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Pain Management Toolkit

Iowa's Guide to Opioid Stewardship

Developed by the Iowa Healthcare Collaborative in collaboration with public stakeholders and the Iowa Department of Public Health.

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Introduction

For the past few decades, a conceptual shift has taken place regarding the treatment of chronic pain. Opioids have been encouraged for the treatment of all types of pain. In particular, chronic non-cancer pain was suggested as a treatable condition necessitating long-acting medications, without solid scientific evidence supporting that practice. As a society, we are reaping the consequences of that change in prescribing habits with an increase in opioid dependency, accidental drug overdoses and heroin use. The expectation on the part of the public that there is a medication to be prescribed for any discomfort is harder to quantify but no less important.[1,2,3]

The community consequences of excessive opioid prescribing are manifesting. In addition to the mortality and quality-of-life consequences previously mentioned, we are facing an increase in communicable diseases associated with substance-use disorders (HIV, hepatitis, syphilis), strains on the court system and treatment programs and a "lost generation" of patients dependent upon opioids who are a challenge to treat humanely and effectively.

The message embodied in this document is that opioids are powerful drugs that can create calm and relief when used wisely but can cause great harm when prescribed injudiciously. Every encounter with a patient in pain will require the same analysis, and patient safety should guide all treatment recommendations.

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Iowa Department of Public Health
Iowa Hospital Association
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Telligen

Much of this document is a compilation from other sources. IHC would like to thank the following sources that were utilized in the making of this document including:

The Nebraska Pain Management Guidance Document: A provider and Community Resources developed by the Department of Health and Human Services.

Sooner Care Pain Management Program developed by Oklahoma Healthcare Authority.

Interagency Guideline on Prescribing Opioids for Pain developed by the Washington State Agency Medical Directors' Group.

Utah Clinical Guidelines on Prescribing Opioids for Treatment of Pain developed by the Utah Department of Health and Utah Medical Association.

How to Use this Guidance Document

We understand that practitioners providing care for individuals living with pain need readily accessible guidance and simple best-practice management tools. This document has been created for these practitioners.

The Iowa Opioid Guidance Document is divided into sections that can stand alone for quick reference. In this document, we tried to address the real-world situations practitioners face in daily patient care.

We encourage healthcare organizations large and small to use these tools along with other resources, many of which are referenced in this document, to create treatment guidelines of their own. You may access the Iowa Opioid Guidance Document at **www.ihconline.org**. There you will find a PDF version of the document as well as additional pain management resources.

Treatment and Tapering Flow Sheets

There are four flow sheets that can be laminated and used as a quick reference for the most common situations you encounter. They are the treatment essentials for Acute Pain (**page 38**), Chronic Pain (**page 45**), Opioid Tapering (**page 49**), and Benzodiazepine Tapering (**page 53**). Each of these flow sheets has a corresponding section in the document that provides more in-depth guidance if needed.

Tools

We have collected tools that are useful to the practicing clinician and placed them in the **appendices** of this document. In addition, they may be found in the Tools section of the website and printed directly from there.

The Iowa Healthcare Collaborative website serves as an up-to-date resource for you as well as your patients. Links to the pain management guidance document, PMP user access and training information, prescriber and dispenser resources, patient resources and more are all accessible through **www.ihconline.org**.

Centers for Disease Control and Prevention Guideline for Prescribing Opioids for Chronic Pain 2017

In March 2016, the CDC issued new guidelines on opioid prescribing.[4,5] The importance of these guidelines cannot be overstated as they establish national recommendations for the use of opioids for treatment of chronic pain. Below is a summary of the 12 CDC recommendations. We have organized this guide to ensure they are in compliance with and support these guidelines.

Determining When to Initiate or Continue Opioids for Chronic Pain

Non-pharmacologic therapy and non-opioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with non-pharmacologic therapy and non-opioid pharmacologic therapy, as appropriate.

Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how therapy will be discontinued if benefits do not outweigh risks. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.

Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy.

Opioid Selection, Dosage, Duration, Follow-Up and Discontinuation

When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids.

When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when increasing dosage to ≥50 morphine milligram equivalents (MME) per day, and should avoid increasing dosage to ≥90 MED/day or carefully justify a decision to titrate dosage to ≥90 MME/day.

Long-term opioid use often begins with a treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or fewer will often be sufficient; more than seven days will rarely be needed.

Clinicians should evaluate benefits and harms with patients within one to four weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every three months or more frequently. If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.

Assessing Risk and Addressing Harms of Opioid Use

Before starting and periodically during the continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase the risk for opioid overdoses, such as the history of overdose, history of substance-use disorder, higher opioid dosages (≥50 MME/day) or concurrent benzodiazepine use are present.

Clinicians should review the patient's history of controlled-substance prescriptions using state Prescription Monitoring Program (PMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put the patient at high risk for overdose. Clinicians should review PMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every three months.

When prescribing opioids for chronic pain, clinicians should use urine drug screening before starting opioid therapy and consider urine drug screening at least annually to assess for prescribed medications as well as other controlled prescription drugs, illicit drugs and alcohol.

Clinicians should avoid prescribing opioid pain medication and benzodiazepines (BZDs) concurrently whenever possible.

Clinicians should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine, naltrexone, or methadone in combination with behavioral therapies) for patients with opioid-use disorder.

The CDC has several resources to assist with the opioid crisis. These resources can be found here: **https://www.cdc.gov/drugoverdose/prescribing/clinical-tools.html**.

The CDC Opioid Guideline App is now available for free download on **Google Play** (Android devices) and in the **Apple Store** (iOS devices).

Board of Medicine Opioid Standard of Care Rules

653—13.2(148,272C) Standards of Practice – Appropriate Pain Management

This rule establishes standards of practice for the management of acute and chronic pain. The board encourages the use of adjunct therapies such as acupuncture, physical therapy and massage in the treatment of acute and chronic pain. This rule focuses on prescribing and administering controlled substances to provide relief and eliminate suffering for patients with acute or chronic pain.

This rule is intended to encourage appropriate pain management, including the use of controlled substances for the treatment of pain, while stressing the need to establish safeguards to minimize the potential for substance abuse and drug diversion.

The goal of pain management is to treat each patient's pain in relation to the patient's overall health, including physical function and psychological, social and work-related factors. At the end of life, the goals may shift to palliative care.

The board recognizes that pain management, including the use of controlled substances, is an important part of general medical practice. Unmanaged or inappropriately treated pain impacts patients' quality of life, reduces patients' ability to be productive members of society, and increases patients' use of health care services.

Physicians should not fear board action for treating pain with controlled substances as long as the physicians' prescribing is consistent with appropriate pain management practices. Dosage alone is not the sole measure of determining whether a physician has complied with appropriate pain management practices. The board recognizes the complexity of treating patients with chronic pain or a substance abuse history. Generally, the board is concerned about a pattern of improper pain management or a single occurrence of willful or gross overtreatment or undertreatment of pain.

The board recognizes that the undertreatment of pain is a serious public health problem that results in decreases in patients' functional status and quality of life, and that adequate access by patients to proper pain treatment is an important objective of any pain management policy.

Inappropriate pain management may include nontreatment, undertreatment, overtreatment, and the continued use of ineffective treatments. Inappropriate pain management is a departure from the acceptable standard of practice in Iowa and may be grounds for disciplinary action.

13.2(1) Definitions

For the purposes of this rule, the following terms are defined as follows:

"*Acute pain*" means the normal, predicted physiological response to a noxious chemical, thermal or mechanical stimulus and typically is associated with invasive procedures, trauma and disease. Generally, acute pain is self-limited, lasting no more than a few weeks following the initial stimulus.

"*Addiction*" means a primary, chronic, neurobiologic disease, with genetic, psychosocial and environmental factors influencing its development and manifestations. It is characterized by behaviors that include the following: impaired control over drug use, craving, compulsive use and continued use despite harm. Physical dependence and tolerance are normal physiological consequences of extended opioid therapy for pain and are not the same as addiction.

"*Chronic pain*" means persistent or episodic pain of a duration or intensity that adversely affects the functioning or well-being of a patient when (1) no relief or cure for the cause of pain is possible; (2) no relief or cure for the cause of pain has been found or (3) relief or cure for the cause of pain through other medical procedures would adversely affect the well-being of the patient. If pain persists beyond the anticipated healing period of a few weeks, patients should be thoroughly evaluated for the presence of chronic pain.

"*Pain*" means an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage. Pain is an individual, multifactorial experience influenced by culture, previous pain events, beliefs, mood and ability to cope.

"*Physical dependence*" means a state of adaptation that is manifested by drug class-specific signs and symptoms that can be produced by abrupt cessation, rapid dose reduction, decreasing blood level of the drug or administration of an antagonist. Physical dependence, by itself, does not equate with addiction.

"*Pseudoaddiction*" means an iatrogenic syndrome resulting from the misinterpretation of relief-seeking behaviors as though they are drug-seeking behaviors that are commonly seen with addiction. The relief-seeking behaviors resolve upon institution of effective analgesic therapy.

"*Substance abuse*" means the use of a drug, including alcohol, by the patient in an inappropriate manner that may cause harm to the patient or others, or the use of a drug for an indication other than that intended by the prescribing clinician. An abuser may or may not be physically dependent on or addicted to the drug.

"*Tolerance*" means a physiological state resulting from regular use of a drug in which an increased dosage is needed to produce a specific effect, or a reduced effect is observed with a constant dose over time. Tolerance may or may not be evident during opioid treatment and does not equate with addiction. "Undertreatment of pain" means the failure to properly assess, treat and manage pain or the failure to appropriately document a sound rationale for not treating pain.

13.2(2) Laws and Regulations Governing Controlled Substances

Nothing in this rule relieves a physician from fully complying with applicable federal and state laws and regulations governing controlled substances.

13.2(3) Undertreatment of Pain

The undertreatment of pain is a departure from the acceptable standard of practice in Iowa. Undertreatment may include a failure to recognize symptoms and signs of pain, a failure to treat pain within a reasonable amount of time, a failure to allow interventions (e.g., analgesia)to become effective before invasive steps are taken, a failure to address pain needs in patients with reduced cognitive status, a failure to use controlled substances for terminal pain due to the physician's concern with addicting the patient or a failure to use an adequate level of pain management.

13.2(4) Assessment and Treatment of Acute Pain

Appropriate assessment of the etiology of the pain is essential to the appropriate treatment of acute pain. Acute pain is not a diagnosis; it is a symptom. Prescribing controlled substances for the treatment of acute pain should be based on clearly diagnosed and documented pain. Appropriate management of acute pain should include an assessment of the mechanism, type and intensity of pain. The patient's medical record should clearly document a medical history, a pain history, a clinical examination, a medical diagnosis and a treatment plan.

13.2(5) Effective Management of Chronic Pain

Prescribing controlled substances for the treatment of chronic pain should only be accomplished within an established physician-patient relationship and should be based on clearly diagnosed and documented unrelieved pain. To ensure that chronic pain is properly assessed and treated, a physician who prescribes or administers controlled substances to a patient for the treatment of chronic pain shall exercise sound clinical judgment and establish an effective pain management plan in accordance with the following:

Patient Evaluation

A patient evaluation that includes a physical examination and a comprehensive medical history shall be conducted prior to the initiation of treatment. The evaluation shall also include an assessment of the pain, physical and psychological function, diagnostic studies, previous interventions, including medication history, substance abuse history and any underlying or coexisting conditions. Consultation/referral to a physician with expertise in pain medicine, addiction medicine or substance abuse counseling or a physician who specializes in the treatment of the area, system or organ perceived to be the source of the pain may be warranted depending upon the expertise of the physician and the complexity of the presenting patient. Interdisciplinary evaluation is strongly encouraged.

Treatment Plan

The physician shall establish a comprehensive treatment plan that tailors drug therapy to the individual needs of the patient. To ensure proper evaluation of the success of the treatment, the plan shall clearly state the objectives of the treatment, for example, pain relief or improved physical or psychosocial functioning. The treatment plan shall also indicate if any further diagnostic evaluations or treatments are planned and their purposes. The treatment plan shall also identify any other treatment modalities and rehabilitation programs utilized. The patient's short- and long-term needs for pain relief shall be considered when drug therapy is prescribed. The patient's ability to request pain relief as well as the patient setting shall be considered. For example, nursing home patients are unlikely to have their pain control needs assessed on a regular basis, making prn (on an as-needed basis) drugs less effective than drug therapy prescribed for routine administration that can be supplemented if pain is found to be worse. The patient should receive prescriptions for controlled substances from a single physician and a single pharmacy whenever possible.

Informed Consent

The physician shall document discussion of the risks and benefits of controlled substances with the patient or person representing the patient.

Periodic Review

The physician shall periodically review the course of drug treatment of the patient and the etiology of the pain. The physician should adjust drug therapy to the individual needs of each patient. Modification or continuation of drug therapy by the physician shall be dependent upon evaluation of the patient's progress toward the objectives established in the treatment plan. The physician shall consider the appropriateness of continuing drug therapy and the use of other treatment modalities if periodic reviews indicate that the objectives of the treatment plan are not being met or that there is evidence of diversion or a pattern of substance abuse. Long-term opioid treatment is associated with the development of tolerance to its analgesic effects. There is also evidence that opioid treatment may paradoxically induce abnormal pain sensitivity, including hyperalgesia and allodynia. Thus, increasing opioid doses may not improve pain control and function.

Consultation/Referral

A specialty consultation may be considered at any time if there is evidence of significant adverse effects or lack of response to the medication. Pain, physical medicine, rehabilitation, general surgery, orthopedics, anesthesiology, psychiatry, neurology, rheumatology, oncology, addiction medicine or other consultation may be appropriate. The physician should also consider consultation with, or referral to, a physician with expertise in addiction medicine or substance abuse counseling, if there is evidence of diversion or a pattern of substance abuse. The board encourages a multidisciplinary approach to chronic pain management, including the use of adjunct therapies such as acupuncture, physical therapy and massage.

Documentation

The physician shall keep accurate, timely and complete records that detail compliance with this subrule, including patient evaluation, diagnostic studies, treatment modalities, treatment plan, informed consent, periodic review, consultation, and any other relevant information about the patient's condition and treatment.

Pain management agreements. A physician who treats patients for chronic pain with controlled substances shall consider using a pain management agreement with each patient being treated that specifies the rules for medication use and the consequences for misuse. In determining whether to use a pain management agreement, a physician shall evaluate each patient, taking into account the risks to the patient and the potential benefits of long-term treatment with controlled substances. A physician who prescribes controlled substances to a patient for more than 90 days for treatment of chronic pain shall utilize a pain management agreement if the physician has reason to believe a patient is at risk of drug abuse or diversion. If a physician prescribes controlled substances to a patient for more than 90 days for treatment of chronic pain and chooses not to use a pain management agreement, then the physician shall document in the patient's medical records the reason(s) why a pain management agreement was not used. Use of pain management agreements is not necessary for hospice or nursing home patients. A sample pain management agreement and prescription drug risk assessment tools may be found on the board's web site at **www.medicalboard.iowa.gov**.

Substance Abuse History or Comorbid Psychiatric Disorder

A patient's prior history of substance abuse does not necessarily contraindicate appropriate pain management. However, treatment of patients with a history of substance abuse or with a comorbid psychiatric disorder may

require extra care and communication with the patient, monitoring, documentation and consultation with or referral to an expert in the management of such patients. The board strongly encourages a multidisciplinary approach for pain management of such patients that incorporates the expertise of other health care professionals.

Drug Testing

A physician who prescribes controlled substances to a patient for more than 90 days for the treatment of chronic pain shall consider utilizing drug testing to ensure that the patient is receiving appropriate therapeutic levels of prescribed medications or if the physician has reason to believe that the patient is at risk of drug abuse or diversion.

Termination of Care

The physician shall consider termination of patient care if there is evidence of noncompliance with the rules for medication use, drug diversion or a repeated pattern of substance abuse.

13.2(6) Pain Management for Terminal Illness

The provisions of this sub-rule apply to patients who are at the stage in the progression of cancer or other terminal illness when the goal of pain management is comfort care. When the goal of treatment shifts to comfort care rather than cure of the underlying condition, the board recognizes that the dosage level of opiates or controlled substances to control pain may exceed dosages recommended for chronic pain and may come at the expense of patient function. The determination of such pain management should involve the patient, if possible, and others the patient has designated for assisting in end-of-life care.

13.2(7) Prescription Monitoring Program

The Iowa board of pharmacy has established a prescription monitoring program pursuant to Iowa Code sections 124.551 to 124.558 to assist prescribers and pharmacists in monitoring the prescription of controlled substances to patients. The board recommends that physicians utilize the prescription monitoring program when prescribing controlled substances to patients if the physician has reason to believe that a patient is at risk of drug abuse or diversion. A link to the prescription monitoring program may be found at the board's website at **www.medicalboard.iowa.gov**.

13.2(8) Pain Management Resources

The board strongly recommends that physicians consult the following resources regarding the proper treatment of chronic pain. This list is provided for the convenience of licensees, and the publications included are not intended to be incorporated in the rule by reference.

American Academy of Hospice and Palliative Medicine or AAHPM is the American Medical Association-recognized specialty society of physicians who practice in hospice and palliative medicine in the United States. The mission of the AAHPM is to enhance the treatment of pain at the end of life.

American Academy of Pain Medicine or AAPM is the American Medical Association-recognized specialty society of physicians who practice pain medicine in the United States. The mission of the AAPM is to enhance pain medicine practice by promoting a climate conducive to the effective and efficient practice of pain medicine.

American Pain Society or APS is the national chapter of the International Association for the Study of Pain, an organization composed of physicians, nurses, psychologists, scientists and other professionals who have an interest in the study and treatment of pain. The mission of the APS is to serve people in pain by advancing research, education, treatment and professional practice.

DEA Policy Statement: Dispensing Controlled Substances for the Treatment of Pain. On August 28, 2006, the Drug Enforcement Agency (DEA) issued a policy statement establishing guidelines for practitioners who dispense controlled substances for the treatment of pain. This policy statement may be helpful to practitioners who treat pain with controlled substances.

Interagency Guideline on Opioid Dosing for Chronic Non-cancer Pain. In March 2007, the Washington State Agency Medical Directors' Group published an educational pilot to improve care and safety of patients with chronic, noncancer pain who are treated with opioids. The guidelines include opioid dosing recommendations.

Responsible Opioid Prescribing: A Physician's Guide. In 2007, in collaboration with author Scott Fishman, M.D., the Federation of State Medical Boards' (FSMB) Research and Education Foundation published a book on responsible opioid prescribing based on the FSMB Model Policy for the Use of Controlled Substances for the Treatment of Pain.

World Health Organization: Pain Relief Ladder. Cancer pain relief and palliative care. Technical report series 804. Geneva: World Health Organization.

[**ARC 9599B, IAB** 7/13/11, effective 8/17/11]

Axioms and Pain Treatment

The Axioms of Pain Treatment are a contribution from Gary Franklin, MD, MPH, University of Washington and Michael Von Korff, senior investigator, Group Health Research Institute. It provides current best practices regarding acute and chronic pain management. Along with the Chronic Pain, Acute Pain and Tapering Flow Sheets, we hope to bring tools to the practicing clinician that make compliance with appropriate pain management accessible and easy to follow.

Acute Pain

For most injuries and minor procedures (e.g., dental extraction, sports injuries), prescribe no more than a three-day supply or 10 doses of a short-acting opioid.

For more severe injuries (e.g., fractures), prescribe no more than a seven-day supply of a short-acting opioid.

Do not prescribe extended-release opioids for acute pain.

Chronic Conditions with Acute Pain Flares

Do not use opioids for acute flares of non-specific musculoskeletal pain, headaches or fibromyalgia.

For acute flares of other chronic conditions (e.g., osteoarthritis, sickle cell anemia), limit prescribing to a three-day supply of a short-acting opioid. In rare instances, up to a seven-day supply may be appropriate.

Check the state Prescription Monitoring Program (PMP) with any first opioid prescription.

Subacute (6 — 12 Weeks) Opioid Use and Transition to Chronic Opioid Therapy (>12 weeks)

Don't start long-term use of opioids without a visit devoted to evaluation of suitability of long-term opioid use and discussion of all opioid risks and realistic expectations of benefits.

Use non-opioid alternatives in combination with opioids (non-opioid analgesics, graded exercise, cognitive behavioral therapy, mindfulness, and relaxation techniques) for better long term pain control.

Unless opioid use has resulted in clinically meaningful improvement in pain and function (at least 30% improvement documented with validated instruments), discontinue prescribing.

If opioid use results in clinically meaningful improvement in pain and function, use best- practice screenings (e.g., substance-use disorder, depression, PDMP) for opioid- related risks. Assess signs of prescription opioid-use disorder by asking the patient or family members about history of substance abuse. Discuss risks and benefits of long-term opioid use and document via a signed informed consent form.

At every prescribing visit for opioids, the total opioid dose should be recorded using an online morphine milligram equivalent (MME) calculator and measures of pain and function using brief validated instruments.

Chronic Opioid Use (>12 weeks)

Do not prescribe chronic opioids for non-specific musculoskeletal pain, headache or fibromyalgia.

Do not combine opioids with benzodiazepines, muscle relaxants or sedative hypnotics.

Repeat PDMP check and urine drug screen (UDS) periodically, based on risk.

Avoid exceeding 90 mg/day MED. For patients with one or more risk factors (e.g., history of substance-use disorder, tobacco users, mental health disorders, cannabis-use disorder), do not prescribe more than 50 MME/day.

Non-pharmacological alternatives to opioids should be used and incented for most chronic-pain conditions, especially multimodal use of reactivation methods (e.g., graded exercise, activity diaries, mindfulness and relaxation techniques) in combination with brief interventions, such as cognitive behavioral therapy, that can effectively address psychosocial barriers to recovery (e.g., fear avoidance, catastrophizing, low expectations of recovery).

Periodically ask if the patient would like to consider trying a gradual opioid taper to reduce dose or discontinue use.

Tapering Chronic Opioid Therapy

Discontinue opioids if patient has not achieved clinically meaningful improvement, had an overdose event, develops a serious adverse outcome (e.g., endocrine dysfunction, severe dependence or opioid-use disorder), demonstrates aberrant behaviors, or requests a taper.

Tapering to zero can be accomplished in most cases by reducing the dose up to 10 percent per week, with pauses as needed, with or without adjuvant medications (e.g., clonidine, promethazine).

A list of helpful medications to help decrease many of the side effects of opioid tapering is in Appendix R, Opioid Withdrawal Attenuation Cocktail.

Refer patients with symptoms of severe dependence or opioid-use disorder for evaluation and treatment. If indicated, help patients get medication-assisted treatment along with behavioral therapy.

Perioperative Opioid Use

For patients on chronic opioid therapy, develop a coordinated treatment plan, including a timeline for tapering opioids post-operatively. Doses by six weeks post-operatively should not exceed preoperative doses.

For minor surgeries (e.g., carpal tunnel release), discharge patients with acetaminophen, NSAIDs, or a limited supply (two or three days) of short-acting opioids.

For patients undergoing elective surgery who are opioid naïve, opioids should only be prescribed if required to manage severe pain and they should be discontinued as soon as pain is tolerable (not when the patient is pain-free), no later than six weeks post-operatively.

Team Approach to Pain Management

As you read this document, it should become clear that chronic pain management can be challenging – and rewarding. The evaluation requires attention to history and physical findings as well as the use of assessment tools that may require additional time to administer and interpret. Treatment often utilizes behavioral, motivational and other ancillary modalities. Follow- up requires attention to safety monitoring using tools such as the Iowa Prescription Monitoring Program (PMP), UDS, and pill counts. Most experts agree that pain management is best accomplished in a team-based care model, not unlike the approach of the treatment of other chronic diseases such as diabetes, or congestive heart failure.

Larger clinics can access nurses, counselors, OT/PT, pharmacists and peers within their organization. Smaller medical practices should develop strong relationships with local specialists who have expertise in the treatment of pain.

Just as your patients often need help from their support network, providers also need help from others to institute the chronic disease model of care in the management of chronic pain.

Morphine Milligram Equivalents

MME is referred to in this document frequently. MME is the amount of morphine an opioid dose is equal to when prescribed, often used as a gauge of the abuse or overdose potential of the amount of opioid that is being given at a particular time.

Converting drugs to their MME measurements will assist Prescription Monitoring Programs (PMPs), regulatory boards, enforcement agencies and other stakeholders in determining the seriousness of the problem, evaluating the appropriateness of the prescribing and dispensing of these drugs, and assisting in prevention and treatment efforts.[6]

MME Calculator

The CDC's new Opioid Guideline App is designed to help providers apply the recommendations into clinical practice by putting the tools and resources into the palm of their hand. Managing chronic pain is complex, but accessing prescribing guidance has never been easier.

The application includes a Morphine Milligram Equivalent (MME) calculator, summaries of key recommendations and a link to the full Guideline, and an interactive motivational interviewing feature to help providers practice effective communications skills and prescribe with confidence.

The CDC has a pocket guide on calculating MME which can be found here: **https://www.cdc.gov/drugoverdose/pdf/calculating_total_daily_dose-a.pdf**.

Morphine Milligram Equivalent (MME)

Doses for commonly prescribed opioids[7]

Opioid	Conversion Factor	Dosage Mg/Day	MME Calculation
Buprenorphine	20 – 40	1 mg po BID (2 mg)	40-80 MME
Codeine	0.15	15 mg po QID (60 mg)	9 MME
Fentanyl transdermal (in mcg/hour)	2.4	12.5 mcg/hour patch (0.3 mg per 24 hours)	30 MME
Hydrocodone	1	5mg po QID	20 MME
Hydromorphone	4	2 mg po QID (8 mg)	32 MME
Methadone	Highly Variable	5 mg po TID (15 mg)	60 MME
Morphine	1	15 mg po QID (60 mg)	60 MME
Oxycodone	1.5	5mg po QID (20 mg)	30 MME
Oxymorphone	3	5 mg po QID (20 mg)	60 MME
Tapentadol	0.4	50 mg po QID (200 mg)	80 MME
Tramadol	0.1	50 mg po QID (200 mg)	20 MME

Multiply the dose for each opioid by the conversion factor to determine the dose in MMEs. The following cautions should be noted: 1) All doses are in mg/day except for fentanyl, which is mcg/hr. 2) Equianalgesic dose conversion are only estimates and cannot account for individual variability in genetics and pharmacokinetics. 3) Do not use the calculated dose in MMEs to determine the doses to use when converting opioid to another; when converting opioid to the new opioid is typically dosed at substantially lower than the calculated MME dose to avoid accidental overdose due to incomplete cross-tolerance and individual variability in opioid pharmacokinetics. 4) use particular caution with methadone dose conversions because the conversion factor increases at higher doses. 5) Use particular caution with fentanyl since it is dosed in mcg/hr instead of mg/day, and its absorption is affected by heat and other factors.

Risk Stratification

Separating your patients into high, medium, and low-risk categories is a common approach to determining the level of scrutiny to apply to a given individual. The advantage to risk stratification is that it allows you to provide additional scrutiny to individuals who are more likely to fail opioid therapy. The disadvantage is that all chronic opioid therapy (COT) patients are at risk for complications of treatment and risk-stratifying your patients may provide a false sense of security to the clinician. Here are some generally accepted guidelines:

Red flags or conditions that require additional scrutiny on the part of the provider (Source: David Tauben, MD, Chief of Pain Medicine at the University of Washington):

Red Flags Upon Intake

- Evidence of PMP irregularities
- Benzodiazepine use
- Use of two or more psychoactive drugs
- Methadone use
- History of medication assisted treatment
- MEE/day ≥ 90
- History of prior overdose
- History of current or active opioid or substance abuse
- **Opioid Risk Tool (ORT) >8**
- **Screening and Opioid Assessment for Patients with Pain (SOAPP-R®) >18**
- **Drug Abuse Screening Test (DAST-10) >3**
- DAST-20 >6
- Patients with severe depression (**PHQ-9 >15**), anxiety (**GAD-7 >12**), or PTSD (**PC-PTSD >2**)
- Patients with a listed diagnosis in the medical record of bipolar disorder, personality disorder or schizophrenia

Current Patient Red Flags

- Losing prescriptions, running out early or borrowing opioids
- Illicit use of prescription or use of illicit substances
- Recurring ED visits
- Demanding opioids
- Obtaining opioids from multiple prescribers
- Multiple pharmacies used
- Unexpected UDS results
- Non-compliance with clinic policies

Response to Red Flags

- If continued prescribing puts your patient at risk or puts you at risk of violating the law, then you may need to discontinue prescribing immediately.
- You rarely will need to "fire" a patient from your practice. You can discontinue prescribing while still maintaining a therapeutic and professional relationship.
- Increased scrutiny is often helpful to delineate whether you are dealing with substance- use disorder versus other treatment issues. These strategies may be useful:
    - Increasing the frequency of UDS
    - Instituting pill counts and/or "callbacks" (asking a patient to return to the clinic within 24 hours to evaluate and count remaining medication)
    - Frequent query of the PMP
    - Shorter duration of prescription medication (fill every 7 days instead of every 30 days)

The Art of Difficult Conversations

It is common for the provider/healthcare team to experience challenging conversations with patients as safety guidelines in the area of chronic pain and prescription opioids are implemented. Some topics that may elicit fear in patients and therefore potential discord include:

- Discussing controlled substance client/clinic agreements.
- Discussing community, state, and national guidelines for safe-prescribing practices.
- Informing new patients that opioids or other controlled substances will not be prescribed and/or increased.
- Informing patients that opioids will be discontinued and/or tapered.
- Discussing the dangers and side effects of the medication.

It is understandable and predictable for patients to express strong feelings when they are presented with information such as the need to reduce or eliminate opioids. Opioid medications can become a patient's primary coping strategy for dealing with physical, emotional, psychological and post-traumatic pain. Delivering a message about reducing or stopping such medications can be triggering and even terrifying for a patient and the patient's family. In such situations, patient's emotions are commonly first expressed in the form of anger directed toward the prescribing provider and healthcare team. When facing a highly emotional patient, it is helpful to consider what may be underlying the strong emotional expression. Often underneath the heightened emotional response such as anger, there is fear, grief, panic, sadness and/or a belief that living without prescription opioids is impossible. Being curious and understanding about what may be beneath a highly emotional expression does not mean one should not take action in the service of safety; however, treading lightly and following the recommendations below will make for a more positive outcome. Remember, patients genuinely do not initially understand the rationale for tapering or removing opioids when appropriate. They also do not set out to develop problematic use patterns.

Value Identification

Prior to engaging in potentially challenging conversations, it is advisable to spend time reflecting on the core values and principles that you are upholding in the difficult conversation. For example, it may be in the service of practicing safe medicine, being in alignment with your colleagues, the medical board and/ or community, state and national safe opioid prescribing guidelines. When you are in alignment with your values and the healthcare team believes that the change is in the patient's best interest, the difficult conversations are often more manageable and rewarding.

Realistic Expectations

When asking a patient to do something they may be afraid to do or that they do not want to do, they may leave the appointment highly distressed, very angry, and/or inconsolably sad. It is common for providers and the healthcare

team to feel that if a patient leaves in such a highly agitated state, the outcome of the appointment was a failure. Reconsider this belief. When a provider or healthcare team member asks a patient to make a change that is guided by core principles and values and a belief that it is in the patient's best interest to make the change, then the state the patient is leaving in can be considered a natural part of the patient's therapeutic process. This is also a positive step toward the individual's overall health and well-being.

Willingness to Feel Uncomfortable

Difficult conversations often bring about discomfort for patients, their families, providers, and healthcare team members. When we model our willingness to be uncomfortable to our patients, it helps the process. Consider saying to yourself before engaging in such a conversation, "I am willing to be uncomfortable having this conversation because it is in the service of my value of safety and best-practice medicine." It can be helpful to notice your own sympathetic nervous system activation (e.g., rapid, shallow breathing; clenching fists or jaw), and then engage in an activity to activate your parasympathetic nervous system (e.g., slowing down your exhale and softening your hands or jaw). Just as these situations can be highly triggering for our patients, they can be highly triggering for providers and the healthcare team as well. These conversations go more smoothly when providers or healthcare team members can identify which types of patients and situations trigger them the most and develop an intervention strategy to notice the trigger and proceed calmly and effectively with delivering effective patient care.

Relationship as a Resource

It is important not to underestimate the relationship between the patient and the provider or healthcare team as a resource. Most patients genuinely care for their providers and/or healthcare team and want to work collaboratively with them. Often, genuinely communicating with patients that you will stick by their side through the changes can be one of the most powerful tools. Patients often fear their providers or healthcare team will abandon them, ask them to make changes too quickly, not listen to their fears and/or "fire" them from their practice. Proactively quashing such fears and acknowledging that the fear is real to them will go a long way toward reducing those fears.

Belief and Confidence

Expressing the belief in the patient's ability to make the change is one of the most valuable tools for creating positive clinical outcomes such as removing or reducing opioids. You may think the patient knows this; however, it is highly advisable to overtly tell the patient, even over multiple appointments, and even if it feels redundant or if you don't completely believe that your patient will be able to make such changes. Believing the patient can change is critical to the success of the process. Over time, as you see your patient making such changes and actually increasing functioning and quality of life, you will be more confident in your patient's abilities and it will be easier to relay your belief in them.

Motivational Interviewing

Development of a treatment relationship in which patients are active collaborators in the process is an important component in making changes. Motivational interviewing (MI) provides a basic foundation for engagement in treatment and commitment to making changes. The tenets to MI include: empathy, develop discrepancies between present behavior and desired behavior,

avoiding argumentation, rolling with patient's resistance, and promotion of self-efficacy. The belief is that the patient has the capacity to make change and the responsibility for their quality of life. The stages of change serve as a guide to the intervention. The spirit of MI includes collaboration, evocation – "drawing the patient out", and promotion of autonomy. Confrontation, education, and authority are not considered part of MI.

