert Jones**
Age:	**50**
Marital status:	**Married**
Children:	**2 children; ages 13 and 17**
Occupation:	**Mechanic**
Pain issue:	**Chronic right ankle pain**

Setting: **This is your second visit to this primary care physician. The interview starts with you having a conversation about how your pain is on the ibuprofen and acetaminophen you were prescribed at the last visit 1 month ago.**

Scenario:
Your name is Robert Jones, and you are a 50-year-old mechanic with chronic right ankle pain. You transferred your primary care to this physician because your previous primary care provider moved out of state to Florida. You had been seeing your previous primary care physician for more than 10 years before he moved. You are worried about having a new physician, but you were told that this medical center has excellent physicians. You presented last month (your first visit) with a copy of your old medical records, which includes notes from your primary care physician and your orthopedic surgeon.

Two years ago, you fractured your right ankle when you fell off a ladder while cleaning out the gutters. You had been drinking with friends earlier in the day while watching football games, but you have not attributed your accident to your alcohol use. Your ankle fracture required several surgeries with placement of screws and plates to restore relatively normal function. Your orthopedist recently told you that your ankle is "well-healed" but will likely always cause you significant pain. You were told that no additional surgeries are indicated at this time. Your orthopedist also told you that your new primary care provider should take over the treatment of your ankle pain.

You have taken multiple medications over the past year for your pain including ibuprofen, naproxen, acetaminophen, and tramadol. None of these medications worked, and naproxen made you sick with abdominal pain.

Your have good and bad days depending on the pain in your ankle. When asked to rate your ankle pain on a scale of 0 to 10, with 0 being no pain and 10 being the worst pain of your life, your pain on good days is a 6 out of 10. You can sometimes manage this level of pain with ibuprofen alone. On bad days your pain is very severe and disabling and is 15 out of 10, and you only get relief when you take “Oxys” (OxyContin 10 mg) that a friend gives you. You recently started taking one or two Oxys 10 mg tablets 2 times per day, allowing you to start working again as a mechanic. You have started buying Oxys on the street for $10–$20 a tablet. When you don’t take Oxys, your pain is unbearable and you feel anxious and sick to your stomach.

Your right ankle is somewhat deformed from the facture and surgeries, and you have small areas of numbness and very sensitive painful areas on the top and inside of your right foot.

Personality:
You do not like going to doctors, but you really liked your previous doctor. You are cooperative but suspicious of why this new doctor is asking so many questions since your previous doctor didn't usually ask about alcohol and drug use. You consider yourself to have a high tolerance to pain, but your ankle pain is starting to depress you. All you want to be able to do is to put in an honest day's work without suffering so much and to sleep at night comfortably.

Current life situation:
You live with your wife, Mary, and your two children, 17-year-old David and 13-year-old Susan. You have a small three-bedroom house in a suburb of Boston. You work as a mechanic at a Ford dealership. You feel a lot of pressure to work full-time and support your family because your wife is not working currently. Your wife is very concerned about your alcohol use and the fact that you are spending so much money on OxyContin. She is also concerned about how much pain you have when you don't have any OxyContin.

Past medical/surgical/psychiatric history:
Other than a tonsillectomy, appendectomy, and fractured right ankle, you have been healthy. Your ankle fracture occurred 2 years ago when you fell off a ladder at home while cleaning out the gutters. You had been drinking heavily with your friends while watching football games on that day. You were reluctant to go up on the ladder, but your wife had been nagging you about cleaning out the gutters.

Family history:
Your father was an alcoholic and died 3 years ago of cirrhosis.
Your mother was treated for depression and died of breast cancer 7 years ago.
You have 1 brother who is 48 and is healthy but smokes marijuana daily.

Psychosocial history:
You have no history of depression, but your wife thinks that you are depressed about your ankle pain. To relax you drink beer with your friends and play poker.

Life-style history:

Smoking: You smoke 1–2 packs of cigarettes per day. You are thinking about quitting since it is getting too expensive to continue smoking, but your smoking helps you relax. Your wife, Mary, does not let you smoke in the house.

