Risk stratification is the ongoing process of integrating data about a patient’s pain and function in order to determine if the benefit of prescribing controlled substances outweighs the risk of developing aberrant behaviors or a substance use disorder. It is not a single number from a screening form, though screening tools have a role in this process. Initial risk stratification relies heavily on the comprehensive assessment of pain at a patient’s first visit, while ongoing risk stratification relies on monitoring a patient’s response to treatment, adverse effects, and aberrant behaviors. Here is a brief overview of initial and subsequent risk stratification.

Initial risk stratification starts with identifying the patient’s pain generator to determine if it is appropriate for the use of opioid pain relievers. This is accomplished by performing a comprehensive assessment of pain, though it may also involve specialty consultations or trial of some treatment modalities. In general, musculoskeletal pains, such as from active inflammatory arthritis or worsening degenerative musculoskeletal injuries, respond better to opioid pain relievers than dull, persistent, aching, neuropathic or visceral pains, or hypersensitivity conditions such as fibromyalgia.

There are several conditions where opioid pain relievers are not first line because they are not shown to have significant improvement in function. These include migraine headaches, fibromyalgia, and neuropathic pain. In addition, non-specific chronic pain that is not linked to a specific injury or musculoskeletal dysfunction is unlikely to improve with opioid pain relievers. There are some exceptions to this rule, but they are rare and rely on patients having truly tried all other modalities first.

After determining if a patient’s pain is likely to respond to opioid pain relievers, the next step is to evaluate the risk of aberrant behaviors and risk of developing a substance use disorder. This process is facilitated by using screening tools such as the ORT, DIRE, or SOAP-R. Each tool is a little different, with different sensitivities and specificities for predicting aberrant behaviors or substance use disorder. These tools identify patients as low, moderate or high risk for aberrant behaviors or substance use disorder. There are more details on each screening tool on the Opioid Guideline LibGuide.

Taking this risk of aberrant behaviors and substance use disorder into account, the provider can assess whether the potential for improved function outweighs the risks of aberrant behaviors, substance use disorder, or side effects of the medication. This involves informed consent about opioid pain relievers, setting ground rules for controlled substances with a medication treatment agreement, and goal setting with the patient to determine how function will be measured. There will be much more to come in future communications about informed consent, medication treatment agreements, and goal setting.

After the initial risk stratification and prescription of opioid pain relievers, providers will need to reevaluate patients at each follow up visit. The higher the risk of the patient, the more frequent the office visits and urine drug testing. At each office visit, providers need to assess the nature of pain, the treatments of pain (analgesia), the effect those treatments have on function (activity), the adverse effects of the treatments, and any aberrant behaviors. Good function with few adverse effects or aberrant behaviors tends to predict a lower risk of future problems, while poor function with many adverse effects or aberrant behaviors points toward higher risk of those problems and may indicate a substance use disorder. Future communications we will address specific adverse effects, aberrant behaviors, substance use disorders, and how to discuss all of these with patients.

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