Scripting

Maine Quality Counts

- **Scripts for Having Difficult Conversations with Patients**
- **Frequently Asked Questions by Patients & Scripted Responses for Practices**

Medicine Abuse Project

- **Parent Talk Kit**

Group Health Research Institute and the University of Washington Videos

- **Diversion Scenario**
- **Positive UDS Scenario**
- **Patient-Centered Changes**

Oregon Pain Guidance

- **Difficult Conversations resource page** – handouts, videos, examples, books

The Doctors Company

- **Prescribing Opioids Safely: How to Have Difficult Patient Conversations**
- **Patient-Centered Communications: Building Patient Rapport**

TurnTheTideRx

- **Having A Difficult Conversation**

Michigan State Medical Society

- **Prescribing Opioids Safely: How to Have Difficult Patient Conversations**

Joint Commission of Pharmacy Practitioners Pharmacist's Patient Care Process

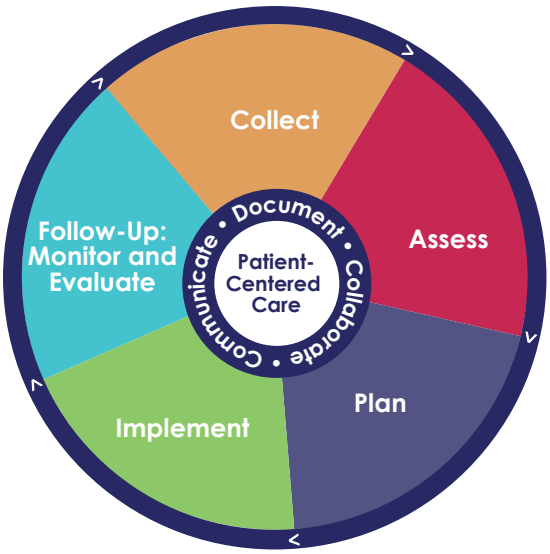


Figure 1. Pharmacists' Patient Care Process

Pharmacists' Patient Care Process

Pharmacists use a patient-centered approach in collaboration with other providers on the health care team to optimize patient health and medication outcomes.

Using principles of evidence-based practice, pharmacists:

Collect

The pharmacist assures the collection of the necessary subjective and objective information about the patient in order to understand the relevant medical/medication history and clinical status of the patient.

Assess

The pharmacist assesses the information collected and analyzes the clinical effects of the patient's therapy in the context of the patient's overall health goals in order to identify and prioritize problems and achieve optimal care.

Plan

The pharmacist develops an individualized patient-centered care plan, in collaboration with other health care professionals and the patient or caregiver that is evidence-based and cost-effective.

Implement

The pharmacist implements the care plan in collaboration with other health care professionals and the patient or caregiver.

Follow-Up: Monitor and Evaluate

The pharmacist monitors and evaluates the effectiveness of the care plan and modifies the plan in collaboration with other health care professionals and the patient or caregiver as needed.

For more information go to **https://www.pharmacist.com/sites/default/files/files/PatientCareProcess.pdf**.

Resources

Difficult Conversations: Real life examples, Helpful Hints and Tools – **Provider Substance Misuse Quick Reference Sheet**. This resource includes information when talking to a patient who may be resistant or not receptive, CDC videos to help improve prescriber and patient communication, and screening tools.

Motivational Interviewing Resources – **www.motivationalinterviewing.org**

Book Option: Motivational Interviewing in Healthcare: Helping Patients Change Behavior by Stephen Rollnick, William Miller, Christopher Butler

Diagnosis

New Patient Visit Check

Clinically Meaningful Improvement and Function

Tracking function as well as pain is critical in determining the patient's ongoing response to opioids and whether any improvement is consistent with potential changes in opioid dosing. Because of the well documented evidence of risk and the limited evidence of effectiveness beyond the period of acute pain, the use of opioids should result in clinically meaningfully improvement in function and pain and therefore, quality of life.

Clinically meaningful improvement is defined as an improvement in pain AND function of at least 30 percent as compared to the start of treatment or in response to a dose change. A decrease in pain intensity in the absence of improved function is not considered meaningful improvement except in very limited circumstances such as catastrophic injuries (e.g. multiple trauma, spinal cord injury, etc.).

Chronic Opioid Analgesic Therapy (COAT) that focuses only on pain intensity can lead to rapidly escalating dosage with deterioration in function and quality of life. During the chronic phase, providers should routinely review the effects of opioid therapy on function to determine whether opioid therapy should continue. A brief but effective way to assess function is to determine the degree to which pain interferes with a patient's activities, as this is highly correlated with pain intensity when changes are tracked over time (Figure A and Figure B).

Continuing to prescribe opioids in the absence of clinically meaningful improvement in function and pain, or after the development of a severe adverse outcome (e.g. overdose event) is not considered appropriate care. In addition, the use of escalating doses to the point of developing opioid use disorder, as defined by DSM 5, is not appropriate.

Patients who used opioids for at least 90 days were greater than 60 percent more likely to still be on chronic opioids in 5 years.[1]

Clinical Recommendations

1. Assess and document function and pain using validated tools (Figure A and Figure B) at each visit where opioids are prescribed.
2. Expect patients to improve in function and pain and resume their normal activities in a matter of weeks after an acute pain episode. Strongly consider re-evaluation for those who do not follow the normal course of recovery.
3. Evaluate function and pain using brief validated instruments at these critical decision-making phases:
    a. At the end of the acute phase (6 weeks following an episode of pain or surgery), to determine whether continued opioid therapy is warranted.
    b. At the end of the subacute or perioperative phase (12 weeks following an episode of pain or surgery), to determine whether non-opioid treatment will help or if prescribing COAT is warranted.

c. During chronic use with regular assessment and documentation of function and pain.

4. Use only validated instruments to measure clinically meaningful improvement in function and pain. The following tools have been validated and are easy ways to track function and pain:
   a. PEG – A 3-item tool to assess Pain intensity, interference with Enjoyment of life, and interference with General activity.[8]
   b. Graded Chronic Pain Scale – A 2-item tool to assess pain intensity and pain interference.[9]

PEG Assessment Scale

1. What number best describes your *pain on average* in the past week?

No Pain										Pain as Bad as You Can Imagine
0	1	2	3	4	5	6	7	8	9	10

2. What number best describes how, during the past week, pain has interfered with your *enjoyment of life*?

Does Not Interfere										Completely Interferes
0	1	2	3	4	5	6	7	8	9	10

3. What number best describes how, during the past week, pain has interfered with your *general activity*?

Does Not Interfere										Completely Interferes
0	1	2	3	4	5	6	7	8	9	10

Figure A. Three Item PEG Assessment Scale

Graded Chronic Pain Scale: A Two-Item Tool to Assess Pain Intensity and Pain Interference

In the last month*, on average, how would you rate your pain? Use a scale from 0 to 10, where 0 is "no pain" and 10 is "pain as bad as could be." *[That is, your usual pain at times you were in pain.]

No Pain										Pain as Bad as Could Be
0	1	2	3	4	5	6	7	8	9	10

***In the last month*, how much has pain interfered with your daily activities? Use a scale from 0 to 10, where 0 is "no interference" and 10 is "unable to carry on any activities."**

No Interference with Activities										Unable to Carry On
0	1	2	3	4	5	6	7	8	9	10

Figure B. Two Item Graded Chronic Pain Scale

Dosing Thresholds

While there is evidence that opioids can provide significant pain relief in the short term, there is little evidence for sustained improvement in function and pain relief over longer periods of time. COAT is associated with the development of tolerance, a decrease in analgesic effect with the same dose over time. Providers must pay attention to the development of tolerance and avoid ongoing dose escalation to overcome this effect.

The 2010 edition recommended a 120 mg/day MED threshold to seek consultation with a pain specialist as a strategy to prevent serious adverse outcomes, including fatal overdoses. Group Health Cooperative (GHC), which implemented the best practices from the 2010 edition, has demonstrated a reduction in opioid doses for their COAT patients. For the last quarter of 2014, less than one-quarter of COAT patients seen by GHC providers received 50 mg/day MED or greater and only 7.3% exceeded 120 mg/day MED.

Recent studies support a dose-related risk and shed new light on significant risks occurring at doses lower than 120 mg/day MED. Overdose risk approximately doubles at doses between 20 and 49 mg/day MED, and increases nine-fold at doses of 100 mg/day MED or more (Figure C). Although the 2015 guideline maintains the 120 mg/day MED threshold for consultation and some guidelines have lower dose thresholds ranging from 50 to 90 mg/day MED, there is no completely safe opioid dose.

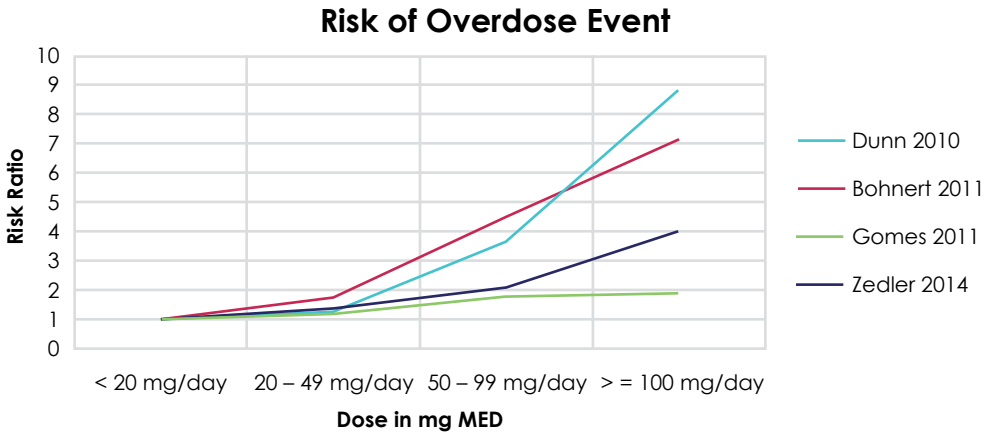


Figure C. Risk of Overdose Events in Four Different Populations

Providers should be especially cautious and assess risk for ongoing opioid therapy when a patient transitions from acute opioid use to COAT, continuing COAT at a dose to which a patient has already become accustomed or escalating the opioid dose. Use the electronic **MME calculator** for determining dose when a patient is on one or more opioids. The calculator should not be used to determine doses when converting a patient from one opioid to another.

There is a correlation between the amount of opioids prescribed for patients and their potential availability for diversion, with associated risks for individuals in the community. The recommendations below are intended to reduce the risks to both patients and the community.

There is no completely safe opioid dose.[10] COAT patients should be routinely assessed for risk as medical conditions and life circumstances may change during treatment.

Clinical Recommendations

1. Avoid COAT if the patient has any of the following FDA or clinical contraindications:
    a. Significant respiratory depression (e.g. respiratory failure), acute or severe asthma in an unmonitored setting or in the absence of resuscitative equipment, known or suspected paralytic ileus or hypersensitivity (e.g. anaphylaxis)
    b. Current substance use disorder as defined by DSM 5 (except tobacco) or past opioid use disorder
    c. History of prior opioid overdose
    d. Pattern of aberrant behaviors
2. Use great caution at any dose, monitor more frequently and consider prescribing take-home naloxone if the patient has one or more of the following risk factors:
    a. Mental health disorder per DSM 5
    b. Family or personal history of substance use disorder
    c. Medical condition that could increase sensitivity to opioid-related side effects (e.g. impaired respiratory function, sleep apnea, high fall risk, altered drug metabolism related to advanced age or impaired renal, hepatic and/or cardiac function)
    d. Current use of benzodiazepines
3. Do not escalate COAT to more than 120 mg/day MED without first obtaining a consultation from a trained pain specialistiii who agrees that a high dose is indicated and appropriate. Providers must routinely monitor and document sustained improvement in function and quality of life and an absence of the risk factors listed in recommendations 1 and 2.

Correct Diagnosis and Realistic Expectations

Effective treatment of pain begins with an accurate diagnosis. Beyond the acute injury, the underlying cause of ongoing pain can be difficult to identify. Pain is generally described as either nociceptive (somatic) or neuropathic, but symptoms may not fit neatly into one group, often overlap and may change over time. Another common way to categorize pain is based on chronicity. Acute pain, whether related to disease, injury, or recent surgery, usually diminishes with tissue healing, whereas chronic pain typically lasts >3 months and involves neurological, emotional, and behavioral features that often impact a patient's quality of life, function, and social roles.[11]

Studies of interventions for chronic pain have often been of low quality, including problems associated with an increased risk of bias including difficulty with randomization and inadequate blinding.[12] The best recent systematic reviews have shown only modest benefits.[13,14] Patient expectations regarding expected outcomes may be unrealistic; expected outcomes should be balanced by potential risk of harm. Pursuing greater pain reduction via escalating opioid doses may contribute further to unrealistic expectations and even iatrogenic injury.

The CDC provides a checklist to use when prescribing opioids. This checklist can be found here: **https://www.cdc.gov/drugoverdose/pdf/PDO_Checklist-a.pdf**.

Non-Opioid Treatment Interventions and Goals

Non-Pharmacological Interventions

Pain is a multidimensional experience; so therefore, pain management is most effective when a multimodal approach is utilized (Table 1). In addition to medication, therapies should include physical activation and behavioral health interventions (such as cognitive behavioral therapy, mindfulness, coaching, patient education and self-management).

Cognitive	Address distressing negative cognitions and beliefs, catastrophizing (pain coping characterized by excessively negative thoughts and statements about the future)
Behavioral Approaches	Mindfulness, meditation, yoga, relaxation, biofeedback
Physical	Activity coaching, graded exercise
Spiritual	Identify existential distress, seek meaning and purpose in life
Education (patient and caregivers)	Promote patient efforts aimed at increased functional capabilities

Table 1. Cognitive Behavioral and Non-Pharmacological Therapies for Chronic Pain
Adapted from Argoff, 2009 & Tauben, 2015

Clinical Recommendations

1. Perform a thorough history and physical examination at initial visit for pain management.
2. Do not pursue diagnostic tests unless risk factors or "red flags" indicate the need for further evaluation (Table 2), especially getting an MRI in the first 6 weeks following low back injury **http://www.choosingwisely.org/american-society-of-anesthesiologists-asa-releases-choosing- wisely-list-for-pain-medicine/**.
3. Re-evaluate the patient for other diagnoses if pain persists beyond a few weeks, or if "red flags" develop (Table 2).
4. Identify functional goals that are important to the patient, as this increases the likelihood that treatment will improve quality of life, even if the pain intensity rating itself does not change.
5. Engage patients in behavior change counseling that promotes self-care and consider emphasizing evidence-based principles of motivational interviewing
6. Use powerful interventions such as listening, providing reassurance, and involving the patient in his or her care.
7. Do not prescribe analgesics or perform interventions (e.g. injections) without also tracking pain and function over time using validated instruments.
8. Use validated instruments to assess predictors of suboptimal recovery such as depression, fear avoidance, and catastrophizing, which can lead to persistent pain and functional limitation.

9. Consider behavioral interventions to improve patient self-efficacy and address psychosocial barriers to recovery, such as cognitive behavioral therapy, Mindfulness-based Stress Reduction (MBSR), yoga, various forms of meditation and chronic pain self-management.
10. Recommend graded exercise unless contraindicated. Group exercise may have significant benefit and is available to most patients. Use of an activity diary may assist the patient and physician in monitoring progress.
11. Consider spinal manipulation in patients with low back pain.
12. Encourage and facilitate those who have work-related injuries to participate in programs that coordinate efforts to help them get back to work. Do this early in their recovery.
13. Address sleep disturbances by encouraging sleep hygiene (Table 3) or effective pharmacological therapy (**clinical recommendation #6** under Non-opioid Analgesics). Achieving a minimum of six hours of restful sleep per night is a reasonable goal.
14. Refer patient to a multidisciplinary rehabilitation program if s/he has significant, persistent functional impairment due to complex chronic pain.

Presence of neurological deficit(s)
History of malignancy
New signs and symptoms of underlying disease
Sudden increase in severity or nature of previous pain complaint
Unexpected results from urine drug tests (e.g. positive for cocaine, amphetamines, alcohol, etc.)
Wounds that don't heal within normal time expectations
Evidence of adverse side effects from current treatment regimen

Table 2. "Red Flags" Indicating Need for Further Patient Evaluation
Adapted from Tauben 2015

Maintain a regular wake/sleep schedule: fixed bed and wake-up times, regardless of weekday or weekend
Establish a relaxing routine before bedtime
Refrain from taking naps
Make the bedroom "device-free": no TV, computer, or handheld devices
Use the bedroom only for sleep, intimacy, and dressing routines
Set environment (light, noise, temperature) at comfortable levels
No caffeine after noon; some may need to avoid caffeine altogether
No exposure to TV or computer screens 2 hours prior to bedtime
Exercise – but not within 3 hours of bedtime
Avoid alcohol close to bedtime

Table 3. Recommended Sleep Hygiene Habits
Adapted from Tauben 2015

Overtreatment, excess attention or labeling a patient during the acute pain phase can precipitate or increase "sickness behavior," and avoidance of activity.[15] For example, in the absence of "red flags" that indicate the need for further evaluation (Table 2), obtaining an MRI in the first six weeks following low back injury may lead to a cascade of further unnecessary treatments and escalating costs.[16] Further, there is value in having patients with work-related injuries participate in programs that help them return to work, as these appear to have a small but significant impact on reducing disability among those who have missed at least four weeks of work due to acute or subacute musculoskeletal pain.[17]

Importance of Activity

Unless contraindicated, advice to remain active and engaged in usual activity seems to be the most effective intervention early in the course of a pain episode. A well-studied example is low back pain with or without sciatica. For this condition, advice to remain active has been repeatedly shown to predict better pain and functional outcomes than advice to take bed rest, and is as effective as specific exercises.[18,19] Aerobic and strengthening exercises have also been shown to reduce pain and disability in osteoarthritis of the knee,[20] but passive PT interventions have not demonstrated sustained benefit.[21] In subacute or chronic low back pain there is good evidence of moderate efficacy for exercise interventions.[22] In a recent Cochrane review of interventions for subacute or chronic LBP, exercise obtained the best outcomes when done as part of an individualized regimen with supervision during strengthening and stretching.[23] Resistance exercise training and aerobic exercise in women with fibromyalgia may improve pain and multidimensional function.[24] Patient adherence to home exercise programs may be specifically important in evaluating the success of these interventions.[25] This is where keeping an activity diary can be especially helpful.

Psychosocial Factors

Fear of normal activity (fear avoidance), catastrophizing and low expectations of healing are strong predictors of the development of persistent pain in patient populations.[26-28] Practitioners' beliefs and attitudes can impact clinical decision making and subsequent treatment outcomes.[29]

There is good evidence that cognitive behavioral therapy is effective in reducing subacute or chronic low back pain and other chronic pain conditions, including chronic orofacial pain, chronic pain in children, fibromyalgia, persistent pain in the elderly and inflammatory bowel disease.[27,30-39] The treatment of depression was shown to have significant benefits in terms of pain reduction, improved functional status and quality of life in a group of older individuals with depression and arthritis.[40] Other psychological therapies, such as progressive relaxation and biofeedback aimed at muscle relaxation, have not been shown to be superior to active exercise therapies in large cohorts for most outcomes, in systematic reviews of low back pain treatment[27] although both do provide benefit.

Group Support Activities

While patients with acute pain may not require medically supervised rehabilitation interventions, there is evidence to support their benefits in groups of individuals with atypical recovery or with chronic musculoskeletal pathology such as arthritis. Among the benefits that group interventions provide, chronic pain self-management programs are having increasing success at reducing the physical and psychosocial burden of chronic pain while reducing healthcare costs.[41] These evidence-based programs teach strategies for understanding chronic pain and provide a support network with both clinician and lay led (by fellow chronic pain sufferers) workshops, 2.5 hours once a week for 6 weeks. These offer a free or low-cost community based model that has demonstrated short term improvements in pain and multiple quality of life variables.[42] Modeled after a national study of chronic disease self-management programs, these are being heralded as an effective way to meet the "triple aim goals" of better health, better health care and better value while reducing health care utilization.[43] For resources and workshop information, go to **http://livingwell.doh.wa.gov/workshops**.

Spinal Manipulation, Acupuncture and Yoga

Chou et. al found good evidence of moderate efficacy for spinal manipulation for chronic or subacute low back pain. Acupuncture was associated with moderate short-term improvement in both pain and function, and yoga was associated with moderately superior outcomes in pain and decreased medication use at 26 weeks when compared to self-directed exercise and a self-care education book.[27] In comparative studies, exercise and spinal manipulation, but not acupuncture, appear to have a beneficial impact on improving both pain and function in chronic low back pain.[44] Acupuncture does not appear to be effective when compared to sham acupuncture.[44]

Topical Therapies

Although widely practiced, the application of heat and cold therapies for acute musculoskeletal pain has had a mixed evidence basis. The use of superficial heat has a stronger basis in evidence than the application of cryotherapy, or ice.[27,46] There is insufficient evidence to make conclusive statements about the benefits of massage therapy. There is no evidence that traction, lumbar supports, interferential therapy, diathermy or ultrasound are effective for chronic low back pain. There is good evidence that transcutaneous nerve stimulation (TENS) *is ineffective*.[47]

Structured Intensive Multidisciplinary Pain Programs

Evidence clearly supports the value of multimodal therapies in improving pain and function and reducing disability.[48,49] In chronic back pain and in other pain conditions, multidisciplinary, intensive rehabilitation involving physical, psychosocial and behavioral interventions has good evidence of moderate effectiveness for pain reduction and improvement of function.[50] Various tools such as the STarTBack questionnaire[51] for low back pain or the Functional Recovery Questionnaire (FRQ)[52] can be used to stratify patients into groups that might require increased attention and rehabilitative interventions and to plan treatment.[53]

Sleep Hygiene

There is evidence to suggest that restorative sleep can help predict reduction in pain.[54] Although sleep treatment is not typically considered "analgesic", poor sleep and lack of REM sleep in particular, are acutely hyperalgesic.[55] Further, the DSM 5 has reclassified insomnia as 'sleep-wake' disorders and acknowledges that, if occurring concomitantly with medical conditions and mental disorders, they are interactive and bi-directional.[56] Cognitive behavioral therapy has been shown to be a very effective non-drug strategy for insomnia.[57] Hence, having a sleep management plan is likely to help improve a patient's pain experience. Morin and Benca have published an excellent review of chronic insomnia management in Lancet 2012.[58]

Mindfulness and Stress Reduction

Mindfulness-based therapy techniques such as meditation and Mindfulness-based Stress Reduction (MBSR) and/or yoga, may be reasonable alternative therapies for chronic pain as they have been successful in helping patients learn to self-manage their pain sensations. Recent systematic reviews have shown these approaches may be as effective as cognitive behavioral therapy, which has consistently been demonstrated in randomized trials to improve chronic pain outcomes.[59-62] In addition, the specific neural mechanisms activated by these treatments have been reported.[62]

To see more extensive list of non-opioid pain management options, please review:

- Katz, Nathaniel, MD. Tufts University School of Medicine, Analgesic Research. (2006). *Opioid Prescribing Tool Kit*.
- Utah Department of Health (2009). *Utah Guidelines on Prescribing Opioids for Treatment of Pain*.

Non-Opioid Medication Interventions

For most pain conditions, non-opioid analgesics (e.g. acetaminophen and NSAIDs) and adjuvant analgesics (e.g. antidepressants and anticonvulsants) are equally or more effective with less risk for harm than opioids. Providers should consider these medications during acute and subacute pain episodes and/or before initiating or transitioning patients to COAT. Selection of appropriate non-opioid or adjuvant analgesics requires a thorough history and physical exam, and will depend on the patient's diagnosis, symptoms, pain type, comorbid conditions and overall risk for adverse drug events (**Appendix F: Diagnosis-based Pharmacotherapy for Pain and Associated Conditions**). The use of medical marijuana for pain is beyond the scope of this guideline.

Clinical Recommendations

1. Start with acetaminophen for mild to moderate pain. Acetaminophen may be dosed up to 4 grams for acute use, but <2-3 grams per day may be safer for prolonged use. Assess for all acetaminophen containing products to avoid inadvertent overdose. Use acetaminophen with caution, and at doses of <2 grams daily in those at risk for hepatotoxicity, including those with advanced age and liver disease (e.g. alcohol abuse, hepatitis B and C).
2. Use non-steroidal anti-inflammatory drugs (NSAIDs) for inflammatory, nociceptive pain. Monitor patients for potential renal, gastrointestinal (GI), and cardiac side effects. Consider concurrent H- 2 blockers (e.g. famotidine, ranitidine) or proton pump inhibitors (e.g. omeprazole, pantoprazole) to help protect against GI effects. Avoid NSAIDs in patients with a calculated glomerular filtration rate (cGFR) < 60 ml/min/1.73 m2.
3. Consider tricyclic antidepressants (TCAs) or serotonin-norepinephrine reuptake inhibitors (SNRIs) and anticonvulsants (e.g. gabapentin, pregabalin) for neuropathic pain, other centralized pain syndromes, or fibromyalgia. Watch for potential cognitive impairment or sedation with anticonvulsants and TCAs.
4. Reserve baclofen or tizanidine for pain associated with spasticity from spinal cord injury or disease of the CNS (e.g. multiple sclerosis). Avoid abrupt discontinuation of baclofen because of the risk of precipitating withdrawal.
5. Do not prescribe muscle relaxants (e.g. methocarbamol, cyclobenzaprine) beyond a few weeks as they offer little long-term benefit. Avoid carisoprodol (Soma) due to the risk of misuse and abuse. Cyclobenzaprine, though not classified as a TCA, is structurally similar, so precautions are the same, and risk of adverse side effects are potentiated when used in combination with TCAs.
6. Prescribe trazodone, tricyclic antidepressants, melatonin or other non-controlled substances if the patient requires pharmacologic treatment for insomnia.

Acetaminophen (APAP)

APAP is the most widely used nonprescription pain medication. Although a recent systematic review concluded that the mean changes in pain relief by acetaminophen did not reach minimal clinically important difference as compared to placebo for acute low back and knee osteoarthritis[69] it is still an effective drug for mild to moderate pain.[70,71] When combined with ibuprofen 200 mg, the combination has been demonstrated to be more effective than opioids.[72] Hepatotoxicity can result from prolonged APAP use or doses in excess of recommended maximum total daily dose including combined-acetaminophen OTC products. Although the FDA's current maximum daily dose is 4 grams, some manufactures have voluntarily revised their label to recommend a lower maximum of 3 grams daily. The risk of hepatotoxicity increases significantly with age, concomitant alcohol use, comorbid liver disease or dose.[73]

Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)

NSAIDs are recommended for nociceptive pain such as traumatic musculoskeletal pain syndromes from traumatic, infectious or degenerative conditions (e.g. muscle, ligament, and or tendon injuries) with evidence to support effectiveness for spinal pain from disc, facet, or spinal ligament injuries[74] and neuritis related to

connective tissue disorders.[75] In patients with non-specific low back pain, NSAIDs are equivalent to opioids in relief of pain.[76] The number needed to treat (NNT) for oxycodone 15 mg is approximately 4.6, (95% confidence Interval (CI), 2.9-11) while the NNT for oxycodone 10 mg + acetaminophen 650 mg is only 2.7, (95% CI, 2.4-3.1). The NNT for naproxen 500 mg or naproxen sodium 550 mg is also 2.7, and the NNT for ibuprofen 200 mg + acetaminophen 500 mg is 1.6. Hence, NSAIDs alone or in combinations can be as or more effective than opioids.[77-79] However, their use may be associated with serious cardiovascular (e.g. thrombotic events, myocardial infarction or stroke) and gastrointestinal (e.g. bleeding, ulceration or perforation of the stomach or small intestine) side effects. While cardiovascular risk may increase with duration of use, gastrointestinal events can occur any time during use.

Antidepressants (TCAs/SNRIs)

TCAs have been studied in many clinical trials with positive results in the treatment of various neuropathic pain conditions and are a good first line option.[80-84] Among the drugs reviewed in three different neuropathic pain conditions, low-dose TCAs have the lowest NNT with an average 2.6 (range 2.0 to 5.0). In addition to pain relief, TCAs can offer added benefit to patients who also have depression or whose pain is interfering with sleep. However, caution should be used when prescribing TCAs to elderly patients or those with cardiovascular disorders due to risk of sinus tachycardia, changes in cardiac conduction time or arrhythmias. Besides TCAs, the serotonin norepinephrine reuptake inhibitor (SNRI) duloxetine has been shown to be effective in diabetic peripheral neuropathy, fibromyalgia and chronic musculoskeletal pain.[85] A systematic review found that there were no differences between venlafaxine and either gabapentin, pregabalin or duloxetine on average pain scores or the likelihood of achieving significant pain relief.[86] Serotonin syndrome has been report with SNRIs alone and concurrently with other serotonergic agents (e.g. tramadol, fentanyl, triptans, TCAs, lithium, buspirone, St. John's Wort).

Anticonvulsant Drugs (ACDs)

Gabapentinoids (*gabapentin* and *pregabalin*) have been found to be moderately superior to other ACDs for achieving pain relief.[86] They have robust evidence in treating diabetic peripheral neuropathy, other neuropathies and fibromyalgia.[87,88] Gabapentin was found to be effective in painful polyneuropathy with an average NNT of 6.4.[89] In another systematic review of antiepileptic drugs used to treat neuropathic pain, gabapentin was found to be effective at doses of 1800 mg and 2400 mg, although side effects such as dizziness and drowsiness were reported at these doses.[86] Pregabalin has been studied in neuropathic pain conditions such as diabetic neuropathy and spinal cord injury and is FDA-approved to treat those neuropathies as well as fibromyalgia. The efficacy of pregabalin was found to be comparable to duloxetine, amitriptyline and gabapentin, however, pregabalin is classified as a controlled substance (Schedule V) with the potential for misuse or abuse, so it argues for a more cautious approach to the use of this agent.[86] Other anticonvulsants such as carbamazepine, oxcarbazepine, and lamotrigine have limited or conflicting evidence of efficacy in spontaneous shooting pain of trigeminal neuropathy, diabetic peripheral neuropathy, HIV-related peripheral neuropathy, and multiple sclerosis.[35,90] All non-gabapentinoid ACDs are associated with risk of hepatotoxicity, hyponatremia, neutropenia, rash (including Stevens-Johnson Syndrome), sedation and suicidality.

Muscle Relaxants and Antispasticity Drugs

Muscle relaxants have limited evidence for effectiveness for chronic pain and are predominantly sedative.[91] Carisoprodol (Soma) should never be used due to lack of long-term efficacy, a high risk for abuse and misuse, and serious withdrawal symptoms.[64] When true painful spasticity is present, for instance in spinal cord injury and multiple sclerosis, antispasticity agents (e.g. baclofen and tizanidine) are good treatment options; however, serious and life threatening reactions can occur with abrupt discontinuation.

Sleep Medications

If non-pharmacologic options to aid sleep are not effective, treatment with OTC melatonin (1-5 mg) can help, especially since endogenous levels decrease with age.[101] This naturally occurring hormone plays a pivotal role in the physiological regulation of sleep by reinforcing circadian and seasonal rhythms; side effects can include drowsiness, dizziness, headache, nausea, and nightmares.[58] Tricyclic antidepressants (TCAs) are sedating and may assist with sleep initiation and maintenance.[63] Trazodone, another antidepressant, is widely used for sleep but does not have any analgesic properties; and caution is advised if the patient is taking selective serotonin reuptake inhibitors (SSRIs), serotonin-norepinephrine reuptake inhibitors (SNRIs), triptans, or tramadol.[64] SNRIs are much less sedating and may disturb sleep by provoking periodic leg movement disorders; and SSRIs decrease REM sleep, increase REM latency and fragment sleep so they are not good options for insomnia.[65,66]

Benzodiazepines

Use of benzodiazepines for sleep is not recommended in chronic pain patients because they do not improve patients' reported pain scores,[111] and they increase the risk of rebound insomnia, overdose (especially when combined with opioids), reduced REM sleep, and the development of tolerance, dependency, and addiction.[64] Although benzodiazepine receptor agonists, (e.g. the Z- drugs: zolpidem, zaleplon, zopiclone, and eszopiclone) are FDA-approved to treat insomnia, they can potentially impair cognitive and psychomotor skills that can increase the risk of falls, sleep-walking, sleep-eating and driving unaware, or dependence and abuse.[101,109] For these reasons, these drugs should not be used with patients who have Alzheimer's disease and other comorbid disorders.[56,67,68]

Acute Pain Treatment (0 – 6 Weeks Post-Episode of Pain or Surgery)

In most cases, acute pain can be treated effectively with non-opioid or non-pharmacological options (e.g., elevation, ice). With more severe acute injury (e.g., significant trauma, fracture, crush injury, postoperative pain, extensive burns), short- term use of opioids may be appropriate. Initial opioid prescriptions should not exceed seven days for most situations, and two to three days of opioid medication will often suffice92-96 If an individual needs medication beyond three days (or beyond the average expected time for initial healing) a reevaluation of the patient should be performed prior to further opioid prescribing. Physical dependence on opioids can occur within only a few weeks of continuous use so great caution needs to be exercised during this critical recovery period.

In general, reserve opioids for acute pain resulting from severe injuries or medical conditions, surgical procedures, or when alternatives are ineffective or contraindicated. If opioids are prescribed, it should be at the lowest necessary dose and for the shortest duration (usually less than 14 days). The use of opioids for non-specific low back pain, headaches, and fibromyalgia is not supported by evidence.