Alcohol: You drink alcohol "socially" to relax. You drink beer 4–5 days per week. On a typical drinking day, you drink 4–6 beers. This is the same amount your friends drink. You minimize any consequences of your alcohol use.

- You have never tried to cut down on your drinking.
- You get annoyed with your wife when she complains about your drinking.
- You have never felt guilty about your drinking,
- You never drink first thing in the morning.

You have never failed to fulfill social obligations because of your alcohol use and have never suffered any legal consequences (for example, no driving under the influence violations). However, you do sometimes drive after heavy drinking with your friends, but not if you think you are too drunk. You do not think your drinking is on the same level as your father's drinking since he drank "hard liquor" and "never worked a day in his life."

Drugs: You smoked marijuana and sniffed cocaine in your early 20s, but have not used illicit drugs for over 20 years.
==========

Interview challenge for resident:

- The resident will start the encounter by summarizing your pain and functional history and asking you if there is anything you would like to add. Then the resident will:
    - Assess your baseline risk for opioid analgesics
    - Discuss the potential risks and benefits of opioid analgesics for your chronic pain
    - Discuss the monitoring strategies that will be required

General approaches during the interview:

Beginning: Start the interview by being very complimentary of the doctor, saying "you are the first doctor that I have ever felt comfortable with" and "the nurse who took my blood pressure said you are one of the best doctors here." Emphasize that the Motrin and Tylenol that were prescribed last time are like "vitamins," and they don't even come close to helping your pain. Be insistent that you have high tolerance to medications and that you are going to need something stronger. You can add some information about your pain if the doctor leaves something out. Act somewhat naïve and then defensive about your purchase of "street" OxyContin. You feel like you have no choice because your pain is "15/10" since starting to work full-time again. The main reason you have come to this doctor's visit is to get a prescription of OxyContin. You have no intention of misusing or abusing OxyContin, and you take offense if you get the sense from the doctor that you are addicted to OxyContin. You minimize any problems with your alcohol use because alcohol is your only release from the daily stress of trying to support your family while suffering from terrible ankle pain. You are <u>not</u> interested in quitting alcohol at this time, but would be willing to cut down if the doctor gives you safe drinking limits. You are willing to consider quitting smoking if the doctor discusses it with you. You have realistic expectations of OxyContin, realizing that your pain will not go away but will be manageable so as to allow you to work (to support your family) and to sleep.

Middle: You are taken aback if the physician talks about monitoring your OxyContin use with urine drug tests and pill counts. Your previous primary care doctor and orthopedist never required such close monitoring when you were prescribed narcotic pain meds after your ankle surgery. Tell the resident that you feel that you are being singled out for this close monitoring. The resident should tell you that all the patients on opioids in his/her clinical practice are monitored closely. The resident should explain why the monitoring is necessary. The resident should also explain what your responsibilities are for making sure you take the medication exactly as prescribed.

End: If the physician is empathic and nonjudgmental then agree to comply with all the requests for close monitoring, such as urine drug tests and pill counts. You can start to acknowledge that your drinking may be risky. If the physician is not empathic and is judgmental, you can continue to question the need for such close monitoring with statements like, "Do you think I am an addict?" and "Don't you trust me?"

Appendix C. Standardized Patient Instructions

Station #2: Mary Tempo

Patient information:

Name:	**Ms. Mary Tempo**
Age:	**33**
Marital status:	**Divorced and single**
Children:	**None**
Occupation:	**Registered nurse on disability**
Pain complaint:	**Chronic low back pain**

Setting: **This is a regularly scheduled follow-up visit with your primary care physician. You have been seeing this doctor for the past 9 months and are very satisfied with the care you have been receiving. You recently had an MRI of your back to evaluate your worsening back pain, and you are very eager to hear the results of the MRI.**

Scenario:
Your name is Mary Tempo, and you are a 33-year-old nurse in recovery from benzodiazepine (i.e., Klonopin and Xanax) addiction. You have an 8-year history of chronic low back pain. You are arriving for a follow-up visit after recently having a back MRI. You are very focused on the results of the MRI because your back pain seems to be getting worse. You have been on disability for the past 5 years because of your back pain. You have been seeing this physician for the past 9 months.