Clinical Recommendations

Opioids serve as the cornerstone for severe acute postoperative pain management with proven efficacy for this indication. Nevertheless, patients must be counseled on the limited effectiveness of any analgesic in eliminating pain entirely. A balanced, rational multimodal analgesic approach is most effective in controlling pain while at the same time, minimizing analgesic doses and their resultant side effects that interfere with rehabilitation. Patients on COAT who are undergoing elective surgeries present challenges for perioperative pain management. For this reason, it is important to assess patients' risks for both severe postoperative pain and side effects of opioids. The following recommendations are intended to help manage patients' pain and minimize risk associated with perioperative opioid use.

Preoperative Period

Clinical Recommendations

1. Conduct a thorough preoperative evaluation, including history and physical:
    a. Ask about past and current use of, response to and preferences for analgesics.
    b. Check the Prescription Monitoring Program (PMP), especially for patients with a history of COAT or benzodiazepine or sedative-hypnotic use.
    c. Assess risk for potential postoperative opioid over-sedation and/or respiratory depression (Table 4) and difficult postoperative pain control (Table 5). Inform the entire perioperative team of the results of the risk assessment.

   d. Consider consultation with a specialist (e.g. pain management, addiction medicine, behavioral health), particularly in patients at risk for both over-sedation (Table 4) and difficult postoperative pain control (Table 5).
2. Develop a coordinated treatment plan, including a timeline for tapering perioperative opioids. Identify which provider will be responsible for managing postoperative pain and prescribing opioids. Share this treatment plan with other members of the healthcare team. Each interaction between a healthcare team member and the patent, review the treatment plan to engage the patient in their care:
   a. Generally, in opioid naïve patients, any opioids prescribed during the first 6 weeks postoperatively should be managed solely by the surgeon.
   b. If a patient was previously using chronic opioids for the condition being addressed by surgery, the surgeon should consult with the outpatient prescriber as to whether or not the patient is likely to need continued COAT after surgery. If so, develop a plan for transition of pain care back to the outpatient prescriber.
   c. In the immediate postoperative period, during the hospital stay, the surgeon (or a specialist consultant) should manage all pain medication, including chronic methadone, buprenorphine/naloxone or other COAT, as well as any additional opioids added for acute postoperative pain. These acute post-surgical opioids should be tapered off during the first few weeks after surgery. Continuation of previous COAT upon hospital discharge should be the responsibility of the outpatient prescriber.
3. Inform patient and family of the perioperative pain plan. Set expectations with them about realistic pain management goals, including functional recovery activities, need for multimodal treatment, limits of therapy, timely return to preoperative baseline opioid dose (if any) or lower and the analgesic tapering timeline.
4. Avoid new prescriptions of benzodiazepines, sedative-hypnotics, anxiolytics, or other central nervous system (CNS) depressants.
5. Avoid escalating the opioid dose before surgery. The lowest effective dose should always be sought, but there is insufficient evidence to recommend routinely lowering chronic opioid doses or discontinuing opioids prior to surgery.

Intraoperative Period

Clinical Recommendations

1. Provide balanced multimodal analgesia, including adjuvant analgesics, when possible (e.g. acetaminophen, NSAIDs, gabapentin and local anesthetic infiltration). Under specialist direction, ketamine, lidocaine, and regional local anesthetic techniques can also help minimize perioperative opioids and their side effects.
2. Provide sufficient intraoperative opioid doses to avoid acute withdrawal in patients who are on high doses of preoperative opioids.

Immediate Postoperative Period

Clinical Recommendations

1. Reserve the use of opioids for moderate to severe acute pain. If used, utilize the lowest possible dose as part of a multimodal regimen, including NSAIDs, acetaminophen, and non-pharmacologic therapies, unless contraindicated.
2. Monitor sedation and respiratory status in patients receiving systemic opioids for postoperative analgesia (e.g. **Comfort Scale**). Due to the risk of excessive sedation and respiratory depression, patients should be

monitored closely in the initial hours following surgery and with subsequent dose escalations. Monitoring should include assessments of alertness and signs or symptoms of hypoventilation or hypoxia:
    a. The use of routine oxygen is discouraged as hypoxia is a late sign of respiratory compromise and this sign will be delayed still further by supplemental oxygen.
    b. There is insufficient evidence to recommend the routine use of more sophisticated noninvasive methods (such as capnography) for monitoring hypoventilation postoperatively.
    c. Providers should be prepared to change or reduce opioids or administer opioid antagonists in patients who develop excess sedation or respiratory depression (Table 4).
3. Use oral opioids for managing postoperative pain in patients who can tolerate oral medications, particularly following the first or second postoperative day, as pain levels at rest and during activity become less variable.
    a. Consider the use of patient controlled analgesia (PCA) initially in cases where repeated doses of parenteral opioids are anticipated or required. Providers should be aware of the doses being self-administered by their patients via PCA to guide adjustments. Routine use of continuous opioid infusions (basal rates with PCA) is NOT recommended.
    b. Consider consultation with specialists for patients receiving high dose PCA, and when opioids, benzodiazepines or sedative-hypnotics are being used in combination with the PCA.
4. Use short-acting as needed opioids as the foundation for acute severe postoperative pain in the opioid naïve patient. For the opioid tolerant patient, do not add or increase extended release or long-acting opioids for the immediate postoperative period.
    a. Avoid therapeutic duplication of opioids consisting of more than one type of PRN short-acting opioid (e.g. oxycodone and morphine). Avoid co-administration of parenteral and oral PRN opioids for ongoing pain. If PRN opioids from different routes are needed, provide a clear indication for use (e.g. for a brief, severely painful, closely monitored procedure such as a dressing change).
    b. Consider scheduling non-opioids for more steady analgesia and to avoid multiple PRNs for pain.
5. Resume chronic regimen as soon as possible if patients were previously on chronic opioids and are expected to continue these postoperatively.
6. Avoid new prescriptions of benzodiazepines, sedative-hypnotics, anxiolytics or CNS depressants. If patients were previously on chronic sedatives, restart these at lower doses in the setting of postoperative opioids to avoid synergies between CNS depressant and opioid side effects.
7. Initiate a bowel regimen as soon as possible postoperatively to minimize opioid-induced bowel dysfunction (constipation). This side effect may still require opioid dose reductions if unresponsive to stool softeners, laxatives or enemas.

At Time of Hospital Discharge

Clinical Recommendations

1. Avoid continuing or adding new prescriptions of benzodiazepines, sedative-hypnotics, anxiolytics or CNS depressants. Counsel patients and families about risks of using alcohol and other CNS depressants with opioids.
2. Inform the patient and family which provider will be responsible for managing postoperative pain, including who will be prescribing any opioids. Instruct the patient and family on the planned taper of postoperative opioids, including a timeline for return to preoperative or lower opioid dosing for those on chronic opioids.
3. Remind the patient of the dangers of prescription opioid diversion and the importance of secure storage of their medications. Sharing medications with others is never appropriate and is illegal. Instruct the patient and

family on prompt disposal of controlled substances either through a **local medication disposal box**, a **DEA-approved take-back program**, or FDA guideline for **safe disposal of medicine**.

4. Follow through with the agreed upon preoperative plan to taper off opioids added for surgery as surgical healing takes place. The goal is always the shortest duration and lowest effective dose:
   a. Most patients with major surgeries should be able to be tapered to preoperative doses or lower within 6 weeks (approximately 20p percent of dose per week although tapering may be slower in the 1st week or 10 days and then become much more rapid as healing progresses).
   b. It is important to remember that for some minor surgeries, it may be appropriate to discharge patients on acetaminophen or NSAIDs only or with only a very limited supply of short-acting opioids (e.g. 2-3 days) – even if they were taking opioids preoperatively.
   c. For patients who were not taking opioids prior to surgery, but who are still on them after 6 weeks, follow the recommendations in the **Subacute Phase**.

Sleep apnea or high risk sleep disorder (morbid obesity/history of snoring/positive STOP Bang score ≥4)
Age (<1 and >65 years old)
History of over-sedation with opioids
Opioid analgesic tolerance or increased opioid dose requirement
Concurrent use of other sedating drugs (e.g. benzodiazepines, antihistamines, sedative/anxiolytics or other CNS depressants)
History of difficult to control postoperative pain
Long (>6 hours) duration of general anesthesia
Surgery location and/or type (e.g. airway, upper abdominal, thoracic, scoliosis repair in children)
Medical comorbidities (e.g. pulmonary disease/smoker, cardiac disease, other major organ failures)

Table 4. Risks for Over-Sedation and/or Respiratory Depression from Postoperative Opioids[97-107]

History of severe postoperative pain
Opioid analgesic tolerance (daily use for months)
Current mixed opioid agonist/antagonist treatment (e.g. buprenorphine, naltrexone)
Chronic pain (either related or unrelated to the surgical site)
Psychological comorbidities (e.g. depression, anxiety, catastrophizing)
History of substance use disorder
History of "all over body pain"
History of significant opioid sensitivities (e.g. nausea, sedation)
History of intrathecal pump use or nerve stimulator implanted for pain control

Table 5. Risks for Difficult-to-Control Postoperative Pain[107-116]

Assessment

- Review medical history, including records from previous providers, when available.
- Administer a physical exam to determine diagnosis and appropriate care. Document baseline function and baseline pain.
- Determine whether the injury can be treated without opioids or if the severity of the injury justifies the risks of opioid therapy.

Opioid Treatment Options

If the severity of the injury indicates that limited opioid treatment is appropriate, before prescribing, you:

- Should perform a simple screen for substance use disorder (e.g., ORT). Individuals in active recovery are at high risk of being "triggered" by even small amounts of opioids, and you can inadvertently put them in harm's way with your prescription. Those with a history of attempted suicide or overtaking opioids should be prescribed the least amount of medication necessary.
- Should identify other prescribed medications or conditions that would preclude co-prescribing opioids.
- Recognize the increased risk of death when opioids and benzodiazepines are used in combination.[27]
- Must inform the patient about the risks and side effects of opioids. Many young people who became dependent on opioids say they were never informed of their risks. You may want to have the patient sign a treatment agreement if the patient returns requesting a refill of opioids. A urine drug screen and PMP query should be performed prior to writing the second prescription. Continued prescribing might indicate the need for the patient to sign a treatment agreement.
- Opioid prescriptions should be for the shortest appropriate period of time, usually two to three days of treatment post injury or surgery, followed by over-the-counter treatments if further medications are indicated.
- Opioid overprescribing puts your patients at risk. Four out of five recent heroin initiates (79.5%) previously used prescription pain killers.[117]
- Some major surgeries, injuries, and certain disease states may require longer periods of opioid treatment.
- Justification for prescribing outside the guidelines should be documented in the patient record.
- If pain continues a reevaluation is usually indicated because pain beyond the expected timeframe may indicate a complication (e.g., infection, re-injury, displacement, and dehiscence).
- Complaint of ongoing pain may indicate an unrecognized substance-use disorder, which may require greater scrutiny and an alternative treatment modality.
- At each follow-up visit, assess and document comfort and function and educate the patient on the importance of self-management and appropriate activity.
- Patients with acute pain that have no insurance coverage have a hard time getting follow up and thus they return to the emergency department.

The Four A's of Opioid Management:

Analgesia

Is the opioid leading to a meaningful reduction in the pain reported by the patient?

Adverse Effect

Is the patient experiencing adverse effects at a dose required to reduce the pain?

Activity
Is there a measurable or meaningful increase in the patient's ability to perform activities of daily living?

Aberrant Behaviors
Demonstration of an accumulation of aberrant behaviors is evidence that the patient is losing control over the use of the medications. This can become evidence of development of substance use disorder.

Clinical Recommendations
1. Explore non-opioid alternatives for treating pain and restoring function, including early activation.
2. Prescribe opioids for dental pain only after complex dental procedures and at the lowest dose and duration.
3. Help the patient set reasonable expectations about his or her recovery, and educate the patient about the potential risks and side effects. Provide patient education on safekeeping of opioids, benzodiazepines, and other controlled substances.
4. Expect patients to improve in function and pain and resume their normal activities in a matter of days to weeks after an acute pain episode. Strongly consider re-evaluation for those who do not follow the normal course of recovery.
5. Check the state's Prescription Monitoring Program (PMP) to ensure that the patient's controlled substance history is consistent with the prescribing record. Prescribers may delegate the ability to query the PMP database to any licensed health care professional
6. Assess function and pain at baseline and with each follow-up visit when opioids are prescribed. Document clinically meaningful improvement in function and pain using validated tools.

Patient Instructions and Take Home Items

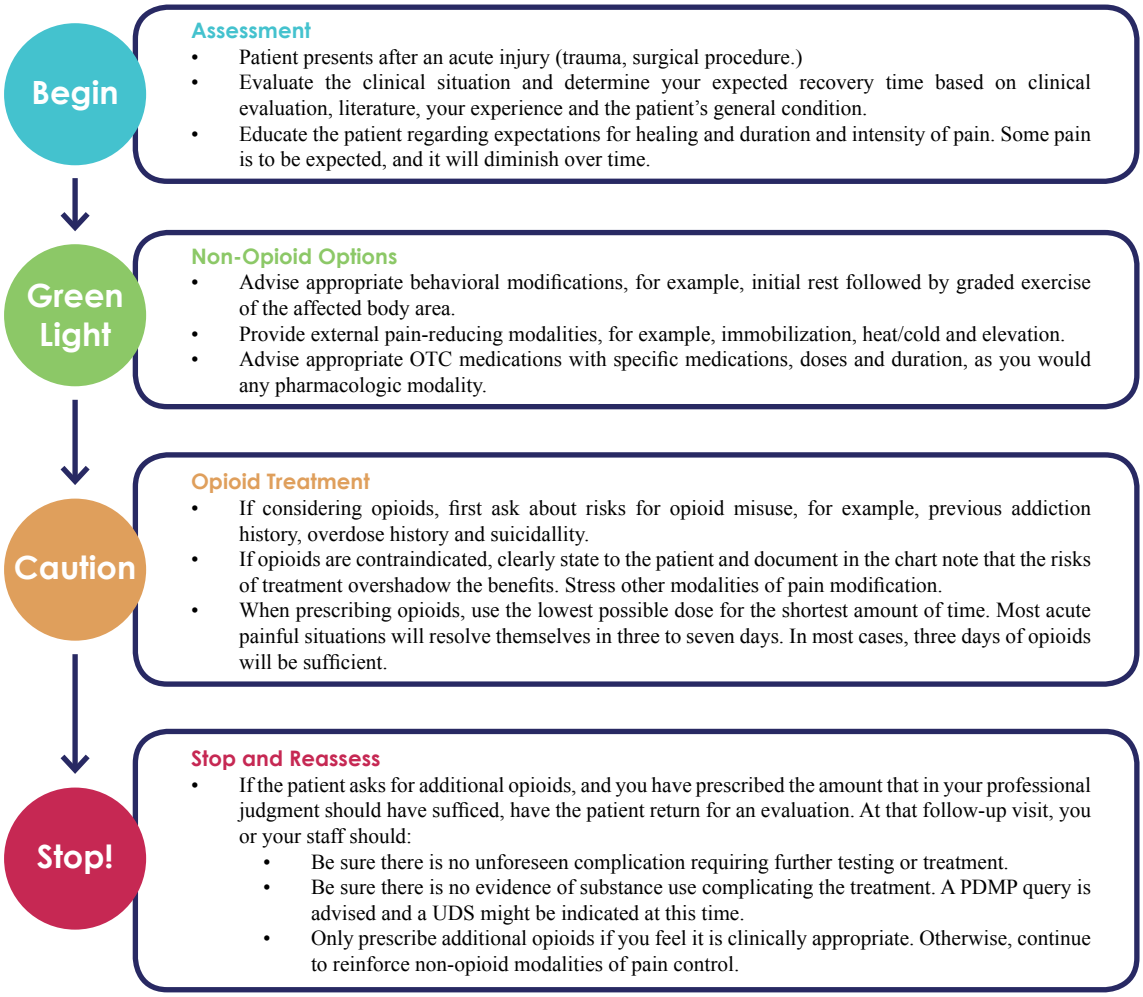
Dosage instructions need to be clear. PRN prescribing should be only as liberal as necessary as it can lead to inadvertent large doses (e.g., hydrocodone/acetaminophen 5/325 one to two every three to six hours can be as much as 50 mg MEE a day—a lot of medication for an opioid-naïve individual).

The quantity prescribed sets up "dosing expectations" for the patient. Prescribing #40 tablets for a time-limited painful experience may send an inadvertent message to the patient, giving permission for the casual use of opioids.

Tools

Screening tools for substance abuse: **ORT**, **DAST-20**, and **SOAPP-R**.
- Screening tools for function: **Oswestry Disability Index** (ODI); **PEG-3** (Krebs et al 2009).
- Screening tools for co-occurring mental health conditions: **PHQ-9 GAD-7**.
- **Prescription Monitoring Program** (PMP)
- Screening tools can be found in the appendix starting on **page 87**.

Acute Pain Flow Sheet



Subacute Pain Treatment (6 – 12 Weeks or Less Post-Episode of Pain or Surgery)

With some exceptions, resumption of normal activities should be expected during this period. Use of activity diaries is encouraged as a means of improving patient participation and investment in recovery. Non-pharmacological treatments such as cognitive behavioral therapy, activity coaching, and graded exercise are also encouraged. With the exception of severe injuries, such as multiple trauma, opioid use beyond the acute phase (longer than six weeks) is rarely indicated. If opioids are to be prescribed for longer than six weeks, the following clinical recommendations should be followed.

Clinical Recommendations

1. Do not continue to prescribe opioids if use during the acute phase does not lead to clinically meaningfully improvement in function or to a pain interference with function level of ≤4 (Figure B).
2. Prescribe opioids in multiples of a 7-day supply to reduce the chance of them running out on a weekend.
3. Have a plan for how and when to discontinue opioids if treatment has not resulted in clinically meaningfully improvement in function and pain or the patient has had a severe adverse outcome.
4. Check the state's Prescription Monitoring Program (PMP) to ensure that the patient's controlled substance history is consistent with the prescribing record. Prescribers may delegate the ability to query the PMP database to a licensed health care professional (Training available at **https://www.iarx.org/content.asp?contentid=239**).
5. Screen for depression using PHQ-9 and for anxiety using GAD-7 or other validated tools. If comorbid mental health conditions exist in the presence of pain, they need to be treated or the patient's pain will not improve regardless of opioid therapy.
6. Administer the 4-item **PC-PTSD** screen or other validated tools if the patient's history suggests PTSD, or if PHQ-9 or GAD-7 remains elevated after treatment.
7. Screen for opioid misuse risk using the Opioid Risk Tool, SOAPP-R, DIRE, CAGE-AID or other validated tools. Review the patient's medical records and include the patient's support system (e.g. family, friends, etc.) to verify the risk assessment results.
8. Do not prescribe opioids if results of a baseline UDT reveal "red flags" such as the confirmed presence of cocaine, amphetamines, non-prescribed benzodiazepines, alcohol, or any other drugs you did not prescribe or have knowledge of (**Appendix S: Urine Drug Testing for Monitoring Opioid Therapy**). If cannabis is present on a UDT, the patient should be screened for cannabis use disorder, as defined by DSM 5. In addition, it would be prudent to have a policy regarding the concomitant use of cannabis and opioids.
9. Avoid new prescriptions of benzodiazepines and sedative-hypnotics. Consider tapering or discontinuing benzodiazepines and/or sedative-hypnotics.
10. Discontinue opioids during this phase if:
    a. There is no clinically meaningful improvement in function and pain.
    b. Treatment resulted in a severe adverse outcome (e.g. overdose, bowel obstruction, central sleep apnea).
    c. The patient has current or history of substance use disorder (excluding tobacco).

Chronic Pain Treatment (Pain Lasting More Than Three Months)

For almost 30 years, common medical wisdom held that most individuals experiencing chronic pain would benefit from daily doses of opioids. Medical knowledge has matured, and our understanding of the risk/benefit of chronic opioid use has changed, such that we now know the risks of chronic use are significant, and the benefits are often modest.[118] Most patients with chronic non-cancer pain can be managed with non- opioid modalities or occasional opioid use.

The problem we now face is the patients who have been on high-dose daily opioids for years, sometimes passing from provider to provider. Many primary care practitioners care for these patients, though they may not have initiated the opioid treatment regimen. These individuals deserve compassionate care and may sincerely believe that they could not cope without continuing their medication regimen. However, current best practice suggests that a slow-dosage reduction will improve the quality of life for the majority of patients.

The characteristics that contribute to dose escalation for chronic pain patients are the same as those which predispose to Opioid Use Disorder. When appropriate screening, safe monitoring, and dose reduction are instituted, some of these individuals will be found to have the true diagnosis of Opioid Use Disorder. Co-occurring mental health disorders related to trauma, depression and anxiety may be revealed, as well. Management of these emerging disorders may require a shift in treatment modalities or a specialty-care referral. A strong partnership with behavioral health experts is essential to managing these patients.[119]

Involvement in daily activities and improved quality of life are the goals of chronic pain treatment. Monitoring function, rather than simply measuring the perception of pain, is the method of assessing patient improvement. Many patients do better after tapering and are grateful to "have their lives back" despite their initial fears of dose reduction. Studies demonstrate that improvement in function is the single most important data point to demonstrate that opioids are effective and appropriate. Conversely, if no meaningful or measurable improvement in function is seen, opioid use is less likely appropriate.

Categorizing Chronic Pain

It may be helpful to think of chronic pain patients as having pain belonging to one of three broad categories: peripheral (nociceptive), neuropathic and central (non-nociceptive).

Nociceptive pain is pain whose etiology is ongoing peripheral inflammation or damage. This pain may be responsive to medications or procedures.

Neuropathic pain is pain resulting from trauma to peripheral nerves. This pain may be responsive topharmacotherapy.

Central Pain – this phenomenon has many names, such as "pain amplification," "brain pain," and "non-nociception pain." Fibromyalgia syndrome is the classic example of this type of chronic pain.

Psychotropic and other non-opioid therapies, including behavioral therapies, can be beneficial. Opioids are contraindicated with central pain etiologies.

All three pain types may coexist and may benefit from non-medication pain-management strategies: cognitive behavioral therapy (CBT), movement therapy, physical therapy, occupational therapy and education.

Nociceptive and Neuropathic Pain

Historically, almost all chronic non-cancer pain (CNCP) was thought to be either nociceptive or neuropathic. In this model of CNCP, the underlying cause of pain was believed to result from stimulation of peripheral pain or sensory nerve fibers located within the painful anatomic region. In this pain schema, peripherally directed therapies such as topical treatments, injections, opioids, and surgery are believed to be helpful.

Examples of peripheral nociceptive pain include osteoarthritis, rheumatoid arthritis, and cancer pain. Examples of peripheral neuropathic pain include diabetic neuropathic pain and post-herpetic neuralgia.

However, over the past decade, a body of evidence has accumulated to suggest that a third type of pain, centralized pain, is likely to be much more prevalent than either nociceptive or neuropathic pain amongst working-age adults with CNCP. This distinction is very important to make as centralized pain, unlike nociceptive and neuropathic pain, is not responsive to peripherally directed therapies or opioids.[120]

Central Pain and Central Sensitization/Hyperalgesia

The prototypical central pain state is fibromyalgia syndrome. But current research suggests that centralized pain is a spectrum disorder, which includes a large family of common chronic non- cancer pain diagnoses. Chronic low back pain, chronic headaches, and fibromyalgia are highly associated with CS.[120-122]

Screening for centralized pain syndromes is essential both for successful treatment and to avoid the unnecessary harms of over-medicalization with repeated scans, injections, surgeries, and opioids. Because the examination, imaging, and labs are often unremarkable in centralized pain syndromes, diagnosis rests upon a careful history, review of symptoms, and the use of validated CS screening instruments. Moreover, given the high co-occurrence of depression, anxiety, PTSD and addictive disorders within individuals with CS, it is recommended that screening for these co-morbidities is also included in the initial evaluation.

If we treat centralized pain syndromes with drugs alone, we will fail. This is akin to treating diabetes with insulin or drugs alone, without any corresponding attempt to modify diet or weight.

Opioids are not effective in the management of central pain states in any sustainable fashion. Mu receptor activity is not a part of the mechanism of this type of pain. Therefore, the opioid blockade of mu receptors does not provide long term symptomatic relief. Increasingly, evidence is accumulating to show that dose escalation of opioids in opioid resistant central pain states can become associated with Opioid Induced Hyperalgesia (OIH). When this develops it becomes necessary to taper a patient off opioids to reduce pain.

Assessment for Chronic Non-Cancer Pain

Prior to assuming responsibility for prescribing for these patients, you should obtain and review the following:

- Prior medical and psychiatric records and (ideally) personal communication with the previous prescriber.

- It may be important to know why a patient left the previous practice.
- A complete physical exam, including:
  - Past medical and psychiatric history, longitudinal pain history, family pain history, substance use history, laboratory, and imaging as appropriate.
  - Specific ROS (review of systems) related to CS spectrum: difficulty sleeping, fibromyalgia, headaches, inflammatory bowel syndrome, pelvic pain, memory problems, TMJ, sensory descriptors of pain, (i.e., numbness, tingling, pins and needles, etc.) and history of childhood trauma.
  - Physical exam: A thorough exam will typically rule out undiagnosed nociceptive or neuropathic pain.
- A query of the Iowa PMP.
- Physical findings, imaging and labs are typically unremarkable in controlled substance spectrum disorders.
- UDS (POC [in-office point of care] will provide results at the time of the visit)
- Substance-abuse risk screening.
- Mental health screening, for example, adverse childhood experiences (ACEs), PTSD, anxiety and depression.
- Respiratory disease risk screening.
- Pain and, most important, comfort and functional assessment to evaluate progress with treatment over time. (Oswestry, Low Back Pain Intensity, Visual Analog Scale, PEG 3-item scale for pain tracking).
- Is the diagnosis likely to be opioid responsive (nociceptive) or is it likely to be opioid resistant (central pain)?

Opioid Treatment

Rarely will it be possible to prescribe on the first visit. Once you have decided to assume prescribing responsibility for opioid treatment, you should do the following:

- Discuss the material risk notice with the patient and have it signed in your presence. Many providers also use a controlled substances agreement.
- Consider a lowering of their opioid dose (tapering), as many patients will benefit from a dose reduction. If the patient presents with a total MEE over 90mg per day, a taper plan needs to be discussed with the patient with the understanding that opioid risk is dose related. The safest regimen is the absence of opioids. (See "Tapering" below.)
- Consider and discuss/co-prescribe a naloxone rescue kit. This will require a visit with the patient's loved ones. Naloxone comes as a nasal spray or injectable, is easy to use, carries no substantial risks and has been proven to save lives. (See **Naloxone, page 71**)

Ongoing monitoring should be instituted as clinic policy for all patients. Everyone is at increased risk with opioids, not just those you identify as problem patients or high-dose patients. Risk stratification (see elsewhere in this document, **page 15**) may have some, albeit limited, usefulness. Monitoring should include episodic evaluation of functional improvement, UDS, PMP query, callbacks with pill counts, and documentation of any other changes in behavioral or physical conditions that would influence your prescribing decision.

Opioids and benzodiazepines co-prescribing should be very strongly discouraged as the combination can produce a synergistic effect resulting in respiratory arrest.[123]

Transitioning to methadone use should be avoided, and, if prescribed, doses should be kept below 30mg/d because of its high lethality mg for mg conversion.[124] Other rapidly acting opioids, such as fentanyl, are highly addictive.

There are times when long acting and IV pain medications are needed for chronic pain. Patient education on the dangers of sharing medications, especially IV medications is vital.

Often patients with chronic pain are TOLD to go to the emergency department for chronic pain due to lack of accessibility to treatment. Education on this can reduce ED visits.

Contraindications for opioid treatment:

- Concurrent use of benzodiazepines and other sedative hypnotics (alcohol, muscle relaxants, sleeping medications).
- Increased risk of respiratory depression: severe COPD, sleep apnea, etc.
- Substance-use disorder. History of substance use disorder requires increased scrutiny if any prescribing is undertaken.
- Illegal activities regarding medications.
- Lack of functional improvement while taking opioids.
- Recent – last 12 months – documented prior violation of an opioid treatment agreement with another prescriber.

Contraindications for opioid treatment:

- Analgesia. Is the opioid leading to a meaningful reduction in the pain reported by the patient?
- Adverse Effect: Is the patient experiencing adverse effects at a dose required to reduce the pain?
- Activity: Is there a measurable or meaningful increase in the patient's ability to perform activities of daily living?
- Aberrant Behaviors: Demonstration of an accumulation of aberrant behaviors is evidence that the patient is losing control over the use of the medications. This can become evidence of development of substance use disorder.

Patient Instructions

Dose instructions need to clear. As needed prescribing may lead to inadvertent large doses (e.g., hydrocodone/acetaminophen 5/325 one to two every three to six hours can be as much as 50 mg MME per day, even though each dosage unit represents a small dose of opioids.)

The following should be a part of patient/family education concerning opioids:

- Safe storage to prevent children and others from obtaining the medication.
- Safe disposal when they are no longer needed. (**See page 70** for more information on disposal.)
- Clinic policy regarding inappropriate behaviors. Many clinics have patients sign a patient controlled substance agreement.
- Those disallowed behaviors often include: early refills, lost or stolen prescriptions, Friday and weekend refill requests, obtaining controlled substances elsewhere without disclosure, use of illicit drugs, alcohol abuse, and concomitant marijuana use. Impolite, disrespectful, aggressive, threatening or combative behaviors will lead to immediate dismissal.

Tapering

- Many patients who are on opioids long term are likely to react negatively to a discussion of tapering.
- Preparation for these difficult conversations can be very helpful, and a section of the guidelines is dedicated to that subject.
- Tapering strategies are discussed elsewhere in this document (**page 46**).
- It is essential that patients be provided resources to assist them with the discomfort and anxiety that often accompanies tapering. Learn what local community resources are available to you.
- Many patients are on opioids and benzodiazepines simultaneously. It is inappropriate to have patients on both of these medications, even if you are not the prescriber for both. Patients may be tapered off both simultaneously, but many prefer to taper off one and then the other. Since opioids are more dangerous due to risk of overdose and can

be tapered more rapidly, we recommend starting your taper with opioids and then tapering the benzodiazepines.

- When patients are exhibiting active addiction behaviors (e.g., use of illicit drugs like heroin) an immediate cessation of prescribing may be indicated and accompanied by an addiction treatment referral.

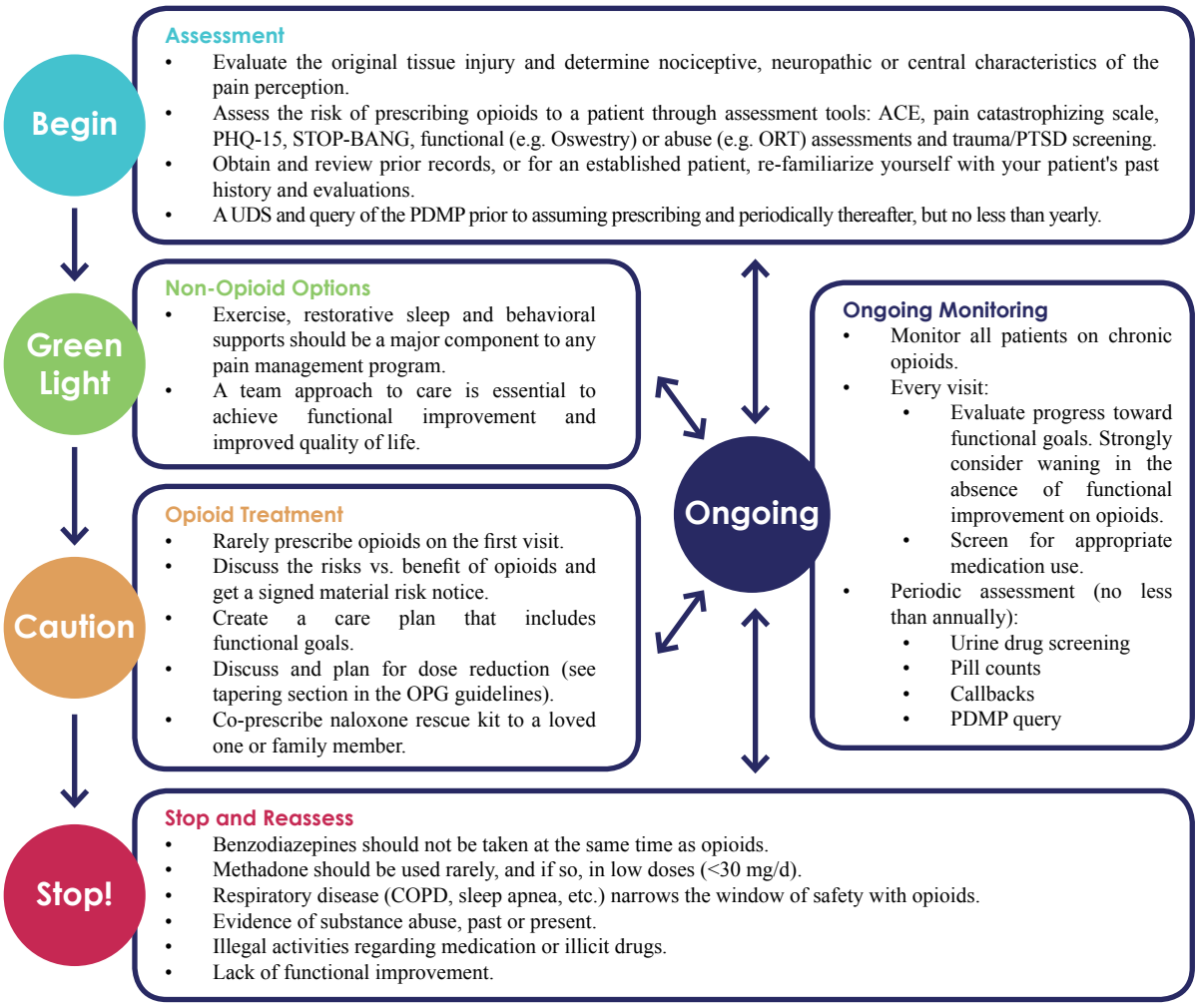
Additional Concerns

- Suicidality: Individuals whose lives have revolved around opioids for decades may have significant and legitimate concerns about dose reduction. These individuals need patience and behavioral support. Be sure to ask about suicidal thoughts and provide referrals to counseling when needed.
- Opioid Use Disorder (OUD): It is sometimes hard to distinguish between patients who take opioids to relieve pain and those who are taking medication to relieve cravings or to achieve a pleasurable effect. Individuals who have an unnatural focus on their medications and respond poorly to opioid treatment may be identified as either having ineffectively treated pain or having an OUD.

You may have patients to whom you were prescribing opioids for the treatment of pain, but who over time showed evidence of OUD. Ideally, if you prescribe opioids for chronic pain, you also have the capability to prescribe buprenorphine (or refer to others with that capability) for your patients who you feel have a Substance Use Disorder (SUD). Regardless of the terminology you use, some patients would be safer being prescribed buprenorphine rather than pure mu agonists.

An in-depth knowledge of your community OUD services is an important component of chronic pain treatment.

Chronic Pain Flowsheet



Tapering

Opioid treatment should be discontinued if adverse effects outweigh benefits, or if aberrant, dangerous or illegal behaviors are demonstrated.[123]

Discontinuation of opioid treatment is recommended if any of the following occurs:

- Dangerous or illegal behaviors are identified;
- Patient claims or exhibits a lack of effectiveness;
- Pain problem resolves;
- Patient expresses a desire to discontinue therapy; and
- Opioid treatment appears to be causing harm to the patient, particularly if harm exceeds benefit.[124]

The decision to discontinue opioid treatment should ideally be made jointly with the patient and, if appropriate, the family/caregiver.[125] This decision should include careful consideration of the outcomes of ongoing monitoring.

When possible, offer to assist patients in safely discontinuing medications, even if they have withdrawn from treatment or been discharged for agreement violations.[124]

The goal is to taper all patients off opioid medications safely. If the patient is discharged, the health care provider is obliged to offer continued monitoring for 30 days post-discharge. Possible complications of opioid withdrawal should be taken into consideration when discontinuing or tapering opioid medications.

Additional information is available at: **http://health.utah.gov/prescription/pdf/guidelines/Strategies_tapering_weaning.pdf**

CDC Pocket Tapering Guide is available at: **https://www.cdc.gov/drugoverdose/pdf/clinical_pocket_guide_tapering-a.pdf**

Preparing the Patient to Taper

Some providers have found the following dialogue useful when explaining the process to patients:

> *"Medical knowledge changes over time, and just as we have discovered that some of our recommendations today concerning the treatment of cancer or heart disease are different from 10 years ago, the same is true of the treatment of chronic pain. We now know that it can be dangerous to take large amounts of opioids every day. We have also learned that pain relief with high doses may not be any better than with lower doses of painkillers.*
>
> *Further, a patient's subjective sense of short-term improvement may not be an adequate indicator of the long term success of the therapy."*

Opioid Tapering/Discontinuation

- Clinicians should keep in mind the four A's:
  - Analgesia. Is the opioid leading to a meaningful reduction in the pain reported by the patient?
  - Adverse Effect: Is the patient experiencing adverse effects at a dose required to reduce the pain?
  - Activity: Is there a measurable or meaningful increase in the patient's ability to perform activities of daily living?
  - Aberrant Behaviors: Demonstration of an accumulation of aberrant behaviors is evidence that the patient is losing control over the use of the medications. This can become evidence of development of substance use disorder.
- Consider tapering if:
  - MME per day is in excess of 90 mg/d or methadone dose is in excess of 30mg per day.
- Should be tapered if:
  - The medication fails to show significant analgesia despite incremental dose increases.
  - The medication fails to show functional improvement over time.
  - Significant physical risk factors are present (sleep apnea, prolonged QT, pulmonary disease, etc.).
  - Side effects of medication are interfering with quality of life.
  - Patient request.
  - Evidence of misuse, abuse, diversion, or other behavioral/psychological dysfunction.
  - Other violations of opioid agreement.

Opioids should be weaned, rather than abruptly stopped, after chronic use (30 days or greater). When opioids are being sold, injected, used in a dangerous or clearly illegal fashion, immediate discontinuation should be undertaken for patient safety and compliance with the law. Referral to a medication-assisted treatment program (methadone, buprenorphine, or naltrexone) may be a safer and more appropriate treatment consideration under these circumstances.

General Considerations

- Some short-term increase in pain is to be expected during the tapering process. This is usually transient, and after achieving a reduced baseline dose, the patient is likely to experience decreased medication-related side effects and a reduced risk of unintentional overdose, without an increase in pain. Many times, opioids may be completely discontinued with no increase in pain, but improved function and quality of life.
- The slower the taper, the less the short-term discomfort. Educating the patient about the risks of their current regimen and what to expect as they taper off the medications is often be helpful.
- Some highly motivated patients prefer a rapid taper (weeks versus months). Patient preference needs to be considered in designing a tapering schedule.
- Psychosocial support is an essential component of successful medication tapering for patients who have been on long-term opioid therapy. Discussions about weaning are often associated with fear and anxiety about the recurrence or worsening of pain and/or the development of other withdrawal symptoms. Reassure the patient that supportive adjunctive treatment of withdrawal will be provided as needed, and may be quite helpful, but set expectations that this will not include replacement medications such as other opioids or benzodiazepines.
- Certain supportive medications that treat autonomic responses, medications such as clonidine, loperamide or hydroxyzine may be useful short-term adjuncts.
- Patient empowerment is key to success. Involve patients in the planning from the beginning.
- Elicit suggestions from them for healthful activities that can replace reliance on medications.
- Certain therapies, Cognitive Behavioral Therapy (CBT) and Living Well With Chronic Illness workshops, for example, can be quite helpful to support patients through the tapering process and beyond.

- The last part of the dosage reduction is the most difficult for the patient. This is a phenomenon that is true for many psychoactive drugs. You and your patient should anticipate this, and engage supports that are meaningful to the patient. In motivated patients, a slow- down of the tapering process may be necessary toward the end. Liquid forms of medication can be helpful for more precise dosing and can be obtained from a compounding pharmacy.
- Ceiling doses of 50 to 90 MME per day are doses where the risks of the medication are felt to outweigh the benefits. Medication dependence, medication side effects, and other physical and behavioral changes experienced with chronic opioid use are related to dose, such that, for many individual's quality of life improves as the dose approaches or reaches zero.

Symptoms of Opioid Withdrawal

Early Symptoms	
Agitation	Insomnia
Anxiety	Runny nose
Muscle aches	Sweating
Increased tearing	Yawning

Late Symptoms	
Abdominal cramping	Goose bumps
Diarrhea	Nausea
Dilated pupils	Vomiting

Initial Steps

1. Calculate the MME per day, review the ORT (or other risk-screening assessments), and assess the patient progress in treatment, including UDS, PDMP, and any signs of aberrant behavior. Use that review to inform the patient concerning the appropriateness of tapering. Involve the patient in the creation of his or her new care plan.
2. Sometimes, giving the patient some time to assimilate this new information may be appropriate. Starting the taper at the follow-up visit may help to build trust.
3. Patients at risk for aberrant behaviors during the tapering process (suicidality, illicit drug use, loss of impulse control) will need referral to a behavioral health specialist prior to the initiation of the taper. It is helpful to work in parallel with such behavioral specialists during the tapering process for those patients.
4. Document your plan and the reasons for the taper in the chart note, and provide appropriate information to your patient.
5. Medication tapering may be a very stressful experience for patients. Close monitoring for aberrant behaviors is critical during this period to assure patient compliance and safety. Misuse of medications, use of illicit drugs, and "doctor shopping" may necessitate a change in approach, requiring a switch from a tapering strategy to substance-abuse treatment (residential care or Medication Assisted Treatment, such as buprenorphine or supportive medications only).

Tapering Steps

Slow-Taper Protocol

1. Long-acting opioids: Decrease total daily dose by 5 – 10 percent of initial dose per week.
2. Short-acting opioids: Decrease total daily dose by 5 – 15 percent per week.

3. These regimens may need to be slowed toward the end of the tapering process (see General Considerations above). Often, once 25 – 50 percent of the total dose is reached, the rate of taper can be slowed to 5 percent per week.
4. You and your patient should know the signs and symptoms of opioid withdrawal. Some of those symptoms may be present during this process, and can be controlled by support medication, psychosocial supports, or slowing the tapering process.
5. Remain engaged with the patient through the taper and provide psychosocial support as needed. Peer-to-peer, Living Well With Chronic Pain workshops, group visits, CBT and other counseling modalities may be quite helpful.
6. Consider the following adjuvants as needed:
    a. Antidepressants to manage irritability, sleep disturbance (e.g., trazodone)
    b. Hydroxyzine for insomnia and anxiety
    c. Anti-epileptics for neuropathic pain
    d. Clonidine for autonomic withdrawal symptoms such as rhinorrhea, diarrhea, sweating, tachycardia, hypertension
    e. NSAIDS for myalgia (e.g., ibuprofen)
    f. Anti-diarrheal agents for diarrhea
    g. Opioid Withdrawal Attenuation Cocktail (**Appendix F**)

Special Considerations for Methadone

Methadone withdrawal symptoms take longer to manifest because of the long and unpredictable metabolism of the drug. Patients may be overconfident early in the tapering process only to experience severe withdrawal over time. The same principles of opioid tapering are true for methadone although a more drawn-out taper may be necessary. Understanding the unique metabolic characteristics of methadone will be helpful for you and the patient to achieve a successful dosage reduction.

The CDC pocket guide for tapering can be helpful in implementing other tapering protocols. This pocket guide can be found here: **https://www.cdc.gov/drugoverdose/pdf/clinical_pocket_guide_tapering-a.pdf**.

Opioid Tapering Flowsheet

Start Here

Consider opioid taper for patients with opioid MME > 90 mg/d or methadone > 30 mg/d, aberrant behaviors, significant behavioral/physical risks, lack of improvement in pain and function.

1. Frame the conversation around tapering as a safety issue.
2. Determine the rate of taper based on the degree of risk.
3. If multiple drugs involved, taper one at a time (e.g., start with opioids, follow with BZPs).
4. Set a date to begin and set a reasonable date for completion. Provide information to the patient and establish behavioral supports prior to instituting the taper.

Opioids

Basic principle: For longer-acting drugs and a more stable patient, use a slower taper. For shorter-acting drugs, less stable patient, use a faster taper.

1. Use an MME calculator to help plan your tapering strategy. Methadone MME calculations increase exponentially as the dose increases, so methadone tapering is generally a slower process.
2. Long-acting opioid: Decrease total daily dose by 5 – 10 percent of initial dose per week.

3. Short-acting opioids: Decrease total daily dose by 5 – 15 percent per week.
4. See patient frequently during process and stress behavioral supports. Consider UDS, pill counts and PMP to help determine adherence.
5. After 25 to 50 percent of the dose has been reached, with a cooperative patient, you can slow the process down.
6. Consider adjuvant medications: antidepressants, gabapentin, NSAIDs, clonidine, anti-nausea, anti-diarrhea agents.

MME for Selected Opioids

Opioid	Approximate Equianalgesi Dose (oral and transdermal)	Opioid	Approximate Equianalgesi Dose (oral and transdermal)
Morphine (reference)	30mg	Codeine	200mg
Fentanyl transdermal	12.5mcg/hr	Hydrocodone	30mg
Hydromophone	7.5mg	Methadone Chronic	4mg
Oxycodone	20mg	Oxymorphone	10mg
Tapentodol	75mg	Tramadol	300mg

Benzodiazepine Tapering/Discontinuation

Benzodiazepines are potentially addictive drugs that may produce physical dependence, amnesia, emotional blunting, psychomotor retardation, and synergistic respiratory depression when combined with opioids.

Anxiety, although initially ameliorated by benzodiazepines taken short term, often returns to near baseline levels with chronic use. Patients may be reluctant to taper off of these medications fearing the exacerbation of anxiety that usually accompanies the dose-reduction process.

Unlike opioids, abrupt withdrawal from high doses of benzodiazepines can result in seizures and death. The detoxification resembles alcohol withdrawal in terms of symptomatology and risk.

Some patients will need medically supervised residential treatment to successfully discontinue benzodiazepines.

Withdrawal: The longer the treatment, the higher the dosage, the shorter the half-life, or the faster the taper, then the more likely the patient will have withdrawal symptoms. Even small doses of benzodiazepines taken chronically may produce uncomfortable symptoms if discontinued abruptly.

Common Benzodiazepine Withdrawal Symptoms

Difficulty Concentrating	Restlessness	Agitation	Tremor
Increased Acuity to Stimuli	Loss of Appetite	Diaphoresis	Anxiety
Faintness/Dizziness	Fatigue/Lethargy	Tinnitus	Nausea
Muscle Cramps/Twitches	Poor Coordination	Insomnia	Paresthesia
Perceptual Distortions	Depersonalization	Confusion	

General Considerations

- Some short-term increase in anxiety is to be expected during the tapering process. This is usually transient, and after achieving a reduced baseline dose, the patient is likely to experience decreased medication-related side effects without an increase in anxiety. Many times, benzodiazepines may be completely discontinued with no increase in symptoms but with improved function and quality of life.
- The slower the taper, the less the short-term discomfort. Educating the patient about the risks of their current regimen and what to expect as they taper off the medications is often/can be helpful.
- Some highly motivated patients prefer a rapid taper (weeks versus months). Patient preference needs to be considered in designing a tapering schedule.
- Psychosocial support is an essential component of successful medication tapering for patients who have been on long-term benzodiazepine therapy. Discussions about weaning are often associated with fear and anxiety about the recurrence or worsening of anxiety and/or the development of other tapering symptoms. Reassure each patient that supportive adjunctive treatment of withdrawal will be provided as needed, and may be quite helpful, but set expectations that this will not include dangerous replacement medications. Certain non-habit forming medications that treat insomnia specifically (such as trazodone or hydroxyzine) might be useful.
- Patient empowerment is key to success. Involve patients in the planning from the beginning. Elicit suggestions for healthful activities that can replace reliance on medications.
- Certain therapies, CBT and trauma-focused care, for example, can be helpful in supporting patients through the tapering process and beyond.
- The last part of the dosage reduction is the most difficult for patients. This is a phenomenon that is true for many psychoactive drugs. You and your patients should anticipate this and use supports that are meaningful to your patients. In motivated patients, a slow-down of the tapering process may be necessary toward the end. Liquid forms of medication can be helpful for more precise dosing and can be obtained from a compounding pharmacy.

Discontinuation Strategies

Two strategies that can be used to taper off of benzodiazepines:

1. Switching to a long-acting benzodiazepine (or phenobarbital) and slower taper.
2. Simultaneous treatment with an anti-epileptic drug during taper; this allows for a more rapid taper.

Special Circumstances

Consider inpatient/medical residential treatment in patients with significant substance abuse history, history of benzodiazepine overdose, seizure disorder or illicit benzodiazepine use. Modified CIWA evaluation or MSSA (withdrawal scoring systems) can be used in such circumstances to determine the total 24-hour dose needed to begin the taper and provide safe medical monitoring of the taper process.

Slow-Taper Method

1. Calculate the dose equivalence of the current benzodiazepine into clonazepam, diazepam, or phenobarbital long-acting drug: (http://www.benzo.org.uk/bzequiv.htm). Provide behavioral support to the patient during the tapering process above (see General Considerations concerning opioid tapering).
2. Switch the patient from the short-acting drug to the longer-acting drug. Be conservative in estimating the long-acting dose since variation in metabolism may create safety issues. Consider a reduction of 25–50% of the calculated dose for initiation of tapering.
3. See the patient for a return visit a few days after initiating the taper to be sure your dose equivalency is appropriate.
4. Reduce the total dose of the long-acting agent by 5–10% per week in divided doses.
5. Consider slowing the taper to 5% or less per week when the dose has been reduced to 25 – 50% of the starting dose.
6. Consider adjunctive agents to help with symptoms: trazodone, buspirone, antidepressants, hydroxyzine, clonidine, neuroleptics and alpha-blocking agents have all been useful.

Benzodiazepine Equivalency Chart

Drug	Action Onset	Peak Onset (hrs)	Half-Life (hrs)	Eliminator	Dose Equivalent
Long-Acting					
Chlordiazepoxide (Librium)	Int	2 – 4	5 – 30 (parent) 3 – 100 (metab)	Oxidation	10mg
Diazepam (Valium)	Rapid	1	20 – 50 (parent) 3 – 100 (metab)	Oxidation	10mg
Flurazepam (Dalmane)	Rapid	0.5 – 2	47 – 100 (metab)	Oxidation	30mg
Phenobarbital (barbiturate)	Slow	0.5 – 4	53 – 118 (metab)	Oxidation	30mg
Intermediate-Acting					
Alprazolam (Xanax)	Int	0 .7 – 1 .6	6 – 20 (parent)	Oxidation	0.5mg
Clonazepam (Klonopin)	Int	1 – 4	18 – 39 (parent)	Oxidation	0.5mg
Lorazepam (Ativan)	Int	1 – 1 .5	10 – 20 (parent)	Conjugation	1mg
Oxazepam (Serax)	Slow	2 – 3	3 – 21 (parent)	Conjugation	15mg
Temazepam (Restoril)	Slow	0.75 – 1 .5	10 – 20 (parent)	Conjugation	30mg
Short-Acting					
Triazolam (Halcion)	Int	0.75 – 2	1.6 – 5 .5 (parent)	Oxidation	0.5mg

Onset of Action

Rapid is within 15 minutes, intermediate is within 15–30 minutes and slow is within 30–60 minutes.

Benzodiazepine Tapering Flowsheet

Start Here

Consider benzodiazepine taper for patients with aberrant behaviors, behavioral risk factors or concurrent opioid use.

1. Frame the conversation around tapering as a safety issue.
2. Determine rate of taper based on degree of risk.
3. If multiple drugs are involved, taper one at a time (e.g. start with opioids, follow with BZPs).
4. Set a date to begin and a reasonable date for completion. Provide information to the patient and establish behavioral supports prior to instituting the taper. See OPG guidelines.

Benzodiazepine Taper

Basic principle: expect anxiety, insomnia and resistance. Patient education and support will be critical. Risk of seizures with abrupt withdrawal increases with higher doses. The slower the taper, the better tolerated.

Slow Taper

1. Calculate total daily dose. Switch from short-acting agent (alprazolam, lorazepam) to longer acting agent (diazepam, clonazepam, chlordiazepoxide or phenobarbital). Upon initiation of taper, reduce the calculated dose by 25 – 50 percent to adjust for possible metabolic variance.
2. Schedule first follow-up visit two to four days after initiating taper to determine if adjustment in initial calculated dose is needed.
3. Reduce the total daily dose by 5 – 10 percent per week in divided doses.
4. After 1/4 to 1/3 of the dose is reached, you can slow the taper with cooperative patient.
5. With cooperative patients who are having difficulty with this taper regimen, you can extend the total time of reduction to as much as six months.
6. Consider adjunctive agents to help with symptoms: trazodone, hydroxyzine, neuroleptics, anti-depressants, clonidine and alpha-blocking agents.

Benzodiazepine Equivalency Chart

Drug	Half-Life (hrs)	Dose Equvalent
Chlordiazepoxide (Librium)	5 – 30 h	25mg
Diazepam (Valium)	20 – 50 h	10mg
Alprazolam (Xanax)	6 – 20 h	0.5mg
Clonazepam (Klonopin)	18 – 39 h	0.5mg
Lorazepam (Ativan)	10 – 20 h	1mg
Oxazepam (Serax)	3 – 21 h	15mg
Triazolam (Halcion)	1.6 – 5.5 h	0.5mg
Phenobarbital (barbituate)	53 – 118 h	30mg

Rapid Taper

1. Pre-medicate two weeks prior to taper with valproate 500mg BID or carbamazepine 200mg every AM and 400mg every HS. Continue this medication for four weeks post-benzodiazepines. Follow the usual safegards (lab testing and blood levels) when prescribing these medications.
2. Utilize concomitant behavioral supports.
3. Discontinue current benzodiazepine treatment and switch to diazepam 2mg BID for two days, followed by 2mg every day for two days, then stop. For high doses, begin with 5mg BID for two days and then continue as described.
4. Use adjuvant medications as mentioned above for rebound anxiety and other symptoms.

Specialty Care for Chronic Pain

Pain is an aspect of many illnesses, as well as a normal part of the aging process. As such, its treatment is an essential component of primary care. The treatment of pain, especially acute pain, may at times require the use of opioids, which have significant risks in addition to their benefits. After years of misguided provider education, millions of patients in our healthcare system are on opioids for inappropriate diagnoses and at inappropriate doses. Even the most skilled providers may at times need specialty care to assist in the management of these complex patients. This guideline will address the following questions:

What kinds of patients are most appropriate for specialty care?

What is the screening and evaluation expected for these high-risk patients?

What kind of oversight should exist to assure consistent and safe management of these patients?

Who is a pain specialist?

What kind of services should constitute a specialty-care clinic? What are the expectations and long-term goals for such patients?

Patient Selection for Pain Specialty Care

- Patients on high doses (>90 mg MME per day) or unsafe drug combinations (e.g., benzodiazepines + opioids) who either refuse dosage reduction, exhibit substance-use disorder behaviors or have significant behavioral conditions beyond the scope of the provider may require referral to a pain specialty program or substance abuse program for evaluation or ongoing care.
- Any chronic pain patient beyond the expertise of the primary care provider.

Screening and Evaluation

- All patients being prescribed chronic opioids need screening for behavioral, respiratory and other psychosocial risks because, by definition, the specialty-referral clients are at higher risk. A more thorough evaluation of such patients is to be expected.
- Ongoing functional evaluation: **PEG**, PDQ, **Oswestry** or similar, monitored over time.
- Respiratory: **S T O P B A N G** or similar, with appropriate referral or further evaluation as necessary.
- Central sensitization screening including but not limited to Central Sensitivity Index, Pain Catastrophizing Scale (PCS), **PHQ-9** etc.
- Validated addiction-screening tests such **ORT**/SBIRT/**DAST-20**, appropriate for age and history.
- Query of the Iowa PMP initially and episodically.
- Evaluation for possible unforeseen sources of nociception, such as identification of ongoing tissue destruction.

Oversight

Pain specialists accredited, or working under the license of others can succumb to lack of time and inadequate resources resulting in a loosening of appropriate safeguards in the management of chronic pain. A process of peer review can provide feedback at the expert level (and can be an educational resource for primary care) to assure quality and consistent care for complex, high-risk patients. This may include:

- Regularly scheduled multi-disciplinary meetings of healthcare professionals, including behavioral specialists, addiction counselors/specialists, pharmacist, case management, and more to facilitate case discussions. Review of treatment data (MME, functional improvement, adherence to risk stratification) in a transparent fashion by the participants is an expected component.
- A committee that could serve as a foundation for others providing pain management in the community.

Pain Specialty

It is clear from the latest research that chronic pain is often, a disorder of nociceptive perception and dysregulation.126,127 Chronic pain patients often represent a subset of the population with specific bio-psycho-social characteristics. This means that a pain specialty clinic needs to have a foundational understanding and resource accessibility to care for individuals with historical trauma, substance-use disorder, catastrophizing, as well as an understanding of the pharmacodynamics of opioids. Chronic pain is often best viewed through the lens of chronic disease management rather than cure. Therefore, to be considered a pain specialty clinic for the purposes of referral and reimbursement, items 1 through 6 will need to be provided by the clinic staff.

Services

A pain specialty clinic should include the following:

1. Clinicians willing to be transparent and share de-identified treatment data with other healthcare team members.
2. Access to and collaboration with behavioral health experts to provide evidence-based counseling, education, and substance-use disorder treatment.
3. Prescribers specifically educated concerning the use and abuse of opioids, or who can demonstrate their expertise through an objective testing process.
4. The ability to provide Medication Assisted Treatment (MAT) to appropriate patients for the treatment of Opioid Use Disorder.
5. The ability to provide referral and expert care for complex chronic pain patients. It should be the goal of pain specialty to develop and establish a treatment plan and return the patient to primary care. In extremely complex patient situations, pain specialty should provide direct care until exceptional care needs are addressed, managed, and a care plan is established; at which point the patient should be returned to primary care. It is expected that all providers participating in a patient's care will employ common treatment goals and communicate regularly amongst themselves.
6. The previously listed components are essential for quality chronic pain care. If they are not offered on site, then close collaboration, integration, and management of such services is expected.

Long-Term Management Goals

Other than data from methadone clinics, the evidence supporting long-term benefits of opioids is limited, while the risks and harms are evident. Tapering opioids after long-term use can be challenging and may elicit preexisting condition(s), including temporary risk of sleep loss, decreased function, and suicidalities. Patients with underlying trauma, mental health disorders, co-existing benzodiazepine use, and substance-use disorders can be exceptionally challenging when tapering, and specialty care can provide additional structure, expertise and support.

- The Iowa Opioid Guidance Document specifies < 50 MME for most patients, with an a recommended maximum dose of < 90MME, which is appropriate for patients managed by pain specialty, as well.
- If exceeding < 90MME per day, a documented justification is expected.
- It is understood that these complex patients may require additional services, support and time to achieve those goals. Specialty care, by definition, will provide that level of expertise and care.
- Please refer to the chronic pain section on **page 40** for additional information.

Treating Pain in Children and Adolescents

The use of opioids to treat pain in infants and children presents challenges. First, with rare exceptions, opioids have not been labeled for use in individuals under 18 years of age. There is a dearth of quality studies on pharmacokinetics, pharmacodynamics, safety and clinical effectiveness. Acute pain problems in pediatrics have many characteristics in common with adult presentations.

Persistent, recurrent and chronic pain in infants, children, and adolescents are often qualitatively different from chronic pain problems in adults. Treatment approaches may vary accordingly.

Assessment in Children and Adolescents

- Review medical history, including records from previous providers, when available. Be sure to elicit family history of chronic pain syndromes, mental health and addiction concerns, as well as potential for history of prior or ongoing neglect or abuse.
- Perform a physical exam to determine diagnosis, baseline function and pain.
- Carefully assess the degree of injury and the normal healing expectations regarding pain and improved function. Determine the need for opioids versus non-opioid therapies.
- Assessment of functional abilities, including school and sports participation, family and recreational activities, as well as efficacy of current and past treatments.

Non-Opioid Treatment in Children and Adolescents

- Describe the nature of the injury or disease to the patient and the parent. Be sure to describe the expected course of recovery and convey that some pain is to be expected and that activities such as exercise can provide some pain relief and may improve healing.
- Explain that OTC pain medications can be highly effective, and be sure they understand dose and frequency recommendations.
- Patients who experience pain extending beyond the expected time of recovery should be reevaluated.

Opioid Treatment in Children and Adolescents

- Only those who understand the differences in pharmacokinetics and pharmacodynamics between children and adults should prescribe opioids for pediatric patients.
- Opioids should be avoided for the vast majority of chronic non-cancer pain in children and adolescents as evidence of safety and efficacy is lacking.

- Opioids are indicated for a small number of persistent, painful conditions, including those with clear pathophysiology and when an endpoint to usage may be defined, such as post- surgical pain and trauma (including burns). Every attempt should be made to limit opiate use.
- Opioids may be indicated for some chronic conditions where there is no definable endpoint (examples: osteogenesis imperfecta or epidermolysis bullosa and sickle cell disease) or for end-of-life care. Such patients are often best treated with specialty care assistance.
- Put safety first when prescribing opioids to younger patients. Limit the total dispensed and educate parents about dosing, administration, storage and disposal to minimize risks of diversion or accidental ingestion. Adolescents should undergo similar screening for risk of substance-use disorder that one would conduct with adults.

Tools for Children and Adolescents

- Screening tools for substance abuse: **DAST–20**, **ORT**, and **SOAPP-R**.
- Screening tools for co-occurring mental health conditions: **PHQ-9**, **GAD-7**, CRSD (Childhood rating scale for depression), KADS (adolescent depression scale), Behavior ADHD rating scale – Brown, Connors rating scales, Vanderbilt rating scales or Aschenbach.
- Prescription Monitoring Program
- Age and developmentally appropriate screening tools for children such as NIPPS, (Neonatal Infant Pain Scale), FLACC (Face, Legs, Activity, Cry, Consolability: ages 2 months thru 7 years), Oucher Scale (ages 5 and above), Bieri-Modified (aka “Faces Scale”: ages 8 and up), Predictive Pain Questionnaire (ages 8 through 17) and McGill Pain Questionnaire (ages 12 and up).
- Screening tools can be found in the appendix starting on **page 87**.

Opioid Use in the Elderly and Cognitively Impaired

Pain in the elderly patient may be more difficult to assess because of the patient's cognitive and physical impairments. Traditional approaches to pain management may need to be modified because of a sometimes-elusive diagnosis, altered patient physiology and the risk of more prominent side effects.

The goals of therapy are to decrease pain while increasing function and enhancing quality of life.

Chronic Pain in the Elderly Population

- Persistent pain (three to six months) is present in 25 – 50 percent of older adults, and increases with age. Nursing home patients may have prevalence as high as 45 – 80 percent.[128]
- Chronologic markers for old age are arbitrary; however, various factors such as socioeconomic impacts, health-style choices and medical comorbidities may all factor into a patient's physiologic age.

Evaluation of the Elderly Patient

- Identify the source of the pain and the impact that pain is having on the patient. Assess previous consultations, workups, and imaging studies. Be suspicious of increases in pain above baseline as pathologic pain promoters are much more likely with advanced age.
- Cognitive impairment resulting from delirium, dementia, or other mental health conditions may make both the assessment and management of symptoms more difficult.
- Patients with complicated emotional issues may describe the pain in imprecise, inconsistent terms.
- Poly-pharmacy is common. Be aware of potential adverse effects from multiple medications.
- Imaging should be symptom and examination driven. Avoid duplication of previous testing.
- The management of symptoms in the older patient follows the same principles as that in younger persons.
- However, the elderly may be more sensitive to medication side effects.[129]

Goals of Treatment for the Elderly Patient

- The goals of treatment are to modulate pain, provide the ability to perform valued activities, improve function, feel well enough to socialize, have the additional freedom from chronic painful conditions; and enhance the quality of life.[130]
- Persistent pain is often multifactorial. It is a treatable, but not curable condition. Let the patient and family know that although pain cannot be eliminated, substantial improvement in function is a realistic goal.

Non-Pharmacological Approach

- Often beneficial with minimal side effects.
- Includes physical therapy, occupational therapy, acupuncture, chiropractic and massage therapy. When ordering therapies, be sure to specify what conditions you want targeted and your goals of treatment.
- Monitor the modalities to ensure that they are being applied appropriately (e.g., positioning, hot/cold).
- Behavioral – Cognitive behavioral therapy and meditation along with patient education.
- Continue these treatments when introducing medications to minimize medications and their side effects.

Pharmacological Approach

Non-Opioids

Non-opioids are preferred over opioids. Use non-opioids primarily for nociceptive pain (post-op pain, mechanical low back pain, injuries/trauma, arthritis). Involve a pharmacist for help in reviewing side effects and concomitant medications (including supplements) for drug-drug/supplement interactions.

- Acetaminophen is the first-line approach to mild, persistent pain
  - Acetaminophen lacks inflammatory activity, therefore, it's use may be limited in the long-term treatment of inflammatory conditions.
  - Beware of potential drug interactions and drug-dosing limits (determine the doses of all acetaminophen-containing products).
  - Reasonable prescribing: 3 grams/24 hours OR fewer than 2 grams in frail patients, those more than 80 years old or those who use alcohol on a regular basis.
- Non-steroidal, anti-inflammatory drugs (NSAIDs)
  - Start at low doses in the elderly.
  - Use briefly; no more than one to two weeks during periods of increased pain.
  - Tailor the medication to the patient's cardiac and GI risk factors.
  - For those at risk for GI complications, add a gastro-protective agent.
  - Potentially lower GI risk with non-acetylate salicylate or COX-2 inhibitors.
  - Use with caution for patients with kidney and heart disease.
- Antidepressants-for chronic neuropathic pain (postherpetic neuralgia, neuropathic back pain, polyneuropathy, trigeminal neuralgia). All have increased side effects in the elderly.131
  - TCAs – Tricyclic antidepressants have been shown to have effectiveness preventing migraine and tension headaches and in treating chronic pain. Common side effects are sedation, cognitive dysfunction, and orthostatic hypotension. Watch for drug and food interactions.
  - SNRIs – Selective noradrenaline reuptake inhibitors (e.g., duloxetine, venlafaxine) are frequently used in treating neuropathic pain.
  - SSRIs – Selective serotonin reuptake inhibitors (e.g., paroxetine, citalopram) have been used in the treatment of neuropathic pain. These agents may be particularly useful in elderly patients because of their favorable side-effect profiles.
- Anticonvulsants – gabapentin, pregabalin, and carbamazepine may be effective for neuropathic pain. Use of these medications is frequently limited because of dizziness, somnolence, fatigue and weight gain. Improved tolerance over time. Their side effects and potential for drug-drug interactions limit their utility in older adults.[132]
  - Start at low doses, titrate slowly upward, and taper off when stopping the medication.

- Transdermal lidocaine can be useful in the elderly to treat neuropathic and localized, nociceptive pain and has a low incidence of side effects which can contribute to falls.
- Muscle relaxants should be avoided in individuals older than 65 because of intolerance to side effects.