In the past, your pain has been treated with ibuprofen, tramadol, gabapentin, tricyclic antidepressants (i.e., Elavil), steroid injections, acupuncture, heat and ice treatments, cognitive behavioral therapy, and physical therapy. You have always been willing to try any treatments recommended to help your pain. Your main focus is on pain relief and not necessarily on getting more medications. However, “narcotics” (i.e., opioids), which you have been taking for over 5 years, are the only treatment that consistently help your pain. You are currently taking sustained-release morphine (MSContin) 30 mg 2 times per day and oxycodone 5 mg every 8 hours as needed for breakthrough pain. You have been on stable doses of opioids for years, and your pain has been well controlled, ranging from 4–6 out of 10. You spend most of your time at home watching TV but have recently started babysitting for your neighbor’s 15-month-old son, Harry.

You signed an up-to-date controlled substances agreement that outlines the need for compliance and close monitoring, including urine drug tests, pill counts, and taking the morphine and oxycodone as prescribed.

For the first 7 months of treatment you have been completely compliant.

For the past 2 months you have been giving your brother, Fred, who is addicted to heroin, some of your morphine and oxycodone to help him prevent opioid withdrawal. He has been having a hard time buying enough heroin as his regular dealer was recently arrested. You feel very uncomfortable with this situation and have pleaded with Fred to go to a detox, but he insists that he can do it on his own. Each time he asks for your pills, he states it is the “last time.” However, he seems to want more and more of your pills lately. Because you have been giving your

brother some of your morphine and oxycodone, your pain has been inadequately treated, and you have had to come to your primary care office early for refills during the past 2 months. As an excuse for these requests for early refills, you tell your primary care physician that your pain has worsened and that is why you need more morphine and oxycodone. You are very reluctant to discuss this problem with your physician because you are afraid that he/she will stop treating your pain with opioids. You also did not leave a urine drug test the last visit because you were afraid that because you are taking less morphine or oxycodone it will not show up in the urine test. You also do not bring in your pills for pill counts as you know they will be short by many pills. You feel stuck because you want to help your brother with his addiction, but you need your pain pills to treat your pain and you are worried that your primary care physician is going to stop prescribing them to you.

At this visit your pain is 9 out of 10, and you "forgot" to bring your pills for a pill count because you "left them on the kitchen counter."

Personality:
You are an outgoing and friendly person. You tend to be an enabler, especially when it comes to your younger brother, Fred, who suffers from heroin addiction. You are intent on pleasing your physician, and you are very sensitive to any sense that your physician is starting to distrust you.

Current life situation:
You live with your younger brother, Fred, who is suffering from heroin addiction. You are on disability because of back pain but have recently started babysitting your neighbor's 15-month-old son, Harry. You don't think you will ever be able to work as a nurse again because of the requirement to be able to lift patients, but you are willing to consider a nursing administrative job. You are thinking about getting some business training at a local community college.

Past medical/surgical/psychiatric history:
- Hypertension (high blood pressure) for the past 5 years treated with Atenolol.
- Depression treated for the past 10 years with Prozac.
- Chronic low back pain that began after slipping on a wet floor at work 8 years ago.

Family history:
- Other than your brother Fred's opioid addiction (which started after he was prescribed narcotics for a shoulder injury), you have no other family substance abuse history.
- Your mother has early onset Alzheimer's disease and is living in a nursing home.
- Your father died from metastatic prostate cancer 6 years ago.
- Your only sibling, your brother Fred, suffers from opioid addiction.

Psychosocial history:
- You have been divorced for the past 3 years. Your husband was an alcoholic and abused you emotionally. You have not had contact with your ex-husband in over a year. You have not been in a relationship since your divorce.
- You have no children.
- You relax by reading a good mystery novel and talking to friends.
- You are very close to your mother and visit her almost daily on the dementia unit of a nursing home.

- You are very stressed about your brother's active opioid addiction and are ambivalent about allowing him to continue to live with you while he is using drugs. However, you do not feel comfortable "kicking him out onto the street."

Life-style history:

Smoking: You smoke half a pack per day, but would like to quit because cigarettes are too expensive.