Opioids – General Considerations

- Opioid analgesics are the mainstay for the treatment of moderate to severe pain in patients with advanced illness. Long-acting or sustained-release analgesic preparations should be considered for continuous pain based on renal function. Scheduled short acting medication could be considered for impaired renal function to prevent build-up.
- Breakthrough pain should be identified and treated by the use of fast-onset, short-acting preparations.
- Elderly are may be more sensitive to the effects of the opioids, with age-related physiologic changes (e.g., decreased renal or hepatic function and altered body-fat distribution) along with comorbid medical conditions.
- Always consider if there is an alternative therapy that is likely to have an equal or better therapeutic benefit for pain control, functional restoration and improvement in the quality of life.
- Is the patient (or caregiver) likely to manage the opioid use responsibly?
- Patients may require other forms of medication other than solid dosage forms. These may be liquid, patch or injections.
- Try to stay with the least-complicated mode of treatment to help with compliance.
- Opioids can cause mental clouding, which may clear over time. However, there may be persistent sedation, cognitive and psychomotor impairment, hallucinations, dreams and nightmares while on the medication.
- Never initiate opioid therapy with patches or other long-acting opiates in opioid-naïve patients.
- Reasonable dosing recommendations should start at 30 percent to 50 percent of the recommended starting dose at the same dosing intervals, and then titrate doses upward in 25 percent increments for comfort and side-effect tolerance. There is substantial individual variation in the response to the different opioids, and the drug with the most favorable balance between analgesia and side effects cannot be predicted.
- Potential medication choices:
    - Morphine, oxycodone, hydrocodone +/- acetaminophen, hydromorphone, tramadol, fentanyl, buprenorphine. Avoid meperidine and methadone. When choosing a medication, identify the targeted goal of treatment, the preferred route of administration, the patient's frailty and comorbid conditions along with your clinical experience.
- Opioid side effects:
    - Constipation – There is little adjustment to this side effect over time. Constipation is predictable, so start prophylactic laxative therapy when initiating narcotics.
    - Balance/Falls
    - Particularly in patients taking poly-pharmacy, who are deconditioned, or who have vision difficulties.
    - If there is evidence of risk for falls, consider not starting narcotics.
    - Consider a possible referral for PT and mobility aids prior to initiating treatment.
    - Ensure a safe environment for the patient with impaired mobility. Consider a home safety evaluation through the appropriate agency.
    - Respiratory
    - Sleep apnea and sleep-disordered breathing are seen with narcotic use.
    - The exaggerated respiratory depression seen with opioid use can be minimized by starting at low doses and with appropriate titration. Use significant caution when increasing doses, especially in elderly individuals with risk factors for sleep apnea.
    - Nausea is common. Nausea can be minimized with a slow titration upward in the narcotic dosing.

- Depression – Opioids may precipitate or worsen depression, which is a treatable condition that may respond to therapy.
- Opioids affect the functioning of the hypothalamic-pituitary-adrenal axis, resulting in increased levels of prolactin, decreased levels of sex hormones and, rarely, secondary adrenal insufficiency.

Pain Treatment in Patients with Dementia

- In those with advanced dementia who may be unable to communicate verbally about their pain, you may need to evaluate their condition (and their response to treatment) by facial expressions, verbalizations, body movements, changes in interpersonal interactions, activity patterns and routines such as sleep disruption and appetite suppression. Multiple questionnaires have been developed with variable success rates in eliciting pain levels in persons with dementia, with no general consensus on which one is superior.[133]
- Patients may also refusal to take medications, agitation, delirium, increased restlessness, and social withdrawal. Rule out other potential infectious, metabolic, medication- related, and social-situation changes as possible causes for acute decline.
- Prescribe a trial of scheduled medications. Be cautious with scheduled NSAIDs. Use a stepwise approach.
- Start low, go slow, be aware of possible under treatment.
- Monitor the patient carefully to balance the risks and benefits of the treatment.
- Be alert to herbal and dietary supplements taken by older patients who may not volunteer this information. They may be prone to drug-supplement interactions.
- Patients who don’t respond to one medication may respond to another.

Pain Control for Cancer and Palliative Care

Pain control for cancer and palliative care is used when pain and symptom control is important for quality of life. An integrated model of care to address the entire patient, body and mind, is the best approach. This may serve as a bridge to hospice care.

What is Palliative Care

- Palliative care employs an interdisciplinary team to focus on relieving suffering in all stages of disease and is not limited to end-of-life care. This care may occur at the same time as curative or life-prolonging treatments.
- Palliative care is not hospice and doesn't need to have a six-month-terminal-condition prognosis.
- The basic goal of palliative care is symptom management. The care team can typically better manage symptoms of pain, anxiety, shortness of breath, nausea, emesis, constipation, and diarrhea than the busy, multitasking provider.
- Palliative care providers continually strive to clarify the goals of treatment interventions and determine whether they are consistent with the values and decisions of the patient and with the reality of the disease process.
- Palliative care improves quality of life for the patient and their family.
- After serious illnesses, the primary care providers, friends, family members, nursing facilities, specialists, and also hospitalists refer patients to palliative care.
- For patients who have a terminal cancer condition and transition into hospice for palliative care, the goal of treatment for cancer pain is to improve comfort (compared to the goal for treatment of CNCP to improve function). Escalating doses and high MEE per day are not unusual in these circumstances. The risk/benefit balance is not the same as it would be in a patient with the expectation of years of productive life. Care must still be taken to ensure that your medication is going to your patient and not being diverted.

Why Palliative Care is Important

- Primary care management of pain and symptom relief in the pre-terminal and terminal patients may vary considerably between provider offices.
- PCPs may not have the training or experience to feel comfortable with symptom management, and their offices may not have the dedicated resources for integrated services.
- Palliative care teams are responsive to the questions and needs of the patient and families, and can serve as the eyes and ears for the provider.
- Palliative care can serve as a seamless transition to hospice care during the last six months of life.

Palliative Care Approaches

- Palliative care, when initiated early in the treatment of terminal cancer may help people live longer with a better quality of life. It helps patients continue their primary treatment schedule and may help them more effectively transfer to hospice care at an appropriate time.
- Non-pharmacologic treatments may include electrical nerve stimulation and TENS units, therapeutic exercise, splints, and nerve blocks.
- Alternative or complementary therapies for pain may include psychological therapies (e.g., guided imagery, cognitive interventions), acupuncture, music therapy, massage, rehabilitation, and physical therapy, along with other mind-body approaches.
- Pharmacologic approaches to pain include the same medications as mentioned above in Pain Control in the Elderly.
- Novel uses of medications to manage a wide spectrum of symptoms may also be effective.
- Major depression is a treatable condition, even in terminally ill patients.
- Opioids are the mainstay of treatment for pain at the end of life.

Opioid Use During Pregnancy

There are many factors that make opioid use in pregnancy a unique issue, requiring special understanding and careful treatment.[134] Beyond the obvious – that you are treating two patients, the fetus and the mother – there are other considerations.

- These are by definition young patients whose appropriateness for chronic pain treatment and risk factors for abuse are different from older adults.
- Opioid withdrawal involves a number of possible serious prenatal consequences including preterm labor, abruption, and fetal demise.[135]
- Guilt and shame may create a situation whereby the patient downplays the seriousness of her opioid use. Providers may be misled into believing they are dealing with occasional use, when they are in fact dealing with an opioid-use disorder.[136]
- Metabolic changes may occur during pregnancy that reduce the effect, and thereby the dose, of opioids needed to prevent withdrawal.
- Neonatal abstinence syndrome (NAS) is common after prolonged opioid use and is best treated when anticipated prior to delivery.[137]
- Buprenorphine and methadone are the drugs of choice for treating opioid-use disorder in pregnancy. Such treatments should be provided by professionals familiar with the special dosing considerations for this population. Methadone has been used successfully for decades, though it has a higher rate of NAS and opioid-related risks. Buprenorphine is safer for the mother and baby and may be the preferred treatment in selected women.

Managing Patients in the Emergency Department

- To the extent possible only one medical professional should provide all opioids to treat a patient's chronic pain.
- The administration of intravenous and intramuscular opioids in the ED for the relief of acute exacerbations of chronic pain is discouraged.
- Emergency medical professionals should not provide replacement prescriptions for controlled substances that were lost, destroyed or stolen.
- EMPs should not provide replacement doses of methadone for patients in a methadone treatment program.
- Long-acting or controlled-release opioids (e.g., oxycodone ER, fentanyl patches, and methadone) should not be prescribed by EMPs.
- EMPs are encouraged to access the state PMP.
- EMPs should exercise caution when considering prescribing opioids for patients who present to the ED without a government-issued photo ID.
- Primary care and pain-management physicians should make patient opioid agreements accessible to local EDs and work to include a plan for pain treatment in the ED.
- EDs should coordinate the care of patients who frequently visit the ED. An ED coordination program can assist these patients.
- The administration of meperidine in the ED is discouraged.
- ED prescriptions for opioid pain medication for acute injuries should be no more than 3 days of medication. For more serious injuries (fractured bones), the amount prescribed should be an amount that will last until the patient is reasonably able to receive follow-up care for the injury. In most cases, this should not exceed 5 days of medication.
- EMPs are encouraged to ask patients about past or current substance abuse prior to the EMP prescribing opioid medication for acute pain. Prescribe opiates with great caution in the context of substance abuse.
- EMPs are required by law to evaluate an ED patient who reports pain to determine whether an emergency medical condition is present. If an emergency medical condition is present, the EMP is required to stabilize the patient's condition. The law allows the EMP to use his or her clinical judgment when treating pain and does not require the use of opioids.

Recommended Opioid Policy for Dentists

Pain management is routinely required for some dental procedures. Patients must receive respectful care and appropriate management of dental pain.

Most often, dental pain management is for acute or episodic situations, requiring short-term prescribing. For many conditions, ibuprofen, acetaminophen, or a combination of the two will suffice for dental pain. In other circumstances, a very small amount of narcotic medications followed by OTCs will provide appropriate pain relief.

- Prescribe opioids cautiously to those with a substance-abuse history. Be aware that such use can trigger relapse behaviors in susceptible individuals.
- Ask if patients are getting medications from other doctors and use the PMP prior to prescribing opioids.
- Do not prescribe opioids to patients in substance-abuse treatment programs without consulting the program's medical staff.
- Do not offer prescriptions with refills. Use caution if replacing prescriptions that were lost, destroyed or stolen.
- Prescribing over the phone is discouraged, especially with patients you have not met, except in rare cases involving known invasive surgery.
- The use of non-combination opioids is discouraged.
- Prescribe opioids only in small dosages, which in most cases should not exceed three days of medication.
- When prescribing an antibiotic with the opioids, stipulate that the opioid must be filled with the antibiotics at the pharmacy.
- Inform patients how to secure medication against diversion and how to dispose of leftover medication.
- Opioids should not be prescribed more than seven days after the last appointment. In most cases, three days of medication will suffice. It is strongly recommended that the patient be assessed in the clinic prior to providing refills.
- A second refill (same or different opioid) request should require patient assessment in the dental clinic and only be provided once a supporting diagnosis is established to continue with narcotic pain management.
- Third refills are strongly discouraged (except in unusual clinical circumstances that are well documented, such as osteonecrosis management); consider the need for chronic pain management by physician.
- Prolonged pain management (while awaiting specialty care) should be managed by and/or coordinated with the patient's primary care provider.

Tools for Success

Prescription Monitoring Program

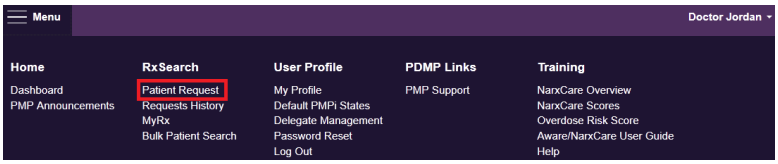
The PMP is an online tool available to all prescribers, pharmacists and delegates in Iowa. Once a prescriber, dispenser and/or designee are registered with the program, he or she can learn exactly which prescription medications have been dispensed to a patient. The value of this information cannot be overstated. We strongly encourage its regular use as an assessment and management tool. Without question, a query of the PDMP should be completed for each patient prior to prescribing/dispensing. Go to **https://iowa.pmpaware.net** for additional details about the Iowa PMP including how to access the PMP and other related resources.

For information on how to perform a request, the Board of Pharmacy has provided the following guide.

Quick Reference Guide – Making a Request in PMP AWARxE

1. Go to the PMP AWARxE login page (https://iowa.pmpaware.net/login). *If a password reset is needed, use the **"Reset Password"** link.*

2. Click the Menu button, then under **RxSearch**, choose **Patient Request**.



3. Enter search criteria.

At a minimum, you must provide:

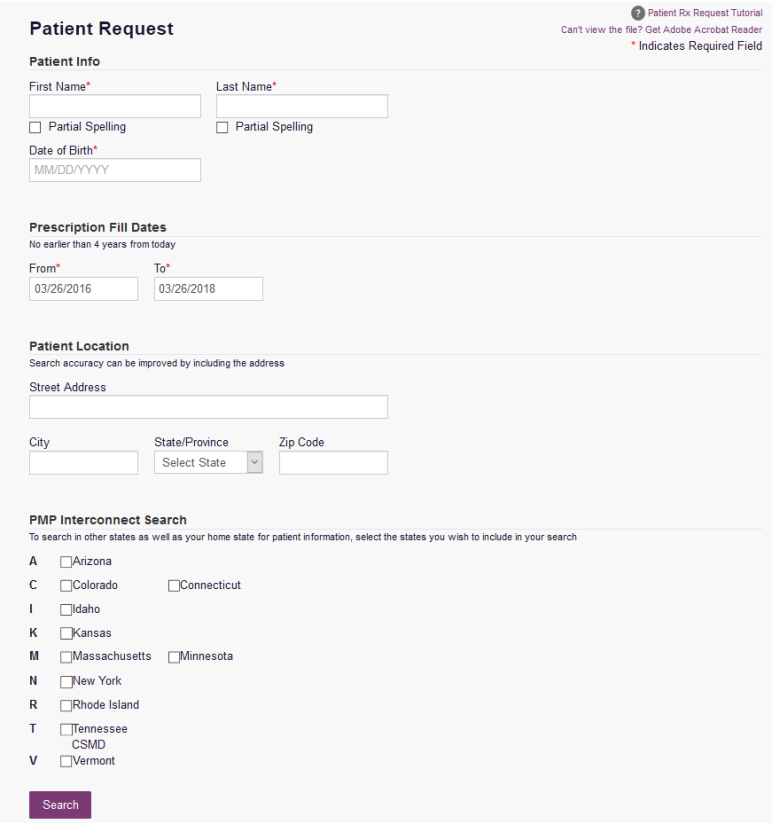
- ***First name*** (full or partial*)
- ***Last name*** (full or partial*)
- ***Date of birth*** (MM/DD/YYYY)
- ***Prescription fill dates*** (MM/DD/YYYY)

4. Click ***Search*** at the bottom of the screen to submit your request.

5. Matching patient history will now display. If ***multiple patients*** are identified, you will be presented with the option to ***refine your search*** by providing additional search information or you can select a ***single, multiple, or all returned patient groups*** to include in your patient prescription request results.

6. Click on "**Run Report**", the patient prescription results will be displayed.

7. Print form by clicking on the PDF button or convert the form to a CSV (Microsoft Excel) file. You may retrieve your searches and the search results of any delegates by clicking on the **Requests History** tab.



Search Tips:

- ***Partial Spelling**:* Using Partial Spelling can be helpful for hyphenated or commonly abbreviated names (Will vs. William). At a minimum, enter the first three characters of the patient's first and/or last name.
- ***Prescription Fill Dates*** - The maximum time period for your search is 48 months.
- ***PMP Interconnect Search*** - allows you to search other participating state databases for the patient's records. Your available states may not match the above image.
    - To improve the likelihood of finding a specific patient:
- For out-of-state searches – Limit your search criteria to only the required fields.
- For in-state searches – In addition to the required fields, include additional details such as ZIP code.

Concomitant Benzodiazepine and Opioid Use

Most experts advise against concomitant use of benzodiazepines and opioids because of the black box warning of increased risk of death when these medications are used in combination exacerbate respiratory depression. As many as 50 percent of opioid overdoses have involved sedative hypnotics. In addition, the anterograde amnesia that is inevitable with benzodiazepines can contribute to inadvertent overdose for predisposed individuals. It is strongly recommended that you check for benzodiazepines use by PMP query as well as observing for impairment or sedation. Psychotherapy is often helpful as an adjunct to tapering (see Tapering in this document). Some individuals may require inpatient treatment to successfully discontinue use. Many patients who are dependent on benzodiazepines have a difficult time abstaining from other sedative hypnotic substances (such as alcohol, barbiturates, and carisoprodol). These drugs have similar risks for overdose when combined with opioids.

Medication Disposal

Unused or expired medication can fall into the wrong hands and lead to accidental poisoning or illegal use. Medications should not be flushed down the toilet or put in the trash. If disposed of improperly, medications can harm the environment. The ability to safely dispose of unused medications is an important strategy in the fight to reduce unnecessary opioids in circulation.

Iowa Board of Pharmacy and the Iowa Office of Drug Control Policy have place medication disposal boxes in pharmacies and law enforcement offices in all 99 counties. Patients can take their unwanted or expired controlled and non-controlled medications to the participating locations and a pharmacist or police officer will assist them with the disposal process.

To locate a participating facilities, go to **https://iowa.maps.arcgis.com/apps/webappviewer/index.html?id=5377c6d482424157aa013cff0afdcd31** and enter the zip code of the patient's location.

Additionally, the Drug Enforcement Agency hosts Drug Take Back days across the state on the fourth Saturday of April and October every year.

Medication-Assisted Treatment

Medication-assisted treatment refers to the use of pharmaceutical agents to treat Opioid Use Disorder. Generally, methadone, buprenorphine, and naltrexone sustained release are used for this purpose. Methadone and buprenorphine have the highest rates of success for opioid-use disorder, an important consideration when weighing the risks associated with misuse versus the greater relapse rate associated with non-medication treatment regimens.

Remember, those with opioid addiction are living with a potentially fatal chronic disease and deserve prompt and effective treatment.

- Methadone can only be prescribed for addiction treatment in a federally monitored treatment facility.
- Methadone treatment for chronic pain should be used cautiously, if at all, and only at low doses. Significantly higher daily doses (80–100 mg average) are used when treating opioid-use disorder because the MAT clinic can institute tight medication oversight such as daily nurse monitoring, counseling, UDS, and PMP query. The use of high-dose methadone in such circumstances does not carry the same degree of risk as it would in a primary-care setting.
- Any prescriber in an office setting can prescribe buprenorphine, after taking a brief educational course and getting an "X" waiver added to their DEA number.[138] Buprenorphine is safer than methadone and generally more

convenient to the patient. It is recommended that if you prescribe opioids for chronic pain, you should either become a buprenorphine prescriber or have ready access to that service.

- Medication-assisted treatment should be accompanied by ongoing behavioral supports, and it is strongly recommended that providers of care utilize such expertise as a part of their treatment plan.
- Recognizing Opioid Use Disorder in your patient should trigger an immediate referral to an effective treatment program or, if you are X waivered, a switch to buprenorphine treatment.
- Naltrexone-sustained release can be another useful tool for the patient motivated looking to maintain opioid abstinence with antagonist-MAT. It also can be provided in a practitioner's office.

To locate the local MAT facility in your areas please visit: **https://iowa.maps.arcgis.com/apps/LocalPerspective/index.html?appid=924e0f99711b406dbf22a34cf46fc6e1**

Heroin

There has been a rise in heroin use, heroin overdoses, and heroin treatment admissions in the U.S. over the past decade.[46] Opioid dependency does not differentiate between mu agonists, so individuals who develop a substance-use disorder with prescription opioids will find symptomatic relief with any opioid, including heroin. In many parts of the country, heroin is cheaper than pills and is accessible almost everywhere. Therefore, many individuals who could not stop using pain medicines because of dependency and whose demand exceeded their supply turned to heroin use.

Heroin can be smoked, snorted, or injected. It comes in various forms: black tar, gunpowder and white powder. The potency of the drug varies both regionally as well as temporally, making dosing decisions on the part of the user difficult and dangerous. Overdoses are common, particularly when an a person with substance use disorder has reduced his or her tolerance (jail, prison, sobriety based on residential treatment) and then resumes use. Concomitant use of sedative hypnotics such as alcohol, benzodiazepines, carisoprodol and sleeping aids increase the risk of overdose.

The most effective treatment for heroin addiction (as well as all Opioid Use Disorder) is Medication Assisted Treatment. Any treatment that results in discontinuation of opioids has a risk of relapse, and with relapse at a reduced tolerance comes increased risk of overdose. Risk of relapse and overdose should be an educational component to all opioid treatment.

Bystander naloxone is an essential "downstream" treatment that reduces mortality from opioid overdose. See the Naloxone section (below) in this document.

Individuals with a history of heroin use, past or present, are at high risk of inappropriate use of prescription opioids. Such individuals can safely be treated using buprenorphine or methadone, and primary-care or pain-specialty providers need to be very cautious treating such individuals for pain using opioids.

Naloxone

Naloxone is a pure mu antagonist, and as such, it is an antidote to the effects of opioid intoxication. It reverses respiratory depression that is the cause of death in an opioid overdose. Naloxone has essentially no adverse effects and is remarkably successful in reversing the life- threatening effect of opioids. The incidence of opioid overdose is dose related, but anyone taking opioids is potentially at risk. Therefore, we recommend co-prescribing naloxone for the families and loved ones of all patients prescribed opioids for chronic use.

Naloxone displaces other opioids off the mu receptor sites, but is has a short half-life, having an effect for 30 to 90 minutes. After the drug wears off, the agonists may again reattach to the receptors. Anyone requiring naloxone

treatment should be transported to an emergency department for further evaluation since return to the overdose state is possible with the passage of time after the initial naloxone treatment.

Naloxone can be administered parenterally (IV or IM), but it is also effective as a nasal spray. The drug has a very rapid onset of effect when given IV. Its onset of action is more gradual, but still lifesaving, when given via intra-nasal spray. Lay persons can easily be trained to use the intranasal product.

Naloxone is a drug administered by another person to rescue an individual who is overdosing on an opioid. Friends or relatives are often the ones who are present at the time of an overdose and are therefore the individuals who need to receive naloxone training.

Naloxone Co-Prescribing

Everyone taking opioids on a daily basis should have their friends or loved ones trained in naloxone use. It should be a part of a routine prescribing protocol for prescribers. It communicates your concerns about safety to your patient. Think of naloxone in the same manner as we prescribe glucose tabs to patients with diabetes or EpiPens to patients with life threatening allergies.

Overdose Risk Factors

As was stated earlier, all individuals taking opioids are at some risk of an overdose. Certain factors will increase that risk:

- Individuals taking sedative-hypnotics (alcohol, benzodiazepines) in addition to opioids are at increased risk. Such individuals may have a partial response to naloxone, since the drug only acts to reverse the opioid component of the overdose.
- Individuals whose opioid tolerance has decreased are at risk. This includes people who leave residential addiction-treatment programs or are released from incarceration.
- Individuals whose dose of opioids is suddenly increased are at risk. A sudden increase in opioid dosing, or a new source of heroin, stronger than what the user was expecting, for example.
- Someone who has previously overdosed is at risk of overdosing again.

Further Resources

- Iowa pharmacies can dispense naloxone without a prescription under a statewide standing order. For more information and to view which pharmacies are participating (note that pharmacies are not required to report if they are participating. Your local pharmacy may be participating but not on this list. Please contact them to inquire about participation) please visit: **https://pharmacy.iowa.gov/naloxone-standing-order**.
- Prescribe to Prevent offers physician and pharmacist resources, advocacy information, patient handouts, research and legal resources. For more information please visit: **http://prescribetoprevent.org/**.
- Resources for advocates, families and providers (including prescribing information): **www.prescribetoprevent.org**
- San Francisco Health Department provider guide to prescribing naloxone: **http://www.sfhealthnetwork.org/wp-content/uploads/26a-Detailing_Provider_final.pdf**
- San Francisco Health Department brochure for patients: **http://www.sfhealthnetwork.org/wp-content/uploads/27-Detailing_Patient_final.pdf**

Tools

Assessment Tools

There are various tools that can assist in evaluating and managing patients with chronic pain. The following is a brief overview of the tools. Tools can be found in the **Appendices**.

Opioid Risk Tool (ORT)

The ORT is one of the easiest assessment tools for establishing a patient's susceptibility to misuse of opioids. Other tools are available and are equally appropriate. The ORT is provided in **Appendix E**. The CDC guidelines suggest that such tools have a low degree of predictability and should be used as only one component of assessment of risk.

SOAPP-R (Screening and Opioid Assessment for Patients with Pain-Revised Screening Test)

The SOAPP-R is a brief screening test to help predict possible opioid abuse in adult chronic pain patients. A high score on the SOAPP-R correlates with an increased likelihood of drug abuse. See **Appendix F**.

Patient Health Questionnaire for Anxiety and Depression (PHQ)

The correlation between mental health issues and opioid misuse is well established. The PHQ is a tool to help you identify individuals who are at risk of misusing opioids and benzodiazepines because of mental health issues. Depression and, to a lesser extent, anxiety, are well-known risk factors. Bipolar disorder, PTSD, and certain personality disorders are risk factors as well. Tools like the PHQ are especially useful when used in the context of behavioral health evaluation and/or physical exam. A positive score on the PHQ or other tests, the presence of suicidal ideation, and/or your clinical judgment may indicate that further assessment is warranted. The PHQ-4 is a short questionnaire and can be found in **Appendix I**.

Screening for Post-Traumatic Stress Disorder (PTSD)

PTSD in the form of childhood trauma is a common confounding problem in patients with chronic pain, and in those who become dependent on benzodiazepines. Ensuring you practice trauma-informed care is essential to managing chronic pain patients. See "Primary Care PTSD Screen" in **Appendix K**.

S T O P B A N G

S T O P B A N G helps evaluate the risk of respiratory depression with opioids. Pain often disrupts sleep in chronic pain patients, and the resulting insomnia may increase pain intensity and reduce the pain threshold. Opioids can significantly increase the chance of central sleep apnea, and must be used with caution, especially in those patients identified to have possible obstructive sleep apnea (OSA) prior to the initiation of opioid therapy. Assessment of sleep disturbances is a key metric for evaluating patient risk as well as for monitoring opioid therapy. The S T O P B A N G assessment is provided in **Appendix M**.

Chronic Pain Treatment Checklist

This checklist may be useful as a means to ensure compliance with these guidelines with a standardized approach to every pain patient. See **Appendix R**.

Laboratory Screenings

Urinary Drug Testing

Urinary drug testing helps monitor for unexpected licit and illicit drugs that may be present in your patient's urine. Urinary drug testing should be used with every chronic pain patient as a standard part of your office policy. There are three basic types of urine drug tests: immunoassay screening methods used in most laboratories, POC testing (in office) and confirmatory (usually larger reference laboratory based chemical methods). See **Appendix G** for urinary drug testing frequently asked questions.

Point of Care (POC)

Advantages and limitations: POC tests are inexpensive and easily performed. Testing kits can be configured to your needs. Most common drugs to be included: opiates, benzodiazepines, methadone, amphetamine/methamphetamine, cocaine, THC and oxycodone. Other tests commonly included are PCP, barbiturates, and alcohol, but many others are often optional single tests (fentanyl, buprenorphine, for example).

Remember that these are management tools, not definitive tests to determine deception or illicit use. These tests have a fairly high rate of false negative and false positives. Their interpretation is fraught with difficulties. Understanding of metabolic pathways, cutoff levels, drug-drug interactions, and what drugs are and are not picked up on a particular test are essential to the interpretation of POC testing. Laboratory-based immunoassays may suffer similar shortcomings. Some examples:

- Hydrocodone and/or oxycodone may not detected by the assay.
- Hydrocodone can metabolize to hydromorphone and be detected as Dilaudid, when in fact none was prescribed.
- Diazepam metabolizes to Oxazepam and can present as a drug not prescribed.
- Clonazepam and lorazepam are sometimes not detected on the benzodiazepine screen.
- Amphetamines appear as a false positive result with some frequency.

Confirmatory Lab-Based Tests

Advantages: These tests, GC-MS and LC/MS-MS, can be highly accurate, depending on the type used. For instance, LC/MS-MS testing allows for extremely low opiate cutoffs.

Limitations: Many lab-based tests are quite expensive. Some clinics use them for verification purposes. One approach is to use POC testing first and, if results are unexpected, following up with a laboratory test.

Metabolism Data for Common Medications

This is a table of useful information regarding the metabolism of common opioids and other medications. The time limits of detection, tests to order, and "expected results" are listed in **Appendix T**.

Patient-Provider Communication

Pain Treatment Agreements

Many providers wish to have conditions of treatment clearly stated in a written document prior to prescribing. Samples patient agreements are provided in **Appendix U**.

Material Risk Notice

This tool outlines parameters, risks, and alternative therapies for patients using opioids. See example in **Appendix V**.

Medical Risks of Long-Term Opioid Use

Many patients are not familiar with the wide range of medical risks of long-term opioid use. When they understand the risks involved, they are more likely to be receptive to reducing or discontinuing opioid use. We recommend that you print out this one-page document, give it to your patient and go over with them the many risks and side effects of using opioids long term. This patient education handout is provided in **Appendix W**.

Assessing Progress

Graded Pain and Function Scale

The goal of opioid treatment is to improve function, both physical and emotional. Activities of daily living (ADLs) are critical to evaluate at each visit, as are other quality-of-life indicators. This is a very simple tool to track function and pain over time. The graded pain and function scale is provided in **Appendix X**.

Oswestry Low-Back Pain Disability Questionnaire

This is a comprehensive functional assessment tool for following a patient's "functional progress" over time. The form is provided in **Appendix Y**.

PEG-3 Pain Screening Tool

This three-question tool helps the provider determine the impact that pain is having on a patient's activity level and quality of life. The PEG-3 is a useful assessment tool that can be used routinely at follow-up visits for chronic pain patients. See **Appendix Z**.

Additional Assessment Tools

A description of many of the commonly used screening tools for substance-abuse history, mental health history (including suicidal ideation or attempts), activities of daily living (ADLs), and a patient's own disability perception. This list is provided in **Appendix AA**.

Opioid Withdrawal Attenuation Cocktail

This is a list of medications that can be used to help manage "withdrawal symptoms" in patients who are being tapered down or off of their opioids. See **Appendix AB**.

Patient and Community Resources

This is a Nebraska resource that includes brief screening tools, referral and treatment options and additional resources available. See **Appendix AC**.

4 As

This is a method to monitor patients who are being treated for pain. Four domains are summarized as the 4 As and are vital data to enter into the medical records as they provide a framework for the appropriate documentation. See **Appendix AD**.

DAST-20

This is a brief and valid method for identifying individuals who use psychoactive drugs that yields the degree of problems related to drug use. See **Appendix AE**.

Iowa Statewide Initiatives

State Targeted Response[139]

Iowa opioid State Targeted Response (STR) is a two-year Substance Abuse and Mental Health Services Administration (SAMHSA) supported initiative to expand and enhance Opioid Use Disorder prevention and treatment services across Iowa. This initiative is housed in the Iowa Department of Public Health.

The purpose is to build community capacity for a successful community response to the opioid crisis through the following goals:

- Build an enhanced, statewide infrastructure to address opioid misuse in Iowa
- Increase awareness of opioid risks through statewide prevention efforts
- Increase the use of Medication Assisted Treatment and other evidence-based practices in Iowa

Additional information can be found at: **https://idph.iowa.gov/mat**

Medication Assisted Treatment Prescription Drug and Opioid Addiction[139]

Medication Assisted Treatment for Prescription Drug and Opioid Addiction (MAT-PDOA) is a three year SAMHSA-supported initiative to expand and enhance Substance Use Disorder (SUD) treatment services across Iowa. This initiative is housed in the Iowa Department of Public Health.

The purpose is to provide a broad array of best practices including MAT for prescription drug and Opioid Use Disorder treatment and integrated care services in four Iowa counties with the demonstrated need to enhancement and expansion of opioid treatment services. This grant includes support for project-specific recovery support services, including medications, medical consultation, and care coordination. Organizations will implement and follow MAT best practices and will leverage funding for related services such as counseling and additional recovery support services through other IDPH- funded sources such as Access to Recovery and the Substance Abuse Prevention and Treatment Block Grant. Organizations will offer a selection of MAT medications including:

- Methadone
- Buprenorphine (Subutex)
- Buprenorphine/Naloxone (Suboxone, Zubsoly)
- Naltrexone (Revia, Depade, Vivitrol)

Additional information can be found at: **https://idph.iowa.gov/mat**

Free training for Medication Assisted Treatment is available through the Providers Clinical Support System and can be accessed at **https://pcssnow.org/**.

More information on how to obtain a DEA DATA 2000 waiver to provide buprenorphine in your practice can be found at **https://www.samhsa.gov/programs-campaigns/medication-assisted-treatment/training-materials-resources/buprenorphine-waiver**.

Opioid Guardianship

The Iowa Healthcare Collaborative Opioid Guardianship Quality Improvement Project is a project that begin in the hospital setting with the goal of reframing expectations of healthcare professionals, patients, caregivers, and the community on proper utilization of opioid medication through the use of comfort resources, individualized treatment plans and reduction of the number of opioids prescribed for acute pain.

Participating facilities are utilizing comfort resources (see Appendix **O**, **P** and **Q**) to frame this discussion and provide a higher level of patient care. Resources can be used without the permission of the organization.

National Movements

Nation Opioid Strategy[140]

The office of the Assistant Secretary for Health and National Institutes of Health of the U.S. Department of Health and Human Services asked the Interagency Pain Research Coordinating Committee to oversee creation of a National Pain Strategy. Experts from a broad array of public and private organizations explored areas identified in the core Institute of Medicine recommendations – population research, prevention and care, disparities, service delivery and reimbursement, professional education and training, and public awareness and communication. This strategy can be found at **https://iprcc.nih.gov/sites/default/files/HHSNational_Pain_Strategy_508C.pdf**

CDC Rx Awareness Campaign[141]

The Rx Awareness campaign tells the real stories of people whose lives were torn apart by prescription opioids. The goal of the campaign is to increase awareness that prescription opioids can be addictive and dangerous. The campaign also strives to decrease the number of individuals who use opioids recreationally or overuse them. Additional information on this campaign can be found at **https://www.cdc.gov/rxawareness/index.html**.