Alcohol: You do not drink as you "never liked the taste of alcohol."

Drugs: You had a benzodiazepine (Klonopin and Xanax) addiction in the past but have been clean for more than 10 years. You previously went to AA meetings but stopped 2–3 years ago. You might go to an occasional meeting during the holidays if you are feeling vulnerable to relapse.

==========

Interview challenge for resident:

- The resident will start the encounter by briefly discussing the results of your MRI scan. Then the resident will:
    - Assess and try to diagnose the cause of your aberrant medication taking behaviors (early refill requests, non-adherence with monitoring)
    - Give feedback and discuss his/her concerns about your aberrant medication taking behaviors
    - Discuss strategies for addressing your aberrant behaviors, including a revised treatment plan with intensified monitoring

General approaches during the interview:

Beginning: When the resident enters the room, say, "What did my MRI show?" and "My back is really killing me these days." Make sure the resident explains the MRI results in terms that are understandable to you. You are reassured by the results of the MRI since they are unchanged from previous MRIs. You can state that you were worried that your back had gotten worse and that you were going to need back surgery.

Middle: The goal of this dialogue is for the resident to make you comfortable enough to disclose that you have been giving some of your morphine and oxycodone to your brother, who is struggling with an active opioid addiction. You know that it is wrong to give pills to your brother, but you feel stuck. You want to help your brother, but you don't want to jeopardize your relationship with your doctor and certainly don't want to risk not getting your pain pills, which you think are helping you a lot. You are relieved once you are able to disclose your situation to your physician because it has been very stressful for you to keep it a secret. You become very sad if the physician is angry and not willing to continue your pain meds. It is very important to you that your physician likes and trusts you.

End: Allow the resident to make a plan for closer monitoring of your prescriptions and mutually work on a plan for dealing with your brother's requests for your pain pills. Be willing to do whatever it takes to allow your physician to keep prescribing your pain pills.

Appendix C. Standardized Patient Instructions

Station #3: Lindsey Beecher

Patient information:

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

Setting: **This is an early follow-up visit that was scheduled after you were seen in the emergency room over the weekend for worsening foot pain. You have been followed by this primary care physician for the past 6 months. You are somewhat nervous since you know that your physician is going to ask you about why you were in the emergency room asking for more pain pills despite knowing that this is breaking your controlled substance (narcotic) agreement, which states that you are not supposed to take more pills than prescribed.**

Scenario:

Your name is Lindsey Beecher and you are a 43-year-old elementary school teacher with type 2 diabetes mellitus and painful bilateral lower leg diabetic neuropathy. Your pain is burning all the time and worse at night when the sheets touch your feet. You are considering going on disability because of your severe foot pain. You describe your pain as 10 out of 10 all the time. If pushed, the best you will ever say your pain is 8–9 out of 10. You have been seeing this physician for the past 6 months and recently had your methadone dose increased from 15 mg to 20 mg three times per day. You are also on gabapentin (Neurontin) 600 mg three times per day and amitriptyline (Elavil) 10 mg at night.

You have an up-to-date controlled substances agreement that outlines the need for compliance and close monitoring, including urine drug tests, pill counts, and taking the methadone as prescribed.

You went to the emergency room on Saturday night because you ran out of your methadone after doubling your dose because your pain was unbearable. The emergency room doctor gave you a 15 day supply of methadone, sent your urine for testing, and scheduled a follow-up visit with your primary care physician in 10 days. You were instructed to bring in your pill bottle for a pill count at that visit.

Your pain is very severe and you often take more methadone than prescribed. Although the methadone does not help the pain, it helps relax you, especially after sniffing cocaine with your husband. You have been very careful not to use cocaine before your doctor's visits because you do not want it to show up in your urine test. You do not like bringing your methadone pills in for pill counts since you often use more than prescribed. You have also given some of your methadone to a drug dealer in exchange for cocaine. This was your husband's idea, and you felt very uneasy about it. Your main focus is on getting more methadone as you are convinced that higher doses will better help your pain. Your husband has expressed some concern to you that you seem to be overly sleepy and "nod out" and slur your words after taking extra

methadone. You attribute this sedation to working extra hard at work and having trouble sleeping. You do not think cocaine is a problem because you feel you can stop anytime you want. You do not think your cocaine use should prevent you from getting more methadone for your pain.