Turn the Tide[142]

Turn the Tide is the Surgeon General's call to end the opioid crisis. There is a pledge that healthcare providers can take to show their support of ending the opioid crisis. For more information and to take the pledge go to **https://turnthetiderx.org/**.

Stem the Tide[143]

Stem the tide is a toolkit released by the American Hospital Association. This toolkit provides guidance and information to hospitals and health systems on how they can partner with patients, clinicians and communities to address the opioid epidemic. More information on this toolkit can be found at **https://www.aha.org/guidesreports/2017-11-07-stem-tide-addressing-opioid-epidemic**.

CMS Medication Management of Opioid Pledge[144]

The Centers for Medicare and Medicaid Services has created a Medication Management of Opioid (MMO) Initiative. The intent of this pledge is to generate commitments from clinicians, practices and improvement networks and

organizations to be in action by signing the MMO Pledge. The pledge is open to all clinicians and partners to complete. For more information and to sign the pledge please go to **https://www.healthcarecommunities.org/Home/MMOPledge.aspx**.

National Vital Statistics Report[145]

National Vital Statistics System (NVSS) houses information on demographic, geographic and cause-of-death. This is one of the few sources of health-related data that are comparable for small geographic areas and are available for a long time period in the United States. More information on the NVSS can be found at **https://www.cdc.gov/nchs/nvss/deaths.htm**.

Federal Information on Opioids[146]

Opioids.gov is the White House's landing page for information on opioids. Information on the crisis, safer prescribing, illicit supply, saving lives and opioids in veterans can be found at **www.opioids.gov**.

American Medical Association End the Epidemic[147]

The American Medical Association convened a task force to create recommendations on PDMPs, education, treatment, stigma, naloxone, and safe storage and disposal of opioids. This website also has information on how to run a social media campaign around opioids. For more information, please visit **www.end-opioid-epidemic.org**.

Crisis Next Door[148]

Crisis Next Door provides an opportunity for patients who have experience Opioid Use Disorder, their families and loved ones to share their story. This site is meant to show the stories of Americans affected by Opioid Use Disorder in the most raw and real state. No makeup, lighting or backdrop required. Join the movement and share your story at **www.crisisnextdoor.gov**.

SAMHSA Mental and Substance Abuse Disorder Website[149]

Resources for mental health disorders, substance use disorders, and co-occurring disorders is available on the Substance Abuse and Mental Health Services Administration (SAMHSA) at **www.samhsa.gov/disorders**.

Prescription Drug Abuse Policy System[150]

The Prescription Drug Abuse Policy System is a source of rigorous legal data for researchers and detailed policy information for the public. Policy, rules, and regulation related to opioids, naloxone, PMPs, and other related topics can be found in both text and map graphic format. For information on states policy, rules, and regulations visit **www.pdaps.org**.

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Appendices

Appendix A: Comprehensive Patient Evaluation

Social history:

- Employment Status
- Social network
- Marital history
- History of legal problems related to controlled substances

Medical History:

- Assess the pain, emphasizing functional deficits prior to treatment
- Determine the cause of the pain and the severity of the pain
- Assess effects of the pain on the patient's life and function, including the functional status of the patient during work, home and family activities, and recreational activities
- Patient's perceived quality of life using a method/instrument that can be used later to evaluate treatment effectiveness
- Assess for the presence of medical conditions that might complicate the treatment of the pain, including medication allergy, cardiac or respiratory disease, liver disease, renal disease, and sleep apnea or the risk factors for sleep apnea

Mental Health and Substance Use History:

- Obtain history of substance use, addiction, or dependence
- Assess the use of other substances, including alcohol, and illicit drug use such as marijuana, cocaine, and methamphetamines
- Identify use of other medications that might interact with medications used to treat the pain. Particular attention should be given to benzodiazepines and other sedative medications
- Identify psychiatric conditions that may affect pain or treatment of pain Ask patient about other depressants they are taking, including benzodiazepines and diphenhydramine which is contained in the over-the-counter products, Benadryl™ and Sominex™ as they are risks for opioid overdose
- Assess and evaluate prior approaches to the patient's pain management
- Assess risk of sleep apnea

Physical Examination: including stigmata of alcohol/tobacco/illicit drug use; sleep apnea risk

Appendix B: PADT™: Pain Assessment and Documentation Tool

PROGRESS NOTE
Pain Assessment and Documentation Tool (PADT™)

Patient Stamp Here

Patient Name: _____ Record #: _____

Assessment Date: _____

Current Analgesic Regimen

Drug name	Strength (eg, mg)	Frequency	Maximum Total Daily Dose

The PADT is a clinician-directed interview; that is, the clinician asks the questions, and the clinician records the responses. The Analgesia, Activities of Daily Living, and Adverse Events sections may be completed by the physician, nurse practitioner, physician assistant, or nurse. The Potential Aberrant Drug-Related Behavior and Assessment sections must be completed by the physician. Ask the patient the questions below, except as noted.

Analgesia

If zero indicates "no pain" and ten indicates "pain as bad as it can be," on a scale of 0 to 10, what is your level of pain for the following questions?

1. What was your pain level on average during the past week? (Please circle the appropriate number)

No Pain 0 1 2 3 4 5 6 7 8 9 10 **Pain as bad as it can be**

2. What was your pain level at its worst during the past week?

No Pain 0 1 2 3 4 5 6 7 8 9 10 **Pain as bad as it can be**

3. What percentage of your pain has been relieved during the past week? (Write in a percentage between 0% and 100%.) _____

4. Is the amount of pain relief you are now obtaining from your current pain reliever(s) enough to make a real difference in your life?
❑ Yes ❑ No

5. **Query to clinician:** Is the patient's pain relief clinically significant?
❑ Yes ❑ No ❑ Unsure

Activities of Daily Living

Please indicate whether the patient's functioning with the current pain reliever(s) is Better, the Same, or Worse since the patient's last assessment with the PADT.* (Please check the box for Better, Same, or Worse for each item below.)

	Better	Same	Worse
1. Physical functioning	❑	❑	❑
2. Family relationships	❑	❑	❑
3. Social relationships	❑	❑	❑
4. Mood	❑	❑	❑
5. Sleep patterns	❑	❑	❑
6. Overall functioning	❑	❑	❑

* If the patient is receiving his or her first PADT assessment, the clinician should compare the patient's functional status with other reports from the last office visit.

(Continued on reverse side)

Appendix B: PADT™: Pain Assessment and Documentation Tool (Cont.)

PROGRESS NOTE
Pain Assessment and Documentation Tool (PADT™)

Adverse Events

1. Is patient experiencing any side effects from current pain reliever(s)? ❑ Yes ❑ No

Ask patient about potential side effects:

	None	Mild	Moderate	Severe
a. Nausea	❑	❑	❑	❑
b. Vomiting	❑	❑	❑	❑
c. Constipation	❑	❑	❑	❑
d. Itching	❑	❑	❑	❑
e. Mental cloudiness	❑	❑	❑	❑
f. Sweating	❑	❑	❑	❑
g. Fatigue	❑	❑	❑	❑
h. Drowsiness	❑	❑	❑	❑
i. Other _____	❑	❑	❑	❑
j. Other _____	❑	❑	❑	❑

2. Patient's overall severity of side effects?
❑ None ❑ Mild ❑ Moderate ❑ Severe

Potential Aberrant Drug-Related Behavior
This section must be completed by the physician.

*Please **check** any of the following items that you discovered during your interactions with the patient.* Please note that some of these are directly observable (eg, appears intoxicated), while others may require more active listening and/or probing. Use the "Assessment" section below to note additional details.

- ❑ Purposeful over-sedation
- ❑ Negative mood change
- ❑ Appears intoxicated
- ❑ Increasingly unkempt or impaired
- ❑ Involvement in car or other accident
- ❑ Requests frequent early renewals
- ❑ Increased dose without authorization
- ❑ Reports lost or stolen prescriptions
- ❑ Attempts to obtain prescriptions from other doctors
- ❑ Changes route of administration
- ❑ Uses pain medication in response to situational stressor
- ❑ Insists on certain medications by name
- ❑ Contact with street drug culture
- ❑ Abusing alcohol or illicit drugs
- ❑ Hoarding (ie, stockpiling) of medication
- ❑ Arrested by police
- ❑ Victim of abuse

Other: _____
_____
_____

Assessment: (This section must be completed by the physician.)

Is your overall impression that this patient is benefiting (eg, benefits, such as pain relief, outweigh side effects) from opioid therapy? ❑ Yes ❑ No ❑ Unsure

Comments: _____
_____

Specific Analgesic Plan:

- ❑ Continue present regimen
- ❑ Adjust dose of present analgesic
- ❑ Switch analgesics
- ❑ Add/Adjust concomitant therapy
- ❑ Discontinue/taper off opioid therapy

Comments: _____
_____
_____
_____
_____

Date: _____ Physician's signature: _____

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Appendix C: BPI©: Brief Pain Inventory

STUDY ID #:_____ DO NOT WRITE ABOVE THIS LINE HOSPITAL #:_____

Brief Pain Inventory (Short Form)

Date: ____/____/____ Time: _____

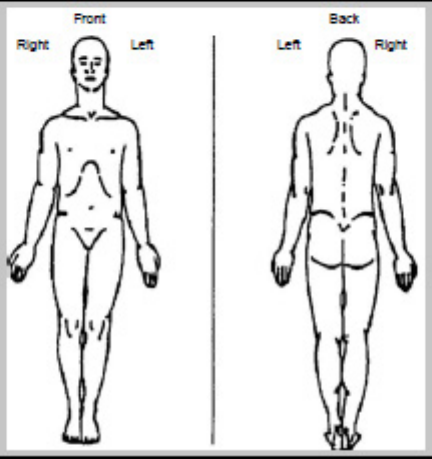
Name: _____ _____ _____

Last First Middle Initial

1. Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain other than these every-day kinds of pain today?

1. Yes 2. No

2. On the diagram, shade in the areas where you feel pain. Put an X on the area that hurts the most.



3. Please rate your pain by circling the one number that best describes your pain at its worst in the last 24 hours.

0	1	2	3	4	5	6	7	8	9	10
No Pain										Pain as bad as you can imagine

4. Please rate your pain by circling the one number that best describes your pain at its least in the last 24 hours.

0	1	2	3	4	5	6	7	8	9	10
No Pain										Pain as bad as you can imagine

5. Please rate your pain by circling the one number that best describes your pain on the average.

0	1	2	3	4	5	6	7	8	9	10
No Pain										Pain as bad as you can imagine

6. Please rate your pain by circling the one number that tells how much pain you have right now.

0	1	2	3	4	5	6	7	8	9	10
No Pain										Pain as bad as you can imagine

Page 1 of 2

Appendix C: BPI©: Brief Pain Inventory (Continued)

STUDY ID #:_____ DO NOT WRITE ABOVE THIS LINE HOSPITAL #:_____

Date:____/____/____ Time:_____

Name:_____ _____ _____

Last First Middle Initial

7. What treatments or medications are you receiving for your pain?

8. In the last 24 hours, how much relief have pain treatments or medications provided? Please circle the one percentage that most shows how much relief you have received.

0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
No Relief										Complete Relief

9. Circle the one number that describes how, during the past 24 hours, pain has interfered with your:

A. General Activity

0	1	2	3	4	5	6	7	8	9	10
Does not Interfere										Completely Interferes

B. Mood

0	1	2	3	4	5	6	7	8	9	10
Does not Interfere										Completely Interferes

C. Walking Ability

0	1	2	3	4	5	6	7	8	9	10
Does not Interfere										Completely Interferes

D. Normal Work (includes both work outside the home and housework)

0	1	2	3	4	5	6	7	8	9	10
Does not Interfere										Completely Interferes

E. Relations with other people

0	1	2	3	4	5	6	7	8	9	10
Does not Interfere										Completely Interferes

F. Sleep

0	1	2	3	4	5	6	7	8	9	10
Does not Interfere										Completely Interferes

G. Enjoyment of life

0	1	2	3	4	5	6	7	8	9	10
Does not Interfere										Completely Interferes

Page 2 of 2

Appendix D: Dire Opioid Risk Tool

DIRE Score: Patient Selection for Chronic Opioid Analgesia

For each factor, rate the patient's score from 1-3 based on the explanations in the right-hand column

SCORE	FACTOR	EXPLANATION
	DIAGNOSIS	1 = Benign chronic condition with minimal objective findings or no definite medical diagnosis. Examples: fibromyalgia, migraine headaches, non-specific back pain. 2 = Slowly progressive condition concordant with moderate pain, or fixed condition with moderate objective findings. Examples: failed back surgery syndrome, back pain with moderate degenerative changes, neuropathic pain. 3 = Advanced condition concordant with severe pain with objective findings. Examples: severe ischemic vascular disease, advanced neuropathy, severe spinal stenosis.
	INTRACTABILITY	1 = Few therapies have been tried and the patient takes a passive role in his/her pain management process. 2 = Most customary treatments have been tried but the patient is not fully engaged in the pain management process, or barriers prevent (insurance, transportation, medical illness). 3 = Patient fully engaged in a spectrum of appropriate treatments but with inadequate response.
0	**R**ISK	(**R** = Total of **P+C+R+S** below)
	Psychological	1 = Serious personality dysfunction or mental illness interfering with care. Example: personality disorder, severe affective disorder, significant personality issues. 2 = Personality or mental health interferes moderately. Example: depression or anxiety disorder. 3 = Good communication with clinic. No significant personality dysfunction or mental illness.
	Chemical Health	1 = Active or very recent use of illicit drugs, excessive alcohol, or prescription drug abuse. 2 = Chemical coper (uses medications to cope with stress) or history of chemical dependence (CD) in remission. 3 = No CD history. Not drug-focused or chemically reliant.
	Reliability	1 = History of numerous problems: medication misuse, missed appointments, rarely follows through. 2 = Occasional difficulties with compliance, but generally reliable. 3 = Highly reliable patient with meds, appointments & treatment.
	Social Support	1 = Life in chaos. Little family support and few close relationships. Loss of most normal life roles. 2 = Reduction in some relationships and life roles. 3 = Supportive family/close relationships. Involved in work or school and no social isolation.
	EFFICACY SCORE	1 = Poor function or minimal pain relief despite moderate to high doses. 2 = Moderate benefit with function improved in a number of ways (or insufficient info – hasn't tried opioid yet or very low doses or too short of a trial). 3 = Good improvement in pain and function and quality of life with stable doses over time.

0 **Total score = D + I + R + E**

Score 7-13: Not a suitable candidate for long-term opioid analgesia

Score 14-21: May be a good candidate for long-term opioid analgesia

NOTES

A DIRE Score of ≤13 indicates that the patient may not be suited to long-term opioid pain management.

Appendix E: ORT©: Opioid Risk Tool

			Mark each box that applies	Item score if FEMALE	Item score if MALE
1	Family history of substance abuse	Alcohol	☐	1	3
		Illegal drugs	☐	2	3
		Prescription drugs	☐	4	4
2	Personal history of substance abuse	Alcohol	☐	3	3
		Illegal drugs	☐	4	4
		Prescription drugs	☐	5	5
3	Age (mark box if 16–45)			1	1
4	History of preadolescent sexual abuse		☐	3	0
5	Psychological disease	Attention deficit disorder	☐	2	2
		Obsessive compulsive disorder	☐	2	2
		Bipolar	☐	2	2
		Schizophrenia	☐	2	2
		Depression	☐	1	1
			TOTAL	_____	_____

Total Score Risk Category

0–3 = low risk

4–7 = moderate risk

≥8 = high risk

Reference: Webster LR. Predicting aberrant behaviors in opioid-treated patients: Preliminary validation of the opioid risk tool. *Pain Medicine.* 2005; 6 (6):432-44. Used with permission.

Appendix F: SOAPP®-R: Screen and Opioid Assessment for Patients with Pain

The following are some questions given to patients who are on or being considered for medication for their pain. Please answer each question as honestly as possible. There are no right or wrong answers.	Never 0	Seldom 1	Sometimes 2	Often 3	Very Often 4
1. How often do you have mood swings?					
2. How often have you felt a need for higher doses of medication to treat your pain?					
3. How often have you felt impatient with your doctors?					
4. How often have you felt that things are just too overwhelming that you can't handle them?					
5. How often is there tension in the home?					
6. How often have you counted pain pills to see how many are remaining?					
7. How often have you been concerned that people will judge you for taking pain medication?					
8. How often do you feel bored?					
9. How often have you taken more pain medication than you were supposed to?					
10. How often have you worried about being left alone?					
11. How often have you felt a craving for medication?					
12. How often have others expressed concern over your use of medication?					
13. How often have any of your close friends had a problem with alcohol or drugs?					
14. How often have others told you that you had a bad temper?					
15. How often have you felt consumed by the need to get pain medication?					
16. How often have you run out of pain medication early?					
17. How often have others kept you from getting what you deserve?					
18. How often, in your lifetime, have you had legal problems or been arrested?					
19. How often have you attended an AA or NA meeting?					
20. How often have you been in an argument that was so out of control that someone got hurt?					
21. How often have you been sexually abused?					
22. How often have others suggested that you have a drug or alcohol problem?					
23. How often have you had to borrow pain medications from your family or friends?					
24. How often have you been treated for an alcohol or drug problem?					

Please include any additional information you wish about the above answers.

Appendix G: RIOSORD: Risk Index for Overdose or Serious Opioid-Induced Respiratory Depression

Risk Index for Overdose or Serious Opioid-Induced Respiratory Depression (RIOSORD)

Description	Y/N	Score
In the past 6 months, has the patient had a health care visit (outpatient, inpatient, or ED) involving:		
Opioid dependence?		15
Chronic hepatitis or cirrhosis?		9
Bipolar disorder or schizophrenia?		7
Chronic pulmonary disease? (e.g., emphysema, chronic bronchitis, asthma, pneumoconiosis, asbestosis)		5
Chronic kidney disease with clinically significant renal impairment?		5
Active traumatic injury, excluding burns? (e.g., fracture, dislocation, contusion, laceration, wound)		4
Sleep apnea?		3
Does the patient consume:		
An extended-release or long-acting (ER/LA) formulation of any prescription opioid or opioid with long and/or variable half-life? (e.g.,OxyContin, Oramorph-SR, methadone, fentanyl patch, levorphanol)		9
Methadone? (Methadone is a long-acting opioid, so also write Y for "ER/LA formulation")		9
Oxycodone? (If it has an ER/LA formulation [e.g., OxyContin], also write Y for "ER/LA formulation")		3
A prescription antidepressant? (e.g., fluoxetine, citalopram, venlafaxine, amitriptyline)		7
A prescription benzodiazepine? (e.g., diazepam, alprazolam)		4
Is the patient's current maximum prescribed opioid dose:		
>100 mg morphine equivalents per day?		16
50-100 mg morphine equivalents per day?		9
20-50 mg morphine equivalents per day?		5
In the past 6 months, has the patient:		
Had 1 or more ED visits?		11
Been hospitalized for 1 or more days?		8
Total Score		**115**

Opioid Induced Respiratory Depression (OIRD) Probability based on Calculated Risk Index

Risk index score	OIRD probability (%)
0-24	3
25-32	14
33-37	23
38-42	37
43-46	51
47-49	55
50-54	60
55-59	79
60-66	75
≥67	86

Adapted from: Zedler B, Xie L, Wang L et al. Development of a Risk Index for Serious Prescription Opioid-Induced Respiratory Depression or Overdose in Veterans' Health Administration Patients. Pain Medicine. Jun 2015. 16;1566-1579.

Appendix H: DAST-10: Drug Use Questionnaire

NAME: _____ DATE: _____

DRUG USE QUESTIONNAIRE (DAST – 10)

The following questions concern information about your possible involvement with drugs not including alcoholic beverages during the past 12 months. Carefully read each statement and decide if your answer is "Yes" or "No". Then, circle the appropriate response beside the question.

In the statements "drug abuse" refers to (1) the use of prescribed or over the counter drugs may include: cannabis (e.g. marijuana, hash), solvents, tranquillizers (e.g. Valium), barbiturates, cocaine, stimulants (e.g. speed), hallucinogens (e.g. LSD) or narcotics (e.g. heroin). Remember that the questions **do not** include alcoholic beverages.

Please answer every question. If you have difficulty with a statement, then choose the response that is mostly right.

These questions refer to the past 12 months.	**Circle Your Response**	
1. Have you used drugs other than those required for medical reasons?	Yes	No
2. Do you abuse more than one drug at a time?	Yes	No
3. Are you always able to stop using drugs when you want to?	Yes	No
4. Have you had "blackouts" or "flashbacks" as a result or drug use?	Yes	No
5. Do you every feel bad or guilty about your drug use?	Yes	No
6. Does your spouse (or parents) ever complain about your involvement with drugs?	Yes	No
7. Have you neglected your family because of your use of drugs?	Yes	No
8. Have you engaged in illegal activities in order to obtain drugs?	Yes	No
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	Yes	No
10. Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding, etc.)?	Yes	No

Appendix I: PHQ-9: Patient Health Questionnaire for Depression

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last *2 weeks,* how often have you been bothered by any of the following problems? *(use "✓" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
		add columns	+	+

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all _____ Somewhat difficult _____ Very difficult _____ Extremely difficult _____

A2663B 10-04-2005

Appendix I: PHQ-9: Patient Health Questionnaire for Depression (Cont.)

PHQ-9 Patient Depression Questionnaire

For initial diagnosis:

1. Patient completes PHQ-9 Quick Depression Assessment.
2. If there are at least 4 ✓s in the shaded section (including Questions #1 and #2), consider a depressive disorder. Add score to determine severity.

Consider Major Depressive Disorder

- if there are at least 5 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

Consider Other Depressive Disorder

- if there are 2-4 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

Note: Since the questionnaire relies on patient self-report, all responses should be verified by the clinician, and a definitive diagnosis is made on clinical grounds taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient.
Diagnoses of Major Depressive Disorder or Other Depressive Disorder also require impairment of social, occupational, or other important areas of functioning (Question #10) and ruling out normal bereavement, a history of a Manic Episode (Bipolar Disorder), and a physical disorder, medication, or other drug as the biological cause of the depressive symptoms.

To monitor severity over time for newly diagnosed patients or patients in current treatment for depression:

1. Patients may complete questionnaires at baseline and at regular intervals (eg, every 2 weeks) at home and bring them in at their next appointment for scoring or they may complete the questionnaire during each scheduled appointment.
2. Add up ✓s by column. For every ✓: Several days = 1 More than half the days = 2 Nearly every day = 3
3. Add together column scores to get a TOTAL score.
4. Refer to the accompanying **PHQ-9 Scoring Box** to interpret the TOTAL score.
5. Results may be included in patient files to assist you in setting up a treatment goal, determining degree of response, as well as guiding treatment intervention.

Scoring: add up all checked boxes on PHQ-9

For every ✓ Not at all = 0; Several days = 1;
More than half the days = 2; Nearly every day = 3

Interpretation of Total Score

Total Score	Depression Severity
1-4	Minimal depression
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression

A2662B 10-04-2005

Appendix J: GAD-7: Generalized Anxiety Disorder-7

GAD-7				
Over the last 2 weeks, how often have you been bothered by the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

(For office coding: Total Score T____ = ____ + ____ + ____)

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.

Appendix K: Primary Care PTSD Screen

In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, **in the past month,** that you*		
1. Have had nightmares about it or thought about it when you did not want to?	☐ YES	☐ NO
2. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?	☐ YES	☐ NO
3. Were constantly on guard, watchful, or easily startled?	☐ YES	☐ NO
4. Felt numb or detached from others, activities, or your surroundings?	☐ YES	☐ NO

Current research suggests that the results of the PC-PTSD should be considered "positive" if a patient answers "yes" to any three items.

A positive response to the screen does not necessarily indicate that a patient has Posttraumatic Stress Disorder.However, a positive response does indicate that a patient may have PTSD or trauma-related problems and further investigation of trauma symptoms by a mental-health professional may be warranted.

If the PC-PTSD screening instrument is utilized, clarify responses to determine:

a. **Whether the patient has had a traumatic experience**

"I notice from your answers to our questionnaire that you experience some symptoms of stress. At some point in their lives, many people have experienced extremely distressing events such as combat, physical or sexual assault, or a bad accident, and sometimes those events lead to the kinds of symptoms you have. Have you ever had any experiences like that?"

b. **Whether endorsed screen items are really trauma-related symptoms**

"I see that you have said you have nightmares about or have thought about an upsetting experience when you did not want to. Can you give me an example of a nightmare or thinking about an upsetting experience when you didn't want to?"

If a patient gives an example of a symptom that does not appear to be in response to a traumatic event (e .g.a response to a divorce rather than to a traumatic event), it may be that he or she is ruminating about a negative life event rather experiencing intrusive thoughts about a traumatic stressor.

c. **Whether endorsed screen items are disruptive to the patient's life**

"How have these thoughts, memories, or feelings affected your life? Have they interfered with your relationships? Your work? How about with recreation or your enjoyment of activities?"

Positive responses to these questions in addition to endorsement of trauma symptom items on the PCPTSD Screen indicate an increased likelihood that the patient has PTSD and needs further evaluation.

Appendix K: Primary Care PTSD Screen (Continued)

Discern Whether Traumatic Events are Ongoing in a Patient's Life

If ongoing traumatic events are a part of the patient's life, it is critical that the primary care practitioner discern whether the patient needs an immediate referral for social work or mental-health services. The practitioner might ask:

"Are any of these dangerous or life-threatening experiences still continuing in your life now?"

If ongoing family violence is suspected, it is imperative that the patient be told the limits of confidentiality for medical professionals, who are mandated to report suspected ongoing abuse of children and dependent adults. Discussion of possible abuse should take place in the absence of the suspected perpetrator; if the abuser is present, victims may deny abuse for fear of retaliation.

If ongoing threats to safety are present:

- Acknowledge the difficulty in seeking help when the trauma has not stopped.
- Determine if reporting is legally mandated. If it is, develop a plan with the patient to file the report in a way that increases rather than decreases the safety of the patient and his or her loved ones.

If reporting is not appropriate, provide written information (or oral if written might stimulate violent behavior in the perpetrator) about local resources that might help the situation.

Establish a plan that the patient will agree to in order to move toward increased safety. The National Domestic Violence Hotline is available to guide callers to local resources: 1-800-799-SAFE or TTY: 1-800-787-3224.

Appendix L: COMM©: Current Opioid Misuse Measure

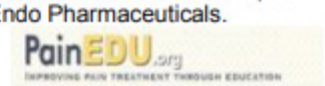
Current Opioid Misuse Measure (COMM)™

The Current Opioid Misuse Measure (COMM)™ is a brief patient self-assessment to monitor chronic pain patients on opioid therapy. The COMM™ was developed with guidance from a group of pain and addiction experts and input from pain management clinicians in the field. Experts and providers identified six key issues to determine if patients already on long-term opioid treatment are exhibiting aberrant medication-related behaviors:

- *Signs & Symptoms of Intoxication*
- *Emotional Volatility*
- *Evidence of Poor Response to Medications*
- *Addiction*
- *Healthcare Use Patterns*
- *Problematic Medication Behavior*

The COMM™ will help clinicians identify whether a patient, currently on long-term opioid therapy, may be exhibiting aberrant behaviors associated with misuse of opioid medications. In contrast, the Screener and Opioid Assessment for Patients with Pain (SOAPP®) is intended to predict which patients, being considered for long-term opioid therapy, may exhibit aberrant medications behaviors in the future. Since the COMM™ examines concurrent misuse, it is ideal for helping clinicians monitor patients' aberrant medication-related behaviors over the course of treatment. The COMM™ is:

- A quick and easy to administer patient-self assessment
- 17 items
- Simple to score
- Completed in less than 10 minutes
- Validated with a group of approximately 500 chronic pain patients on opioid therapy
- Ideal for documenting decisions about the level of monitoring planned for a particular patient or justifying referrals to specialty pain clinic.
- The COMM™ is for clinician use only. The tool is not meant for commercial distribution.
- The COMM™ is **NOT** a lie detector. Patients determined to misrepresent themselves will still do so. Other clinical information should be used with COMM™ scores to decide if and when modifications to particular patient's treatment plan is needed.
- It is important to remember that all chronic pain patients deserve treatment of their pain. Providers who are not comfortable treating certain patients should refer those patients to a specialist.



Appendix L: COMM©: Current Opioid Misuse Measure (Continued)

COMM™

Please answer each question as honestly as possible. Keep in mind that we are only asking about the **past 30 days**. There are no right or wrong answers. If you are unsure about how to answer the question, please give the best answer you can.

Please answer the questions using the following scale:	**Never**	**Seldom**	**Sometimes**	**Often**	**Very Often**
	0	1	2	3	4
1. In the past 30 days, how often have you had trouble with thinking clearly or had memory problems?	O	O	O	O	O
2. In the past 30 days, how often do people complain that you are not completing necessary tasks? (i.e., doing things that need to be done, such as going to class, work or appointments)	O	O	O	O	O
3. In the past 30 days, how often have you had to go to someone other than your prescribing physician to get sufficient pain relief from medications? (i.e., another doctor, the Emergency Room, friends, street sources)	O	O	O	O	O
4. In the past 30 days, how often have you taken your medications differently from how they are prescribed?	O	O	O	O	O
5. In the past 30 days, how often have you seriously thought about hurting yourself?	O	O	O	O	O
6. In the past 30 days, how much of your time was spent thinking about opioid medications (having enough, taking them, dosing schedule, etc.)?	O	O	O	O	O

Appendix L: COMM©: Current Opioid Misuse Measure (Continued)

Please answer the questions using the following scale:	Never 0	Seldom 1	Sometimes 2	Often 3	Very Often 4
7. In the past 30 days, how often have you been in an argument?	O	O	O	O	O
8. In the past 30 days, how often have you had trouble controlling your anger (e.g., road rage, screaming, etc.)?	O	O	O	O	O
9. In the past 30 days, how often have you needed to take pain medications belonging to someone else?	O	O	O	O	O
10. In the past 30 days, how often have you been worried about how you're handling your medications?	O	O	O	O	O
11. In the past 30 days, how often have others been worried about how you're handling your medications?	O	O	O	O	O
12. In the past 30 days, how often have you had to make an emergency phone call or show up at the clinic without an appointment?	O	O	O	O	O
13. In the past 30 days, how often have you gotten angry with people?	O	O	O	O	O
14. In the past 30 days, how often have you had to take more of your medication than prescribed?	O	O	O	O	O
15. In the past 30 days, how often have you borrowed pain medication from someone else?	O	O	O	O	O
16. In the past 30 days, how often have you used your pain medicine for symptoms other than for pain (e.g., to help you sleep, improve your mood, or relieve stress)?	O	O	O	O	O

Appendix L: COMM©: Current Opioid Misuse Measure (Continued)

Please answer the questions using the following scale:	Never 0	Seldom 1	Sometimes 2	Often 3	Very Often 4
17. In the past 30 days, how often have you had to visit the Emergency Room?	O	O	O	O	O

Appendix L: COMM©: Current Opioid Misuse Measure (Continued)

Scoring Instructions for the COMM™

To score the COMM™, simply add the rating of all the questions. A score of 9 or higher is considered a positive

Sum of Questions	COMM Indication
> or = 9	+
< 9	-

As for any scale, the results depend on what cutoff score is chosen. A score that is sensitive in detecting patients who are abusing or misusing their opioid medication will necessarily include a number of patients that are not really abusing or misusing their medication. The COMM™ was intended to over-identify misuse, rather than to mislabel someone as responsible when they are not. This is why a low cut-off score was accepted. We believe that it is more important to identify patients who have only a possibility of misusing their medications than to fail to identify those who are actually abusing their medication. Thus, it is possible that the COMM™ will result in false positives – patients identified as misusing their medication when they were not.

The table below presents several statistics that describe how effective the COMM™ is at different cutoff values. These values suggest that the COMM™ is a sensitive test. This confirms that the COMM™ is better at identifying who is misusing their medication than identifying who is not misusing. Clinically, a score of 9 or higher will identify 77% of those who actually turn out to be at high risk. The Negative Predictive Values for a cutoff score of 9 is .95, which means that most people who have a negative COMM™ are likely not misusing their medication. Finally, the Positive likelihood ratio suggests that a positive COMM™ score (at a cutoff of 9) is nearly 3 times (3.48 times) as likely to come from someone who is actually misusing their medication (note that, of these statistics, the likelihood ratio is least affected by prevalence rates). All this implies that by using a cutoff score of 9 will ensure that the provider is least likely to miss someone who is really misusing their prescription opioids. However, one should remember that a low COMM™ score suggests the patient is really at low-risk, while a high COMM™ score will contain a larger percentage of false positives (about 34%), while at the same time retaining a large percentage of true positives. This could be improved, so that a positive score has a lower false positive rate, but only at the risk of missing more of those who actually do show aberrant behavior.

COMM™ Cutoff Score	Sensitivity	Specificity	Positive Predictive Value	Negative Predictive Value	Positive Likelihood Ratio	Negative Likelihood Ration
Score 9 or above	.77	.66	.66	.95	3.48	.08

Appendix M: S T O P B A N G: Screen for Obstructive Sleep Apnea

Screening for Obstructive Sleep Apnea

Ask your patient to answer the following questions to determine if he or she is at risk of obstructive sleep apnea.