You suspect that the urine test done in the emergency room will have cocaine in it since you had used the previous day. If you had known that the emergency room was checking your urine for drugs, you would have come up with an excuse for not being able to give a sample. You are hoping that your physician does not check the results of the test.

Personality:
You are a matter-of-fact person, somewhat distant and unemotional.

Current life situation:
You are living with your husband, Jimmy, of 23 years who owns a hardware store. Your relationship has always been excellent. Your only child, Steven (22 years old), is separated from his wife, who is currently hospitalized with severe mental illness. Steven works weekends driving a cab. You take care of Steven's only child (your 2-year-old granddaughter Morgan) most weekends. The time you spend with Morgan is wonderful—she is engaging, bright, and an all around wonderful child. You love your job as a third-grade teacher and have been given many awards and accolades for your teaching skills. You have been somewhat stressed lately because you have two difficult children in your class with emotional problems, and you are getting no support from your school principal. You now feel that your pain is getting in the way of your ability to continue teaching, and you are contemplating going on disability.

Past medical/surgical/psychiatric history:
- Type 2 diabetes mellitus for the past 3 years complicated by painful diabetic neuropathy and mild kidney disease. Your diabetes is being treated with Glucophage and Glyburide.
- Hypertension treated with Lisinopril.
- Hypercholesterolemia treated with Simvistatin.

Family history:
- Your parents both have diabetes but otherwise are well.
- Your brother and sister are well without any known medical problems.

Psychosocial history:
Under stress, you like watching TV. In the past, you loved taking long walks but your foot pain makes that impossible these days.

Life-style history:
Smoking: You deny current tobacco use, as you quit more than 5 years ago.
Alcohol: You drink a glass of wine 1–2 times per year.
Drugs: You use intranasal cocaine 2–3 times per week with your husband. You do not think your cocaine use is a problem, and you certainly don't think you are "addicted" because you think you can stop anytime you want.
==========

Interview challenge for resident:

- The resident will start the encounter by asking you about your emergency room visit over the weekend. Then the resident will:
    - Discuss your abnormal urine drug test result and aberrant medication-taking behaviors
    - Discuss the lack of apparent benefit and increased risk of continued use of methadone to treat your pain
    - Discuss the need for tapering your methadone and the need for a referral to substance abuse treatment

General approaches during the interview:

Beginning: Your opening line should be "Doc, I need more methadone, my pain is killing me, I don't think I will be able to continue working if my pain doesn't get any better." Be somewhat curt and focused on the need for getting more methadone for your pain. If the doctor asks you about your urine test result by using a closed-ended question (yes/no question) such as "Are you using drugs" or "Are you using cocaine?" say "no" and say the test result must be wrong. If the doctor asks about your urine result by using an open-ended question such as "Your urine test was positive; can you tell me about it?" ask what was it positive for and then admit to occasional cocaine use with your husband. You should minimize the importance your cocaine use, saying it is just something that you and your husband like to do for fun.

Middle: If the resident shows empathy and asks open-ended non-judgmental questions, reveal the facts about your cocaine use including that you use up to 2–3 times per week and that you sometimes get chest palpitations if you use too much. Also mention that you have been using it more often than you had ever intended and that you like the "energy" it gives you to get things done around the house. If the resident is judgmental, you can continue to deny cocaine use by saying "There must be a problem with the drug test—could the urine have gotten mixed up?" If the resident states that you are "addicted," you should deny being an "addict."

If the resident gives you evidence (feedback) to support his/her concerns regarding the methadone not helping your pain (since you always report 10 out of 10 pain), AND that the risk of increasing methadone dose is great because it may cause you to become overly sleepy, thus heightening the risk of an accident, THEN you can start to consider that your pain is not responding to methadone and that increasing the dose will just make you more sleepy and that maybe there is something more effective and safer for you. If the resident just states that the methadone must be stopped without giving information about why he/she decided this, then push back. State that if he/she will not prescribe methadone, you will have to buy some on the street.