S (snore)	Have you been told that you snore?	YES	NO
T (tired)	Are you often tired during the day?	YES	NO
O (obstruction)	Do you know if you stop breathing, or has anyone witnessed you stop breathing while you are asleep?	YES	NO
P (pressure)	Do you have high blood pressure, or are you on medication to control high blood pressure?	YES	NO

If the patient answered yes to two or more questions on the STOP portion, he or she is at risk of obstructive sleep apnea.

To find out if the patient is at moderate to severe risk of obstructive sleep apnea, he or she should complete the BANG questions below.

B (BMI)	Is your body mass index greater than 28?	YES	NO
A (age)	Are you 50 years old or older?	YES	NO
N (neck)	Are you a male with a neck circumference greater than 17 inches, or a female with a neck circumference greater than 16 inches?	YES	NO
G (gender)	Are you a male?	YES	NO

The more questions the patient answers yes to, the greater his or her risk of having moderate to severe obstructive sleep apnea.

OSA Low Risk: Yes on 0–2 questions

OSA Intermediate Risk: Yes on 3–4 questions

OSA High Risk: Yes on 5–8 questions

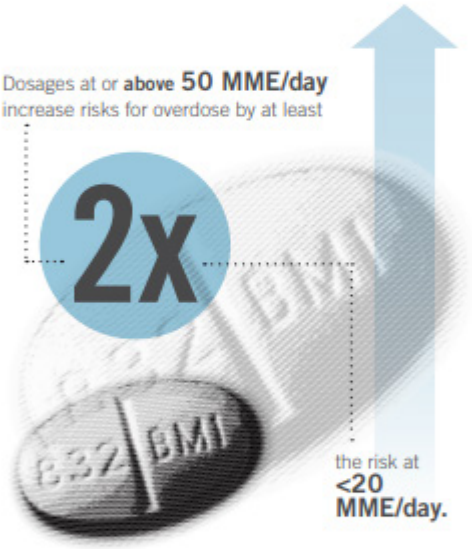
Reference: Modified from Chung F et al J Clin Sleep Med Sept 2014.

Appendix N: Opioid Dose Calculations

CALCULATING TOTAL DAILY DOSE OF OPIOIDS FOR SAFER DOSAGE

Higher Dosage, Higher Risk.

Higher dosages of opioids are associated with higher risk of overdose and death—even relatively low dosages (20-50 morphine milligram equivalents (MME) per day) increase risk. Higher dosages haven't been shown to reduce pain over the long term. One randomized trial found no difference in pain or function between a more liberal opioid dose escalation strategy (with average final dosage 52 MME) and maintenance of current dosage (average final dosage 40 MME).



WHY IS IT IMPORTANT TO CALCULATE THE TOTAL DAILY DOSAGE OF OPIOIDS?

Patients prescribed higher opioid dosages are at higher risk of overdose death.

In a national sample of Veterans Health Administration (VHA) patients with chronic pain receiving opioids from 2004–2009, **patients who died** of opioid overdose were prescribed an average of **98 MME/day**, while **other patients** were prescribed an average of **48 MME/day**.

Calculating the total daily dose of opioids helps identify patients who may benefit from closer monitoring, reduction or tapering of opioids, prescribing of naloxone, or other measures to reduce risk of overdose.

HOW MUCH IS 50 OR 90 MME/DAY FOR COMMONLY PRESCRIBED OPIOIDS?

50 MME/day:

- 50 mg of hydrocodone (10 tablets of hydrocodone/acetaminophen 5/300)
- 33 mg of oxycodone (~2 tablets of oxycodone sustained-release 15 mg)
- 12 mg of methadone (<3 tablets of methadone 5 mg)

90 MME/day:

- 90 mg of hydrocodone (9 tablets of hydrocodone/acetaminophen 10/325)
- 60 mg of oxycodone (~2 tablets of oxycodone sustained-release 30 mg)
- ~20 mg of methadone (4 tablets of methadone 5 mg)

CDC U.S. Department of Health and Human Services Centers for Disease Control and Prevention

LEARN MORE | www.cdc.gov/drugoverdose/prescribing/guideline.html

Appendix N: Opioid Dose Calculations (Continued)

HOW SHOULD THE TOTAL DAILY DOSE OF OPIOIDS BE CALCULATED?

1. **DETERMINE** the total daily amount of each opioid the patient takes.
2. **CONVERT** each to MMEs—multiply the dose for each opioid by the conversion factor. (*see table*)
3. **ADD** them together.

Calculating morphine milligram equivalents (MME)

OPIOID (doses in mg/day except where noted)	CONVERSION FACTOR
Codeine	0.15
Fentanyl transdermal (in mcg/hr)	2.4
Hydrocodone	1
Hydromorphone	4
Methadone	
1-20 mg/day	4
21-40 mg/day	8
41-60 mg/day	10
≥ 61-80 mg/day	12
Morphine	1
Oxycodone	1.5
Oxymorphone	3

These dose conversions are estimated and cannot account for all individual differences in genetics and pharmacokinetics.

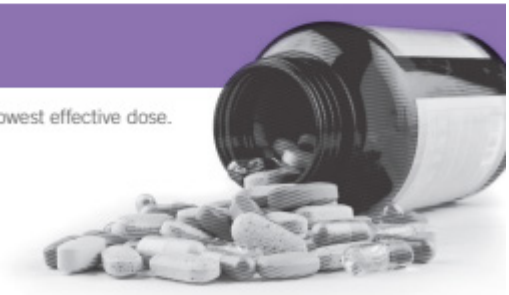
CAUTION:

- Do not use the calculated dose in MMEs to determine dosage for converting one opioid to another—the new opioid should be lower to avoid unintentional overdose caused by incomplete cross-tolerance and individual differences in opioid pharmacokinetics. Consult the medication label.

USE EXTRA CAUTION:

- **Methadone:** the conversion factor increases at higher doses
- **Fentanyl:** dosed in mcg/hr instead of mg/day, and absorption is affected by heat and other factors

HOW SHOULD PROVIDERS USE THE TOTAL DAILY OPIOID DOSE IN CLINICAL PRACTICE?



- Use caution when prescribing opioids at any dosage and prescribe the lowest effective dose.
- Use extra precautions when increasing to ≥50 MME per day* such as:
  - Monitor and assess pain and function more frequently.
  - Discuss reducing dose or tapering and discontinuing opioids if benefits do not outweigh harms.
  - Consider offering naloxone.
- Avoid or carefully justify increasing dosage to ≥90 MME/day.*

* These dosage thresholds are based on overdose risk when opioids are prescribed for pain and should not guide dosing of medication-assisted treatment for opioid use disorder.

LEARN MORE | www.cdc.gov/drugoverdose/prescribing/guideline.html

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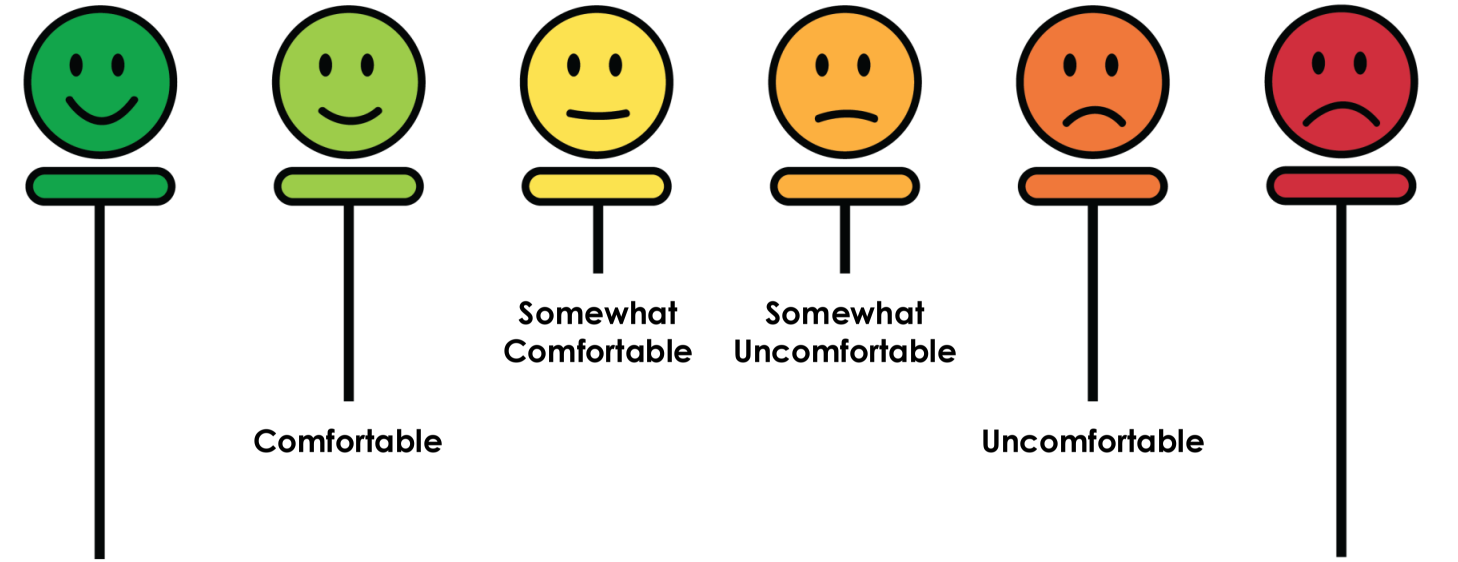
IHC Comfort Scale



IHC Iowa Healthcare Collaborative
A Partnership for Quality, Patient Safety & Value

Partnership for Patients

COMPASS
HOSPITAL IMPROVEMENT INNOVATION NETWORK

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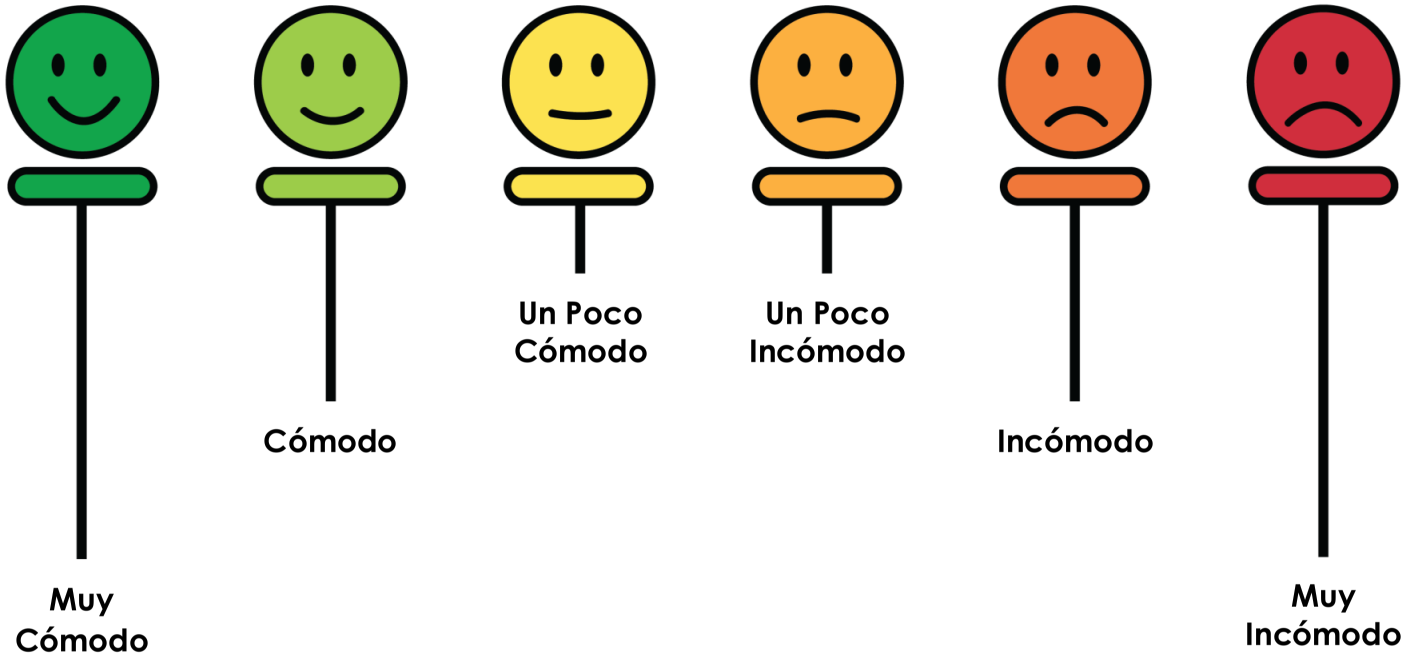
Escala de Comodidad de IHC



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IHC Inpatient Comfort Menu
INSERT HOSPITAL NAME HERE

The comfort menu has been created to assist you and your healthcare team to work together to reach your comfort goals. Your role as the key member of the healthcare team is essential in designing your treatment plan. We encourage the use of menu options listed below prior to moving to medication. We hope the comfort menu will assist in identifying comfort options that will make you feel confident in your treatment plan. These comfort options can be used at home as well. If you have any questions or comments, please speak with a member of your healthcare team.

Comfort

- Eye drops
- Extra pillow
- Fan
- Moisture in your oxygen
- Cold pack
- Warm pack
- Mouth sponge
- Pillow under your knees/ankles
- Saline spray for your nose
- Warm blanket
- Warm washcloth
- Pajamas
- Non-skid socks

Personal Care

- Comb
- Brush
- Shower cap
- Hair ties
- Deodorant
- Lip balm
- Lotion
- Nail file
- Shaver
- Shaving cream
- Shampoo
- Conditioner
- Toothbrush
- Toothpaste
- Dental floss

Comfort Actions

- Shower
- Whirlpool
- Range of motion
- Gentle stretching
- Repositioning
- Walk in the hall
- Birthing ball

Hospital Logo Here

Relaxation

- Ear plugs
- Eye cover
- Massage therapy
- Music therapy
- Chaplain visit
- Visitors
- Quiet, uninterrupted time with your nurse
- Stress ball
- Aromatherapy
- Window shade down
- Lights out
- Door closed
- Playing cards

Medication

- Discuss the realistic comfort goals you have with your healthcare team
- Discuss allergies, side effects and current medication combinations to ensure the medications you will be receiving are safe and effective for you
- Depending on your goals, some medication options may include Tylenol, Advil, Naproxen, and Cymbalta
- While opioids have their place, they should be started at a low dose and stopped as soon as possible

IHC Iowa Healthcare Collaborative — A Partnership for Quality, Patient Safety & Value | Partnership for Patients | COMPASS Hospital Improvement Innovation Network

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Paciente Hospitalizado Menú de Comodidad de IHC
INTRODUCIR NOMBRE DEL HOSPITAL AQUÍ

El menú de comodidad ha sido creado para ayudarlos a usted y a su equipo de atención médica a trabajar en conjunto para alcanzar sus metas de comodidad. Su papel como miembro fundamental del equipo de atención médica es esencial para diseñar su plan de tratamiento. Lo alentamos a usar las opciones del menú enumeradas a continuación antes de pasar a la medicación. Esperamos que el menú de comodidad lo ayude a identificar las opciones que lo harán sentirse confiado en su plan de tratamiento. Estas opciones de comodidad se pueden usar también en casa. Si tiene alguna pregunta o comentario, hable con un miembro de su equipo de atención médica.

Comodidad

- Gotas para los ojos
- Almohada adicional
- Ventilador
- Humectante en su oxígeno
- Paquete frío
- Paquete tibio
- Esponja en la boca
- Almohada debajo de las rodillas/tobillos
- Pulverización de solución salina para la nariz
- Manta caliente
- Paño tibio
- Piyamas
- Calcetines antideslizantesks

Cuidado Personal

- Peine
- Cepillo
- Gorra para la ducha
- Lazos para el cabello
- Desodorante
- Bálsamo para los labios
- Loción
- Lima
- Afeitadora
- Crema de afeitar
- Champú
- Acondicionador
- Cepillo de dientes
- Pasta dental
- Hilo dental

Acciones Para Estar Cómodo

- Duchas
- Hidromasaje
- Rango de movimiento
- Estiramiento suave
- Cambiar de posición
- Caminar por el pasillo
- Pelota de parto

Logotipo del Hospital Aquí

Relajación

- Tapones para los oídos
- Tapaojos
- Terapia de masajes
- Musicoterapia
- Visita del capellán
- Visitantes
- Tiempo tranquilo y sin interrupciones con su enfermero
- Pelota para el estrés
- Aromaterapia
- Persianas bajas
- Luces apagadas
- Puerta cerrada
- Juegos de cartas

Medicación

- Discuta las metas realistas para la comodidad que tiene con su equipo de atención médica
- Discuta las alergias, efectos secundarios y combinaciones de medicamentos actuales para asegurarse de que los medicamentos que recibirá serán seguros y eficaces para usted
- Dependiendo de sus metas, algunas opciones de medicamentos pueden incluir Tylenol, Advil, Naproxeno y Cymbalta
- Si bien los opioides se usan, se deben empezar a tomar a dosis bajas y se deben dejar lo antes posible

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IHC Outpatient Comfort Menu
INSERT FACILITY NAME HERE

The comfort menu was created to assist you and your healthcare team work together to reach your comfort goals. Your role as key member of the healthcare team is important. We encourage the use of menu options listed below prior to moving to medication. The menu can assist in identifying comfort options that will make you feel confident in your treatment plan. If you have any questions or comments, speak with a member of your healthcare team.

Comfort

- Eye drops
- Extra pillow
- Fan
- Humidifier
- Cold pack
- Warm pack
- Pillow under your knees/ankles
- Saline spray for your nose
- Warm blanket
- Warm washcloth
- Pajamas
- Non-skid socks

Personal Care

- Regular personal hygiene
- Apply lotion
- Take a warm bath/shower
- Home health aid
- Shower/Bath
- Whirlpool
- Gentle stretching
- Repositioning
- Exercise
- Exercise ball

Comfort Actions

- In home services
- Meals on Wheels
- Transportation
- Childcare
- Clothing
- Job placement services
- Volunteer in your community

Hospital Logo Here

Relaxation

- Ear plugs
- Eye cover
- Listen to music
- Music therapy
- Spiritual leader visit
- Quiet, uninterrupted time
- Stress ball
- Aromatherapy
- Acupuncture
- Window shade down
- Dark room
- Door closed
- Playing cards
- Read
- Walk
- Time with family/friends
- Walk

Medication

- Discuss realistic comfort goals with your healthcare team
- Discuss allergies, side effects and your current medication to ensure any new medications are safe and effective
- Medication options may include Tylenol, Advil, Naproxen, and Cymbalta
- Opioids have their place, they should be started at a low dose and stopped as soon as possible
- Ask about where and how to dispose your medications

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Paciente Externo Menú de comodidad de IHC
INSERT FACILITY NAME HERE

El menú de comodidad fue creado para ayudarlos a usted y a su equipo de atención médica a trabajar en conjunto para alcanzar sus metas de comodidad. Su papel como miembro clave del equipo de atención médica es importante. Lo alentamos a usar las opciones del menú enumeradas a continuación antes de pasar a la medicación. El menú puede ayudar a identificar las opciones que lo harán sentirse confiado en su plan de tratamiento. Si tiene alguna pregunta o comentario, hable con un miembro de su equipo de atención médica.

Comodidad

- Gotas para los ojos
- Almohada adicional
- Ventilador
- Humidificador
- Paquete frío
- Paquete tibio
- Almohada debajo de las rodillas/tobillos
- Pulverización de solución salina para la nariz
- Manta caliente
- Paño tibio
- Piyamas
- Calcetines antideslizantes

Cuidado personal

- Higiene personal regular
- Aplique loción
- Tome un baño o ducha caliente
- Ayuda para la salud en el hogar
- Ducha/baño
- Hidromasaje
- Estiramiento suave
- Cambiar de posición
- Ejercicio
- Pelota de ejercicios

Acciones para estar cómodo

- Servicios en el hogar
- Comida sobre ruedas
- Transporte
- Cuidado de niños
- Ropa
- Servicios de colocación de empleo

Hospital Logo Here

Relajación

- Tapones para los oídos
- Tapaojos
- Escuche música
- Musicoterapia
- Visite a un líder espiritual
- Tiempo silencioso e ininterrumpido
- Pelota para el estrés
- Aromaterapia
- Acupuntura
- Persianas bajas
- Habitación oscura
- Puerta cerrada
- Juegos de cartas
- Lea
- Camine
- Tiempo con la familia/amigos

Medicación

- Discuta metas realistas para la comodidad con su equipo de atención médica
- Discuta las alergias, los efectos secundarios y sus medicamentos actuales para asegurarse de que cualquier medicamento nuevo sea seguro y efectivo
- Las opciones de medicamentos pueden incluir Tylenol, Advil, Naproxeno y Cymbalta
- Los opioides se usan pero se deben empezar a tomar a dosis bajas y se deben dejar lo antes posible
- Pregunte dónde y cómo deshacerse de sus medicamentos

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Appendix Q: IHC Comfort Treatment Plan – Acute

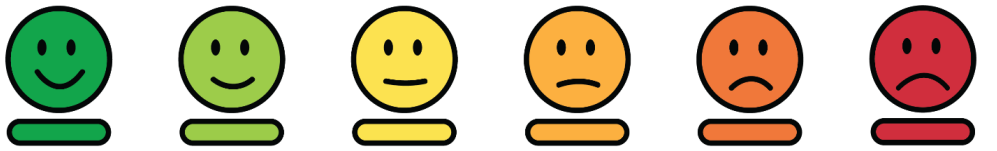
IHC Comfort Treatment Plan

For Acute Conditions

My Realistic Comfort Goals

Timeframe	At Rest	When Moving	Plan to Reach Realistic Goals
First eight hours			
First full day			
Next three days			
Next seven days			
Next two weeks			

Comfort Scale



Very Comfortable | Comfortable | Somewhat Comfortable | Somewhat Uncomfortable | Uncomfortable | Very Uncomfortable

Pain Relief Options

- Use of Comfort Menu items/alternative pain relieving measures – circle those that you want to try at home (see back of this sheet)
- Pain Medication (name, dose, how often, instructions):
  1.
  2.

Before you leave the clinic, make sure you understand your provider's instructions regarding medications to improve your comfort level and treat any pain you might have:

- What pain medication am I taking?
- Why am I taking it?
- How should I take it?
- What are the side effects that I should watch out for?
- When should I stop taking it?
- Where do I dispose of unused medication? After how many days?

Call your primary care provider name: _____ at provider phone number: (____) _____ - _____ if any of the following occurs:

- If your pain suddenly gets worse.
- If you are experiencing unpleasant side effects of pain medication (constipation, confusion, nausea, itching, dizziness).

Call 911 immediately if your skin is clammy or pale, you have a low heart rate, small pupils, slowed breathing, slurred speech, and/or extreme sleepiness.

Clinic or Health System Logo Here

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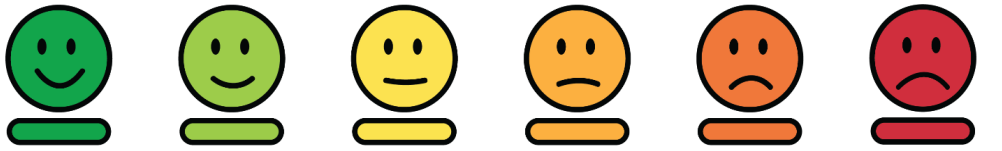
Plan de Tratamientos Paliativos de IHC
Para Afecciones Graves

Mis Metas y mi Plan Palativo Realista

Tiempo	En Reposo	En Movimiento	Plan Para Alcanzar Metas Realistas
Primeras 8 horas			
Primer día completo			
Siguientes tres días			
Siguientes siete días			
Siguientes dos semanas			

Escala de Comodidad



Muy Cómodo | **Cómodo** | **Un Poco Cómodo** | **Un Poco Incómodo** | **Incómodo** | **Muy Incómodo**

Opciones para el Alivio del Dolor

- Use las medidas de alivio de dolor alternativas/puntos del menú de comodidad - marque con un círculo las que desea probar en su casa (vea al dorso de esta hoja).
- Medicamentos para el dolor (nombre, dosis, frecuencia, instrucciones):
  1.
  2.

Antes de irse de la clínica, asegúrese de entender las instrucciones de su proveedor relacionadas con los medicamentos para mejorar su nivel de comodidad y tratar el dolor que pueda tener:

- ¿Qué medicamento estoy tomando?
- ¿Por qué lo estoy tomando?
- ¿Cómo debo tomarlo?
- ¿Cuáles son los efectos secundarios a los cuales debería estar atento?
- ¿Cuándo debo dejar de tomarlo?
- ¿Dónde desecho los medicamentos no utilizados? ¿Después de cuántos días?

Llame a su proveedor de atención primaria: _____ al número de teléfono del proveedor: (____) _____ - _____ en los siguientes casos:

- Si su dolor empeora.
- Si experimenta efectos secundarios molestos del analgésico (estreñimiento, confusión, náuseas, picazón, mareos).

Llame al 911 inmediatamente si siente la piel húmeda o pálida, si tiene frecuencia cardiaca baja, pupilas pequeñas, respiración lenta, si le cuesta hablar o si siente una somnolencia extrema.

Logotipo del sistema de salud o clínica aquí

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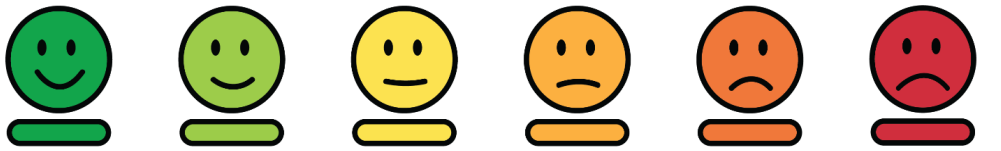
Appendix Q: IHC Comfort Treatment Plan – Chronic

IHC Comfort Treatment Plan
For Chronic Conditions

My Realistic Comfort Goals

Timeframe	At Rest	When Moving	Plan to Reach Realistic Goals
3 months			
6 months			
9 months			
12 months			
> 1 year			

Comfort Scale



Very Comfortable | Comfortable | Somewhat Comfortable | Somewhat Uncomfortable | Uncomfortable | Very Uncomfortable

Pain Relief Options

- Use of Comfort Menu items/alternative pain relieving measures – circle those that you want to try at home (see back of this sheet)
- Pain Medication (name, dose, how often, instructions):
  1.
  2.

Before you leave the clinic, make sure you understand your provider's instructions regarding medications to improve your comfort level and treat any pain you might have:

- What pain medication am I taking?
- Why am I taking it?
- How should I take it?
- What are the side effects that I should watch out for?
- When should I stop taking it?
- Where do I dispose of unused medication? After how many days?

Call your primary care provider name: _____ at provider phone number: (____) _____ - _____ if any of the following occurs:

- If your pain suddenly gets worse.
- If you are experiencing unpleasant side effects of pain medication (constipation, confusion, nausea, itching, dizziness).

Call 911 immediately if your skin is clammy or pale, you have a low heart rate, small pupils, slowed breathing, slurred speech, and/or extreme sleepiness.

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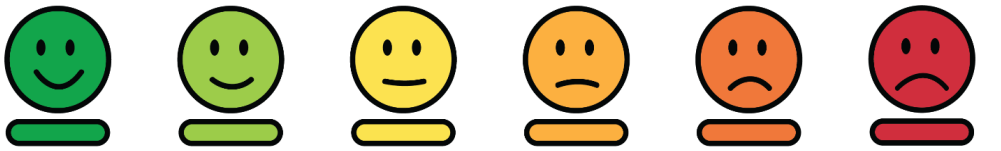
Plan de Tratamientos Paliativos de IHC
Para Afecciones Crónicas

Mis Metas y mi Plan Palativo Realista

Tiempo	En Reposo	En Movimiento	Plan Para Alcanzar Metas Realistas
3 meses			
6 meses			
9 meses			
12 meses			
> 1 año			

Escala de Comodidad



Muy Cómodo | **Cómodo** | **Un Poco Cómodo** | **Un Poco Incómodo** | **Incómodo** | **Muy Incómodo**

Opciones para el Alivio del Dolor

- Use las medidas de alivio de dolor alternativas/puntos del menú de comodidad - marque con un círculo las que desea probar en su casa (vea al dorso de esta hoja).
- Medicamentos para el dolor (nombre, dosis, frecuencia, instrucciones):
  1.
  2.

Antes de irse de la clínica, asegúrese de entender las instrucciones de su proveedor relacionadas con los medicamentos para mejorar su nivel de comodidad y tratar el dolor que pueda tener:

- ¿Qué medicamento estoy tomando?
- ¿Por qué lo estoy tomando?
- ¿Cómo debo tomarlo?
- ¿Cuáles son los efectos secundarios a los cuales debería estar atento?
- ¿Cuándo debo dejar de tomarlo?
- ¿Dónde desecho los medicamentos no utilizados? ¿Después de cuántos días?

Llame a su proveedor de atención primaria: _____ al número de teléfono del proveedor: (____) _____ - _____ en los siguientes casos:

- Si su dolor empeora.
- Si experimenta efectos secundarios molestos del analgésico (estreñimiento, confusión, náuseas, picazón, mareos).

Llame al 911 inmediatamente si siente la piel húmeda o pálida, si tiene frecuencia cardiaca baja, pupilas pequeñas, respiración lenta, si le cuesta hablar o si siente una somnolencia extrema.

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Appendix R: Chronic Pain Treatment Checklist

This checklist may be useful as a means to ensure compliance with these guidelines.

- [ ] Hx and Px with assessment of baseline function and pain.
- [ ] Review all relevant prior records.
- [ ] Has there been a prior unsuccessful attempt to treat with non-opioid modalities?
- [ ] Is the diagnosis appropriate for opioid treatment?
- [ ] Psychosocial and risk assessment: risk of medication abuse (ORT), psychiatric co-morbidity PHQ-4 or other validated tools, evidence of existing abuse (PDMP).
- [ ] Are there co-prescribed drug interaction risks? Benzodiazepines are generally contraindicated.
- [ ] Sleep risk assessment (S T O P B A N G or equivalent).
- [ ] UDS: Any unexpected results?
- [ ] Have you checked the PDMP for prescriptions of which you were unaware?
- [ ] Create a treatment plan that emphasizes patient self-management.
- [ ] Are there appropriate referrals?
- [ ] Have you explored all reasonable non-opioid treatment options: medical, behavioral, physiotherapy, and lifestyle changes?
- [ ] Have you considered partnering with a substance abuse treatment program?
- [ ] Check women of child-bearing age for pregnancy.

If prescribing opioids, proceed with caution:

- [ ] Obtain a signed Material Risk Notice.
- [ ] Establish treatment goals with periodic review of goals over time.
- [ ] Monitor compliance (UDSs, pill counts, PDMP, call-backs).
- [ ] Monitor improvement in pain and function, including overall well-being.
- [ ] Obtain consultation as needed: mental health, substance abuse, pain management, specialty care, pregnant women.
- [ ] Have you considered partnering with a behavioral health specialist (CBT counselor, peer-to-peer coordinator, Living Well with Chronic Disease facilitator, substance abuse counselor)?

Appendix S: Urine Drug Screening (USD) FAQ

Using Urinary Drug Testing to Monitor Opioid Therapy for Complex Chronic Non-Cancer Pain

The purpose of drug testing is to identify aberrant behavior, undisclosed drug use and/or abuse, and to verify compliance with treatment. If a decision has been made to prescribe opioids for chronic non-cancer pain, the prescriber should get a baseline urine drug tests prior to prescribing and periodically thereafter. The frequency of such testing can be determined by risk stratification based upon screening tools already mentioned in this document (**page 15** and **Appendix A**). Risk determination may change over time as you get to know the patient better, so clinical judgment is critical in determining an appropriate testing schedule. Often explaining the need for routine urine drug testing can lead to a beneficial discussion between provider and patient concerning risky concomitant substance use.

Prior to drug testing, the prescriber should inform the patient of the reason for testing, frequency of testing and consequences of unexpected results. This gives the patient an opportunity to disclose drug use and allows the prescriber to modify the drug screen for the individual circumstances and more accurately interpret the results.

Q: Drug screening implies that I don't trust my patients. How do I get around this?

A: A self-report of drug use has limited validity, and monitoring behavior alone can fail to detect problems revealed by urine drug tests. Creating a urinary drug testing policy in advance and applying it consistently to all patients on opioids may help de-stigmatize the testing. Inform patients that drug testing is a routine procedure for all patients starting or maintaining opioid therapy and that it is an important tool for monitoring the safety of opioid therapy.

Possible language for explaining to patient includes:

- "Ensures my capacity to provide treatment for your pain while balancing the need for safety."
- "Provides critical information needed to assess the success of your therapy."
- "Prescription medications are a common form of treatment for chronic pain. However, each person reacts differently to them. Urine drug testing enables us to identify individual risks related to your medications and avoid problems."
- "Our clinic uses 'universal precautions' in opioid prescribing, which includes urine drug testing. This is the same as wearing gloves on all patients when drawing blood."

Q: Can I tell whether my patient has taken the dose of opioid(s) I prescribed?

A: No. It is very difficult to correlate urine drug concentration with a patient's dose. Urine drug tests can detect the parent drug and/or its metabolite(s) and demonstrate recent use of prescribed drugs and illegal substances. However, it cannot determine the amount of drug used and when the last dose was taken, nor can it identify the source of the drug.

Q: My patient says he is a "high metabolizer" and that is why the expected drug is not found in the urine. Is this possible?

A: A small percentage of persons are ultra-rapid metabolizers. They metabolize specific drugs more rapidly than typical patients. It would be rare to take an opioid as prescribed and have

Appendix S: Urine Drug Screening (USD) FAQ (Continued)

a totally negative urine drug tests. It is important that you use testing that is specific to the medication of interest and with cutoff thresholds that are extremely low.

Q: How do I deal with marijuana?