End: If the resident assesses your willingness to try new therapies for your pain, you can agree to consider "anything" that will help. Agree to consider stopping using cocaine and trying nonopioid therapies IF the interviewer uses a patient-centered approach, such as asking you for the pros and cons of cocaine use and helping you understand that use of cocaine and overuse of methadone is putting you at physical risk and possibly compromising your ability to care for your granddaughter. You are not willing to go to addiction treatment (counseling) for your cocaine use, but you will consider cutting down or stopping on your own. If, however, the resident continues to be judgmental, you can state that you do not agree that you are an addict and that you are going to consider finding a new physician who will give you more methadone.

Appendix D. Faculty – Learner Assessment Form

Station # 1: Robert Jones / **Ankle Pain**

Date: _____ Faculty Observer: _____ Learner Name: _____

Resident # _____

Check one response for each item.		Needs Much Improve-ment	Needs Some Improve-ment	Done Well	Done Excel-lently	N/A	Please Write Comments on Back of Form
General Communication Skills / Relationship Development / Rapport Building							
1.	**Allows patient to express self** (uses open-ended questions, does not interrupt, invites questions)	☐	☐	☐	☐	☐	
2.	**Communicates in nonjudgmental fashion** (no leading questions, respectful, non-patronizing)	☐	☐	☐	☐	☐	
3.	**Exhibits empathic/supportive attitude** (expresses concern, acknowledges patient's emotions/coping efforts, facilitative nonverbal behavior)	☐	☐	☐	☐	☐	
4.	**Probes for resistance/denial** (follows up on unclear statements)	☐	☐	☐	☐	☐	
5.	**Uses language appropriate to patient's level of understanding** (avoids medical jargon, explains unfamiliar medical terms)	☐	☐	☐	☐	☐	
6.	**Strengthens treatment alliance** (includes patient perspective in treatment plan)	☐	☐	☐	☐	☐	
Assessment and Management of Problem (station-specific content)							
7.	**Assesses for baseline opioid risk** (screens for unhealthy substance [alcohol, drug, and tobacco] and consequences of substance use, asks about family history of substance abuse)	☐	☐	☐	☐	☐	
8.	**Discusses risks and benefits of opioids for chronic pain** (risks: physical dependence, sedation, constipation, addiction, hyperalgesia ; benefits: modest improvement in pain and function; discuss concern about using friend's opioids)	☐	☐	☐	☐	☐	
9.	**Discusses universal monitoring strategies** (opioid as a "test" not committing to long-term opioids; controlled substance agreement; urine drug testing; pill counts; includes response to aberrant medication taking behaviors – unsanctioned dose escalation, etc.; and short-term follow up arranged for pain/fct assessment and opioid monitoring)	☐	☐	☐	☐	☐	

General Organization—*check one response for each item.*

	Needs Much Improvement	Needs Some Improvement	Done Well	Done Excellently
Time Management	☐	☐	☐	☐
Prioritization	☐	☐	☐	☐
Logical Approach	☐	☐	☐	☐

Overall Performance—*check one response.*

Needs Much Improvement	Needs Some Improvement	Done Well	Done Excellently
☐	☐	☐	☐

Appendix D. Faculty – Learner Assessment Form
Station # 2: Mary Tempo / **Low Back Pain**

Date: _____ Faculty Observer: _____ Learner Name: _____

Resident # _____

Check one response for each item.		Needs Much Improve-ment	Needs Some Improve-ment	Done Well	Done Excel-lently	N/A	Please Write Comments on Back of Form
General Communication Skills / Relationship Development / Rapport Building							
1.	**Allows patient to express self** (uses open-ended questions, does not interrupt, invites questions)	☐	☐	☐	☐	☐	
2.	**Communicates in nonjudgmental fashion** (no leading questions, respectful, non-patronizing)	☐	☐	☐	☐	☐	
3.	**Exhibits empathic/supportive attitude** (expresses concern, acknowledges patient's emotions/coping efforts, facilitative nonverbal behavior)	☐	☐	☐	☐	☐	
4.	**Probes for resistance/denial** (follows up on unclear statements)	☐	☐	☐	☐	☐	
5.	**Uses language appropriate to patient's level of understanding** (avoids medical jargon, explains unfamiliar medical terms)	☐	☐	☐	☐	☐	
6.	**Strengthens treatment alliance** (includes patient perspective in treatment plan)	☐	☐	☐	☐	☐	
Assessment and Management of Problem (station specific content)							
7.	**Assesses for baseline opioid risk** (screens for unhealthy substance (alcohol, drug, and tobacco) and consequences of substance use, asks about family history of substance abuse)	☐	☐	☐	☐	☐	
8.	**Gives feedback and discusses concerns about aberrant medication taking behavior** (gives feedback focused on behavior and allows patient to respond)	☐	☐	☐	☐	☐	
9.	**Discusses universal monitoring strategies** (opioid as a "test" not committing to long-term opioids; controlled substance agreement; urine drug testing; pill counts; includes response to aberrant medication taking behaviors – unsanctioned dose escalation, etc.; and short-term follow up arranged for pain/fct assessment and opioid monitoring)	☐	☐	☐	☐	☐	

General Organization –-*check one response for each item.*

	Needs Much Improvement	Needs Some Improvement	Done Well	Done Excellently
Time Management	☐	☐	☐	☐
Prioritization	☐	☐	☐	☐
Logical Approach	☐	☐	☐	☐

Overall Performance—*check one response*

Needs Much Improvement	Needs Some Improvement	Done Well	Done Excellently
☐	☐	☐	☐

Appendix D. Faculty – Learner Assessment Form

Station # 3: Lindsey Beecher / **Painful Diabetic Neuropathy**

Date: _____ Faculty Observer: _____ Learner Name: _____

Resident # _____

Check one response for each item.		Needs Much Improve-ment	Needs Some Improve-ment	Done Well	Done Excel-lently	N/A	Please Write Comments on Back of Form
General Communication Skills / Relationship Development / Rapport Building							
1.	**Allows patient to express self** (uses open-ended questions, does not interrupt, invites questions)	☐	☐	☐	☐	☐	
2.	**Communicates in nonjudgmental fashion** (no leading questions, respectful, non-patronizing)	☐	☐	☐	☐	☐	
3.	**Exhibits empathic/supportive attitude** (expresses concern, acknowledges patient's emotions/coping efforts, facilitative nonverbal behavior)	☐	☐	☐	☐	☐	
4.	**Probes for resistance/denial** (follows up on unclear statements)	☐	☐	☐	☐	☐	
5.	**Uses language appropriate to patient's level of understanding** (avoids medical jargon, explains unfamiliar medical terms)	☐	☐	☐	☐	☐	
6.	**Strengthens treatment alliance** (includes patient perspective in treatment plan)	☐	☐	☐	☐	☐	
Assessment and Management of Problem (station specific content)							
7.	**Assesses for baseline opioid risk** (screens for unhealthy substance (alcohol, drug, and tobacco) and consequences of substance use, asks about family history of substance abuse)	☐	☐	☐	☐	☐	
8.	**Discusses risks and benefits of opioids for chronic pain** (risks: physical dependence, sedation, constipation, addiction, hyperalgesia ; benefits: modest improvement in pain and function; discuss concern about using friend's opioids)	☐	☐	☐	☐	☐	
9.	**Discusses universal monitoring strategies** (opioid as a "test" not committing to long-term opioids; controlled substance agreement; urine drug testing; pill counts; includes response to aberrant medication taking behaviors – unsanctioned dose escalation, etc.; and short-term follow up arranged for pain/fct assessment and opioid monitoring)	☐	☐	☐	☐	☐	

General Organization–*check one response for each item.*

	Needs Much Improvement	Needs Some Improvement	Done Well	Done Excellently
Time Management	☐	☐	☐	☐
Prioritization	☐	☐	☐	☐
Logical Approach	☐	☐	☐	☐

Overall Performance—*check one response*

Needs Much Improvement	Needs Some Improvement	Done Well	Done Excellently
☐	☐	☐	☐

Resident # _____

Name _____

Appendix E. Learner Self-Assessment Form

Date_____

Opioid Risk Management OSCE

Check off the appropriate box for each station.

Station		Problem	Self Assessment for Overall Case Performance			
			Needs Improvement	**Needs Some Improvement**	**Done Well**	**Done Excellently**
1	Robert Jones	Ankle Pain	☐	☐	☐	☐
2	Mary Tempo	Low Back Pain	☐	☐	☐	☐
3	Lindsey Beecher	Painful Diabetic	☐	☐	☐	☐

Strengths:_____

_____

_____

Area(s) Needing Improvement:_____

_____

_____

Appendix F. Standardized Patient – Learner Assessment Form

Opioid Risk Management OSCE

_____ **Resident Code**	***Station #:*** _____ ***Date:*** _____ **Station Name:** _____ **SP Name:** _____

SATISFACTION WITH DOCTOR *Check one response.*			
Not Satisfied Would not come back.	**Partly Satisfied** Did a few things ok, but not sure if I would continue with doctor.	**Satisfied** Would continue with doctor.	**Very Satisfied** One of the best doctors, would refer friends.
☐	☐	☐	☐

Strengths:_____

_____

_____

Area(s) Needing Improvement:_____

_____

_____

Appendix G. Faculty OSCE Experience Evaluation Form **Date:** _____

A. Please list the station in which you were the faculty observer and indicate your response to each of the three items listed in the columns:

Station		a. Degree of difficulty for residents			b. Educational value for residents			c. SP Performance (believable, consistent)		
#	Name	too low	just right	too high	low	moderate	high	poor	average	excellent

Station-specific comments (please elaborate on above ratings):

B. Please indicate your response to each item below:

In general, the OSCE:		definitely not	maybe	definitely yes
1.	helped residents identify their strengths and weaknesses			
2.	will stimulate residents to learn more about opioid risk management			
3.	taught residents something new			
4.	provided residents with valuable feedback			
5.	evaluated residents' skills fairly			
6.	provided me with new information about residents' level of performance (sometimes confirming and sometimes changing my previous impressions)			
7.	resembled real life clinical encounters			
8.	provided a good cross-section of opioid risk management issues			
9.	gave me some new teaching strategies			
10.	was a valuable learning tool			
11.	had adequate allotted time to complete the learners' tasks			

General comments – what went well, what could be improved? (please continue on the back of this page):

Appendix H. Learner OSCE Experience Evaluation Form

A. Please indicate your response to each of the three items listed in the columns:

	Station	a. Prior exposure to similar case			b. Degree of difficulty			c. Educational value for residents		
		none	some	much	too low	just right	too high	low	mod-erate	high
1.	**Robert Jones / Ankle Pain** (starting opioids for chronic non-cancer pain)									
2.	**Mary Tempo / Low Back Pain** (managing patient with aberrant medication taking behaviors)									
3.	**Lindsey Beecher / Painful Diabetic Neuropathy** (discontinuing opioids due to lack of benefit and increased risks)									

B. Please indicate your response to each item below:

	In general, the OSCE:	definitely not	maybe	definitely yes
1.	helped me identify my strengths and weaknesses			
2.	stimulated me to learn more about opioid risk management			
3.	taught me something new			
4.	provided me with valuable feedback			
5.	resembled real life clinical encounters			
6.	evaluated my skills fairly			
7.	had adequate allotted time to complete the learners' tasks			
8.	provided a good cross-section of opioid risk management issues			
9.	was a valuable learning tool			
10.	provided feedback at a station that helped me at subsequent stations			
11.	was a valuable tool that should be added to resident's training			

Comments about individual stations:

General comments (please continue on the back of this page):

Appendix I. Standardized Patient (SP) OSCE Experience Evaluation Form Date: _____

A. Please list the station in which you were the standardized patient and indicate your response to each of the three questions listed in the columns:

Station		a. Adequacy of SP instruction information			b. Difficulty of case for resident			c. Difficulty of case portrayal for average SP		
#	Name	too little info	just right	too much info	low	mod-erate	high	low	mod-erate	high

Station-specific comments (please elaborate on above ratings and other observations you may have regarding your case/station):