A: This is a complex issue. Marijuana is currently classified as a Schedule I drug by the DEA. For that reason, many providers will not prescribe opioids to patients using cannabis. Other providers reference State "Medical Marijuana" laws (http://apps.leg.wa.gov/RCW/default.aspx?cite=69.51A&full=true) and feel comfortable prescribing opioids to cannabis users. Some providers adopt a "don't ask, don't tell" policy, and request the lab to remove marijuana from the urine drug test so that positive results are not seen. Do your homework and create an office policy. Then disclose this policy to your patients.

Q: Would short-acting opioids show up in urine drug tests?

A: Urine testing typically has a 1- to 3-day window of detection for most drugs depending on dose and individual differences in drug metabolism. If the laboratory uses LC/MS/MS, then it will have a lower limit of detection (LOD) with less interference.

Q: Why confirm results?

A: Immunoassays used in drug screening can cross-react with other drugs and vary in sensitivity and specificity. Thus, confirmation with a more accurate method may be required for clinical decision making. Confirmatory drug testing (GC/MS or LC/MS/MS) of the original specimen is recommended for unexpected results, or in cases where patients are known to be high risk. However, on occasion, even confirmatory testing requires expert assistance for interpretation. Consider consultation with the lab before discussing/confronting the patient with unexpected test results and discontinuing opioid therapy.

Q: Should I use temperature and adulteration strips?

A: It depends. Drug testing for clinical compliance, unlike employment testing, does not require a strict "chain-of- custody." However, if tampering is a concern, the specimen should be monitored for temperature and/or adulterants. Normal human urine should have a temperature between 90°F–100°F, pH between 4.5–8.5 and creatinine >20 mg/dL. Be aware that there are multiple websites and devices devoted to getting a "clean" urine drug screen.

Q: Should I perform a drug screen on every visit for patients using opioids for chronic pain?

A: No. Random screening based on the frequency recommended in the guideline should suffice for most patients. Those patients who you feel require drug screening on every visit are perhaps not candidates for chronic opioid therapy.

Appendix S: Urine Drug Screening (USD) FAQ (Continued)

Risk Category	UDS Frequency	Recommended Drug Panel to Test
LOW RISK by ORT (1 or more/year)	Periodic (e.g. up to 1/year)	Drugs you are prescribing if not listed Amphetamines Opiates Cocaine Benzodiazepines Alcohol Barbiturates Oxycodone Methadone Fentanyl Marijuana *Testing for all drug classes may not be necessary, depending on clinical situation.*
MODERATE RISK by ORT (2 or more/year)	Regular (e.g. up to 2/year)	
HIGH RISK by ORT (3 or more/year) or opioid doses >120 mg MME/d	Frequent (e.g. up to 2+/year)	
Aberrant Behavior (lost prescriptions, multiple requests for early refills, opioids from multiple providers, unauthorized dose escalation, apparent intoxication, etc.)	At time of visit (address aberrant behaviors in person, not by telephone)	

Consideration

Typically, the initial (screening) drug test uses an immunoassay method to identify the presence of a drug (presumptive positive). Because of cross reactivity and different sensitivity and specificity between immunoassays, a second confirmatory test is required unless result is expected or the patient has disclosed drug use. Confirmatory drug tests use gas chromatography/ mass spectrometry or liquid chromatography/ tandem mass spectrometry (GC/MS or LC/MS) to verify a presumptive positive result.

Contact the laboratory director, toxicologist or a certified Medical Review Officer (MRO) in your area for questions about drug testing or result.

If a point of care (POC) test is used, contact technical support from the manufacturer for questions.

Urinary Drug Testing Results

Interpreting urine drug test results can be challenging, especially when the parent drug can be metabolized to other commonly prescribed drugs. The table in Appendix H may aid prescribers when interpreting urine drug test results. The following urine drug test results should be viewed as a "red flag," requiring confirmation and intervention:

- Negative for opioid(s) you prescribed
- Positive for drug (benzodiazepines, opioids, etc.) you did NOT prescribe or have knowledge of
- Positive for amphetamine or methamphetamine
- Positive for alcohol
- Positive for cocaine or metabolites

Appendix S: Urine Drug Screening (USD) FAQ (Continued)

If a confirmatory drug test substantiates a "red flag" result AND is positive for prescribed opioid(s):

- Prescriber should consider a controlled taper and a referral to an addiction specialist or drug treatment program depending on the circumstances.
- Prescriber should consider extraneous circumstance such as duration of action of the drug and timing of last dose. Consultation with your laboratory's pharmacologist may be useful. Discontinue prescribing opioid(s) and consider a referral to an addiction specialist or drug treatment program depending on the circumstances.

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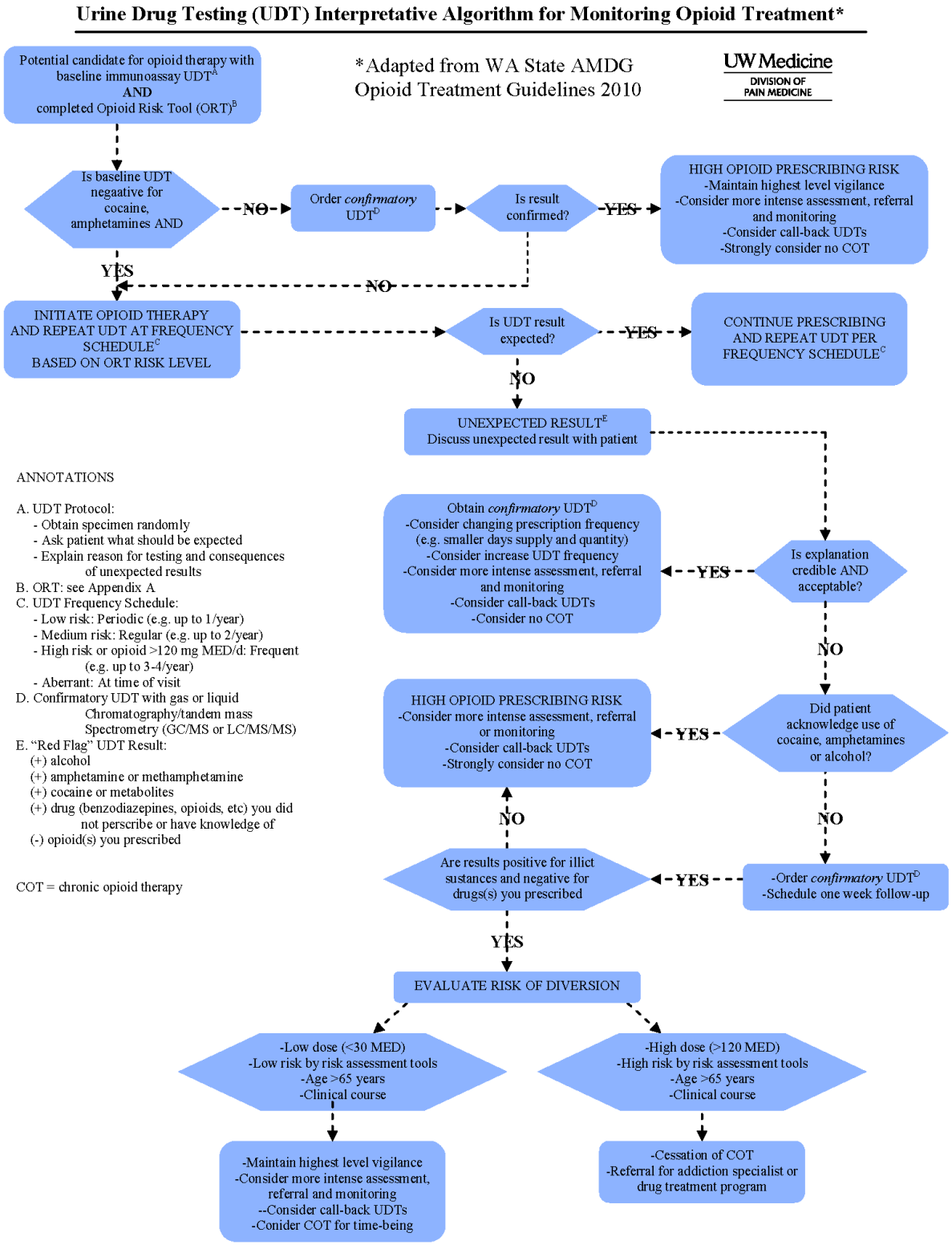
Moeller KE, Lee KC, Kissack JC.Urine drug screening: practical guide for clinicians.Mayo Clinic Proceedings.2008; 83(1):66-76.doi: 10.4065/83 .1.66.

Standridge JB, Adams SM, Zotos AP. Urine drug screening: a valuable office procedure. American Family Physician. 2010; 81(5):635-40.

Appendix S: Urine Drug Screening (USD) FAQ (Continued)



Appendix T: Metabolism Data for Common Medication

Drugs or Drug Classes	Detection Time in Urine*	Urine Drug Screening to Order	Expected Results	Consideration
Opioids or "opiates" – Natural (from opium)				
Codeine (Tylenol #2/3/4)	1–3 days	Opiates Immunoassay + GC/MS or LC/MS/MS Opiates	Opiates Immunoassay – positive GC/MS or LC/MS/MS – codeine, possibly morphine and hydrocodone	Immunoassays for "opiates" are responsive for morphine and codeine but do not distinguish which is present. Confirmatory testing is required to reliably identify drug(s) present. Since codeine is metabolized to morphine and small quantities to hydrocodone, these drugs may be found
Morphine (Avinza, Embeda, MS Contin, Kadian)	1–3 days		Opiates Immunoassay – positive GC/MS or LC/MS/MS – morphine, possibly hydromorphone	(<10%) of hydromorphone.
Opioids – Semisynthetic (derived from opium				
Hydrocodone (Lorcet, Lortab, Norco, Vicodin)	1–3 days	Opiates Immunoassay + GC/MS or LC/MS/MS Opiates	Opiates Immunoassay – positive GC/MS or LC/MS/MS – hydrocodone, possibly hydromorphone	"Opiates" immunoassays may also detect semisynthetic opioids depending on their cross-reactivity pattern. However, a negative result does not exclude use of semisynthetic opioids. Confirmatory testing (GC/MS or LC/MS/MS) is required to verify compliance with the prescribed semisynthetic opioid(s). Since hydrocodone is metabolized in small amounts to hydromorphone, both may be found in the urine. Likewise, oxycodone is metabolized to oxymorphone, so these may both be present in the urine of oxycodone users. However, the reverse is not true. In other words, hydromorphone and oxymorphone use does not result in positive screens for hydrocodone and oxycodone, respectively.
Hydromorphone (Dilaudid, Exalgo)	1–3 days	Opiates Immunoassay + GC/MS or LC/MS/MS Opiates	Opiates Immunoassay –positive GC/MS or LC/MS/MS – hydromorphone	
Oxycodone (Roxicet, OxyContin)	1–3 days	Oxycodone Immunoassay + GC/MS or LC/MS/MS Opiates	Opiates Immunoassay –positive GC/MS or LC/MS/MS – oxycodone possibly oxymorphone	
Oxymorphone (Opana)	1–3 days	Opiates or Oxycodone Immunoassay + GC/MS or LC/MS/MS Opiates	Opiates or Oxycodone Immunoassay – positive GC/MS or LC/MS/MS –oxymorphone	
Opioids – Synthetic (man-made) – *continued on next page*				
Fentanyl	1–3 days	GC/MS or LC/MS/MS Fentanyl	GC/MS or LC/MS/MS – fentanyl & norfentanyl	Current "opiates" immunoassays do not detect synthetic opioids. Thus confirmatory testing (GC/MS or LC/MS/MS) is needed to identify these drugs. If the purpose is to document compliance with treatment, the laboratory can be instructed to remove the cutoff concentration so that the presence of lower concentrations can be identified.
Meperidine (Demerol)	1–3 days	GC/MS or LC/MS/MS Meperidine	GC/MS or LC/MS/MS – normeperidine, possibly meperidine	

Appendix T: Metabolism Data for Common Medication (Continued)

Drugs or Drug Classes	Detection Time in Urine*	Urine Drug Screening to Order	Expected Results	Consideration
Opioids – Synthetic (man-made) – *continued*				
Methadone (Methadose)	3–7 days	Methadone Immunoassay + GC/MS or LC/MS/MS Methadone	Methadone Immunoassay – positive GC/MS or LC/MS/MS – methadone & EDDP	
Propoxyphene (Darvon, Darvocet)	1–3 days	Propoxyphene Immunoassay + GC/MS or LC/MS/MS Propoxyphene	Propoxyphene Immunoassay – positive GC/MS or LC/MS/MS – propoxyphene & norpropoxyphene	
Others				
Alcohol	Up to 8 hours	Alcohol	Alcohol – see Consideration	Additional testing for alcohol metabolites, ethyl glucuronide (EtG) or ethyl sulfate.
Amphetamines	2–3 days	Amphetamines, Methamphetamines or MDMA Immunoassay + GC/MS or LC/MS/MS Amphetamines	Amphetamines, methamphetamines or MDMA Immunoassay – see Consideration GC/MS or LC/MS/MS – amphetamine, methamphetamine or MDMA	Amphetamines immunoassays are highly cross-reactive so results should be interpreted cautiously, and may require consultation with the lab. They may detect other sympathomimetic amines, such as ephedrine, pseudoephedrine or selegiline. Confirmatory testing can identify which amphetamine is present.
Barbiturates	1–3 days w/ short-acting; up to 30 days w/ long acting	Barbiturates Immunoassay	Barbiturates Immunoassay – see Consideration	The clearance half-life of intermediate-acting barbiturates averages 24 hours. It takes about 5 to 7 half-lives to clear 98% of a drug dose. Thus, the presence of an intermediated-acting barbiturate indicates exposure within 5–7 days.
Benzodiazepines	1–3 days w/ short-acting; up to 30 days w/ long acting	Benzodiazepines Immunoassay	Benzodiazepines Immunoassay – see Consideration GC/MS or LC/MS/MS – alprazolam, diazepam, Clonazepam, lorazepam, etc.	Immunoassays for benzodiazepines have a 28% overall false negative rate and vary in cross-reactivity. Certain benzodiazepines (clonazepam and alprazolam) have limited detectability by most available immunoassays. Confirmatory testing is needed when use is expected or suspected.
Cocaine or benzoylecgonine	2–4 days	Cocaine Metabolites Immunoassay	Cocaine Metabolites Immunoassay – see Consideration	Cocaine immunoassays do not cross-react with other topical anesthetics that end in "caine" (e.g. lidocaine) and are highly specific for cocaine use.
Marijuana	2–4 days; up to 30 days w/ chronic heavy use	Cannabinoids (THC) Immunoassay	Cannabinoids Immunoassay – see Consideration GC/MS or LC/MS/MS – THC	THC may be an indicator of the patient's risk category. Prescribers should have an office policy, discuss with the patients reason for use and adjust monitoring plan accordingly.

*Agency Medical Directors Group, Interagency guideline on opioid dosing for Chronic Non-cancer Pain, 2010.

Appendix U: Patient Treatment Agreements

Sample 1. Controlled Substance Agreement

Why an agreement? The medication we are prescribing has the potential to provide much benefit, but it also can do harm to you or others. Misuse of pain medications is becoming a large problem in our community. We are doing our part to ensure that our prescriptions are taken as directed. We also want to protect you and inform you concerning the uses and abuses of this medication.

What are the benefits of opiate treatment? Opiates, also called opioids, provide relief from pain and a sense of well-being. They can allow you to perform activities that you might otherwise find limited due to pain.

What are the risks of opioid treatment? Opioids produce physical dependency with prolonged use. That means that you may experience discomfort if you discontinue these medications abruptly after taking them for over a few weeks. Some individuals have a hard time remaining medication free after being on long term opioids for that reason.

Opioids may decrease your ability to breathe deeply. This is especially true when they are combined with other sedating drugs like alcohol and some tranquilizers. This can lead to accidental overdose deaths.

Less serious side effects may include: constipation, decrease in sexual interest and performance, weight gain, sleepiness, urination difficulties, and itchiness. As with any medication, there is the rare possibility of a severe allergic reaction.

Some people are at risk of abusing these medications and may feel compelled to take them for their pleasurable effect. Therefore we are obliged to provide safeguards to protect you from these potential risks.

What are those safeguards? Our clinic has the following regulations for all patients taking long-term opioids; we will not prescribe these medications for chronic use without first:

- Obtaining all pertinent medical records
- Obtaining a urine drug screening (UDS)
- Reviewing your medical condition and past history
- Having a signed agreement between a clinician and yourself outlining the expectations of both parties.

What can I expect from the clinic? Our clinic agrees to provide you with appropriate doses of medication in a timely fashion and on an ongoing basis as long as there are no contraindications. You will be treated respectfully and professionally.

What does the clinic expect from me? The clinic expects all patients will agree to the following:

- Agree to have only one prescriber of opioids and use only one pharmacy.
- Bring their pill bottles to every clinic visit.
- Have a valid phone number available to our staff and to respond within 24 hours to the clinic if asked.
- Agree to random urine drug screenings and random pill counts.
- Agree to a chemical dependency or other specialist consultation should your provider feel that would be appropriate.

Appendix U: Patient Treatment Agreements (Continued)

- Allow open communication between this clinic and other providers concerning the use of these medications.
- Advise other treatment providers of the medication you are taking and to inform this clinic of any health care emergencies requiring pain or anxiety treatment.
- Agree to treat our staff respectfully and courteously.

Suggestions for safely handling your prescription: These medications can be dangerous if combined with other sedating substances. These medications are sought after by drug abusers. Therefore, we ask that you follow these suggestions to provide safety for you and your medications:

- Keep all medicines in a safe, preferably locked container, out of sight and out of the reach of children.
- Never share these medicines with others. Never take other people's pain medications.
- Avoid drinking alcohol while taking these medicines.
- Never combine these medications with other opioids or benzodiazepines (tranquilizers like lorazepam/ Ativan, alprazolam/Xanax, diazepam/Valium, clonazepam/Klonopin) unless advised to by your provider.
- Never use illicit drugs while using these medications.
- Be aware that opioids may affect your judgment and driving skills, particularly when your dose is increasing.

How will I obtain my refills? The clinic's policy on refills is:

- Refill prescriptions will only be written at a clinic visit. Therefore, refills will not take place over the phone, through the mail, or by calling the pharmacist.
- All dosage changes will occur at the next clinic visit.
- Lost or stolen medications may not be refilled until the next scheduled visit.

Will this medication relieve my pain? It is unrealistic to expect opioids to relieve all discomfort. We hope to reduce your pain so that you can regain function; that is to allow you to enjoy activities that you participated in prior to the onset of your pain. We will continue to ask that you participate in activities that improve your ability to perform daily activities. We may, in the course of your treatment, ask you to exercise, attend classes, or see a specialist of our choosing.

What are the consequences of not following these agreements? Your clinician has agreed to provide you with these medications as long as necessary, but also has the obligation to protect you and the community from abuse of these substances. In the event of suspected misuse, your provider may insist on a referral to a specialist in the assessment and treatment of drug dependency, or may immediately discontinue prescribing. Lack of improvement in function or to achieve adequate pain control may also necessitate the discontinuing of opioid medications.

Appendix U: Patient Treatment Agreements (Continued)

I will receive my prescriptions at the following pharmacy only:

Name and phone: _____

I agree to allow the following health care facilities to share information (including any pertinent mental health, drug or alcohol history or conditions) with my provider, and to allow my health care provider to freely share pertinent health care information with these facilities for the purpose of coordinating my medical care.

Facility: _____

Facility: _____

Facility: _____

Facility: _____

By signing below, I am agreeing to abide by the conditions of this agreement.

Patient's signature: _____ **Date:** _____

Person obtaining the consent: _____ **Date:** _____

Appendix U: Patient Treatment Agreements (Continued)

Sample 2. Patient/Clinic Agreement for the use of Controlled Substances

Your provider has prescribed

_____

for

_____

(diagnosis).

To continue receiving this medication from your provider, you are expected to follow the policies below. If you do not follow them, your provider may decide to stop prescribing the medication for you.

1. You are expected to take the medication as directed by your clinician, and to make your medication last until the next scheduled appointment. We expect our patients to be responsible for their prescription. You should never give any of your medications to someone else. We will not fill requests for lost or stolen prescriptions or medications.
2. Refills for controlled substances will only be done by appointment at the clinic. We will not fill requests for controlled substances by phone, after hours, or on weekends. We expect our patients to plan ahead for upcoming vacations, weekends and holidays and make a timely appointment if a prescription will need to be filled early.
3. By signing below, you agree to submit urine or blood as requested by your provider for random drug screens. You also agree to have a working phone number where clinic staff can reach you within 24 hours. That number is . You agree to update the clinic anytime you move or change your phone number.
4. You agree to bring your medication bottles to each regular visit.
5. Any patient who receives controlled substances from our clinic on an ongoing basis is expected to receive these prescriptions only from our organization. If you receive additional medicines for an unanticipated injury or condition, and these are not prescribed by our clinic provider, you are required to call the clinic the next business day, advise us of the situation, and release records of the encounter to our clinic.
6. While taking narcotics or other controlled substances you are expected to refrain from misusing or abusing other drugs which could alter consciousness, impair judgment, or cause addiction, including, alcohol, marijuana, methamphetamine, or other illegal drugs. If you in any way use these medications to harm yourself, you will no longer receive them at this clinic.
7. You may be required to seek treatments or consultations you have to pay for yourself.
8. In addition to taking pain relief medication, you are expected to comply with your clinician's other recommendations for improving your pain relief, or ability to function.
9. We require you to use only one pharmacy for your refills. Your pharmacy is _____. If you decide to change pharmacies, you must advise us immediately.
10. You authorize, by your signature below, any employee of our clinic to call any other health care provider, including emergency department staff and pharmacies, to obtain information regarding the prescription of any substance.

Appendix U: Patient Treatment Agreements (Continued)

Your signature acknowledges you have received a copy of this agreement.

Patient Signature _____ Date _____

Print Name _____ Medical Record Number _____

The use of narcotics poses risks to patients. By prescribing to you, we expect the following improvements:

____ Increased ability to exercise

____ Increased ability to participate in family activities

____ Increased ability to do housework

____ Lose weight

____ Able to go shopping

____ Able to return to work

OR

Alternatives to taking _____ include: _____

In addition to taking _____ to reduce your chronic pain, you are expected to:

Your allergies are: _____

The following is not necessarily a complete list of the side effects of pain medicines, but common side effects include: _____

BRAIN	Sleepiness, difficulty thinking, confusion, slow reflexes. It is possible to be convicted of driving under the influence (DUI) if you drive while using prescribed medication.
LUNG	Difficulty breathing or slowed breath rate to the point you stop breathing.
STOMACH	Nausea, vomiting. Constipation can be severe.
SKIN	Itching, rash.
GENITO-URINARY	Difficulty urinating. These drugs reduce interest in and ability to perform sexual activities.
ALLERGY	Potential for allergic reaction.
TOLERANCE	With long term use, an increasing amount of the same drug may be needed to achieve the same effect.

Appendix U: Patient Treatment Agreements (Continued)

PHYSICAL DEPENDENCE/WITHDRAWAL: Physical dependence develops within 3-4 weeks when taking these drugs. If they are stopped abruptly, symptoms of withdrawal may occur. Withdrawal can be extremely difficult and last a long time. Use of all controlled substances needs to be slowly tapered off under the direction of your prescriber.

ADDICTION This refers to the abnormal behavior directed toward acquiring or using drugs in a non-medically necessary manner. People with a history of alcohol or drug abuse are at increased risk.

Avoid medications or substances which increase drowsiness or limit the ability to think clearly, react quickly, or which decrease your rate of breathing. Talk to your provider before taking any of these medications, even if you can buy them over the counter.

I understand these risks and agree to accept them. I will let my prescriber know of any problems or side effects I am having with this medication.

Name (print) _____

Signature _____ Date _____

Appendix U: Patient Treatment Agreements (Continued)

Sample 3. Patient Treatment Agreement

I, (patient receiving chronic pain medications), agree to correctly use pain medications prescribed for me as part of my treatment for chronic pain. I understand that these medications may not get rid of my pain but may decrease the pain and increase the level of activity that I am able to do each day. I understand that the Pain Management Clinic will deal with my chronic pain and will not deal with any of my other medical conditions.

I understand that (name) will be my pain management provider and the only provider who will be ordering medications for my chronic pain.

I understand that I have the following responsibilities (initial each item you agree to):

____ I will only take medications at the amount and frequency prescribed.
____ I will not increase or change how I take my medications without the approval of my pain management provider.
____ I will not ask for refills earlier than agreed. I will arrange for refills ONLY during regular office hours. I will make the necessary arrangements before holidays and weekends.
____ I will get all pain medications only at one pharmacy. I will let my pain management provider know if I change pharmacies. Pharmacy _____ Phone Number _____
____ I will allow my pain management provider to provide a copy of this agreement to my pharmacy.
____ I will not ask for any pain medications or controlled substances from other providers and will let my pain management provider know of all medications I am taking, including non-legal drugs.
____ I understand that other physicians should not change doses of my pain medications made by another provider.
____ I will notify the Pain Management Clinic of any changes to my pain medications made by another provider.
____ I will let my other health care providers know that I am taking these pain medications and that I have a pain management agreement.
____ In event of an emergency, I will give this same information to emergency department providers.
____ I will allow my pain management provider to discuss all my medical conditions and treatment details with pharmacists, physicians, or other health care providers who provide my health care for purposes of care coordination.
____ I will inform my pain management provider of any new medications or medical conditions.
____ I will protect my prescriptions and medications. I understand that lost or misplaced prescriptions will not be replaced.
____ I will keep medications only for my own use and will not share them with others. I will keep all medications away from children.

Appendix U: Patient Treatment Agreements (Continued)

In addition, I will do the following (initial each box):

____ I must make an appointment with a drug and alcohol counselor and bring proof of following my treatment plan.
____ I must take a drug test _____ (frequency).
____ I agree to pill counts to prove I am using my medications correctly.
____ If I fail a drug test, I will take the drug test _____ (frequency).
____ If I fail a drug test, I will be referred to Medicaid's Patient Review and Coordination Program that restricts me to certain providers, such as a primary doctor.
____ If I sell my narcotics, my name will be referred to the DSHS fraud unit.
____ If I fail all of the above, I will be discharged from your care with no notice.

Should any of the above not show good faith efforts and my providers feel they can no longer prescribe my pain medications in a safe and effective way, I may be notified and discharged from their care.

I agree to use only the following providers. I will notify my physician of any changes in my health care and/or changes in my providers.

Provider _____ Clinic _____ Phone _____
Provider _____ Clinic _____ Phone _____
Patient Signature _____ Provider Signature _____

Source: Group Health, Chronic Opioid Therapy for Chronic Non-Cancer Pain Guideline, 2010.

Appendix V: Material Risk Notice

This will confirm that you, _____, have been diagnosed with the following condition(s) causing you chronic intractable pain: _____. I have recommended treating your condition with the following controlled substances: _____. In addition to significant reduction in your pain, your personal goals from therapy are: _____ _____. Alternatives to this therapy are: _____ _____. Additional therapies that may be necessary to assist you in reaching your goals are: _____.

Notice of Risk: The use of controlled substances may be associated with certain risks such as, but not limited to: Central Nervous System: Sleepiness, decreased mental ability, and confusion. Avoid alcohol while taking these medications and use care when driving and operating machinery. Your ability to make decisions may be impaired.

Cardiovascular: Irregular heart rhythm from mild to severe.
Respiratory: Depression (slowing) of respiration and the possibility of inducing bronchospasm (wheezing) causing difficulty in catching your breath or shortness of breath in susceptible individuals.

Gastrointestinal: Constipation is common and may be severe. Nausea and vomiting may occur as well. Dermatological: Itching and rash. Endocrine: Decreased testosterone (male) and other sex hormones (females); dysfunctional sexual activity.

Urinary: Urinary retention (difficulty urinating).

Pregnancy: Newborn may be dependent on opioids and suffer withdrawal symptoms after birth.

Drug Interactions: With or altering the effect of other medications cannot be reliably predicted.

Tolerance: Increasing doses of drug may be needed over time to achieve the same (pain relieving) effect. Physical dependence and withdrawal: Physical dependence develops within 3-4 weeks in most patients receiving daily doses of these drugs. If your medications are abruptly stopped, symptoms of withdrawal may occur. These include nausea, vomiting, sweating, generalized malaise (flu-like symptoms), abdominal cramps, palpitations (abnormal heartbeats). All controlled substances (narcotics) need to be slowly weaned (tapered off) under the direction of your physician.

Addiction (Abuse): This refers to abnormal behavior directed towards acquiring or using drugs in a non- medically supervised manner. Patients with a history of alcohol and/or drug abuse are at increased risk for developing addiction.

Allergic reactions: Are possible with any medication. This usually occurs early after initiation of the medication. Most side effects are transient and can be controlled by continued therapy or the use of other medications.

Appendix V: Material Risk Notice (Continued)

This confirms that we discussed and you understand the above. I asked you if you wanted a more detailed explanation of the proposed treatment, the alternatives and the material risks, and you (Initial one):

____ was satisfied with that explanation and desired no further information.

____ requested and received, in substantial detail, further explanation of the treatment, alternatives and material risks.

_____ DATE _____

PATIENT SIGNATURE

Explained by me and signed in my presence.

_____ DATE _____

PATIENT SIGNATURE

Explained by me and signed in my presence.

Appendix W: Medical Risks of Long-Term Opioid Use

Medical risk	How common?	Description and information
Respiratory depression		
Opioid overdose	< 1% per year but increases with dose	Caused by severely slowed breathing, which you may not notice Severe cases are treated in the hospital Can cause death
Breathing problems during sleep	Not known	Opioids may cause or worsen sleep apnea You may not notice breathing problems
Injuries		
Falls and fractures	Not known	
Motor vehicle crashes	Not known	
Gastrointestinal problems		
Constipation	30 - 40%	It helps to use stool-softeners or drugs that stimulate bowel movements
Serious intestinal blockage	<1% per year	Caused by severe constipation Severe cases are treated in the hospital
Hormonal effects		
Hypogonadism, impotence, infertility, osteoporosis	25% - 75%	Hypogonadism = lowered sex hormones, which can worsen sexual function Osteoporosis can make you more likely to fracture or break a bone
Cognitive and neurophysiologic effects		
Sedation	15%	Can cause difficulty driving or thinking clearly
Disruption of sleep	Not known	
Hyperalgesia	Not known	Hyperalgesia = being more sensitive to pain
Psychosocial		
Depression, anxiety, de-activation, apathy	Not known	Depression can worsen pain, while pain can worsen depression. Opioids can cause loss of interest in usual activities, which can increase depression.
Addiction, misuse, and diversion	5 - 30%	Common signs of prescription opioid addiction are preoccupation with opioid use or craving, unsuccessful attempts to discontinue use or cut down, cutting down or giving up activities due to opioid use, and using more medication than prescribed.
Oral Health		
Dry mouth that may sometimes cause tooth decay	Dry mouth is common	Brush your teeth and rinse your mouth often Chew sugarless gum and drink water or sugar-free, non-carbonated fluids
Myoclonus	Not Known	Myoclonus = muscle twitching

Reference: Group Health, Chronic Opioid Therapy for Chronic Non-Cancer Pain Guideline, 2010.

Appendix X: Functional Scales

Pain Intensity and Interference

In the last month, on average, how would you rate your pain? Use a scale from 0 to 10, where 0 is "no pain" and 10 is "pain as bad as could be"? (That is, your usual pain at times you were in pain.)

No Pain										Pain as bad as could be
0	1	2	3	4	5	6	7	8	9	10

In the last month, how much has pain interfered with your daily activities? Use a scale from 0 to 10, where 0 is "no interference" and 10 is "unable to carry on any activities"?

No Interference										Unable to carry on any activities
0	1	2	3	4	5	6	7	8	9	10

Appendix Y: Oswestry Low Back Pain Disability Questionnaire

The Oswestry Disability Index (also known as the Oswestry Low Back Pain Disability Questionnaire) is an extremely important tool that researchers and disability evaluators use to measure a patient's permanent functional disability. The test is considered the "gold standard" of low back functional outcome tools.

Scoring Instructions

For each section the total possible score is 5: If the first statement is marked, the section score = 0; if the last statement is marked, the score = 5. If all 10 sections are completed, the score is calculated as follows:

Example: 16 (total scored)
50 (total possible score) x 100 = 32%

If one section is missed or not applicable, the score is calculated: 16 (total scored) 45 (total possible score) x 100 = 35 .5%

Minimum detectable change (90% confidence): 10% points (Change of less than this may be attributable to error in the measurement.)

Interpretation of Scores

0% to 20%: minimal disability	The patient can cope with most living activities. Usually no treatment is indicated apart from advice on lifting, sitting and exercise.
21%-40%: moderate disability	The patient experiences more pain and difficulty with sitting, lifting and standing. Travel and social life are more difficult, and they may be disabled from work. Personal care, sexual activity and sleeping are not grossly affected, and the patient can usually be managed by conservative means.
41%-60%: severe disability	Pain remains the main problem in this group, but activities of daily living are affected. These patients require a detailed investigation.
61%-80%: crippled	Back pain impinges on all aspects of the patient's life. Positive intervention is required.
81%-100%	These patients are either bed-bound or exaggerating their symptoms.

Instructions

The following questionnaire has been designed to give us information as to how your back or leg pain is affecting your ability to manage in everyday life. Please answer by checking ONE box in each section for the statement which best applies to you. We realize you may consider that two or more statements in any one section apply, but please check only the box that indicates the statement which most clearly describes your problem.

Appendix Y: Oswestry Low Back Pain Disability Questionnaire (Cont.)

Section 1—Pain intensity

- ☐ I have no pain at the moment.
- ☐ The pain is very mild at the moment. The
- ☐ pain is moderate at the moment. The pain
- ☐ is fairly severe at the moment. The pain is
- ☐ very severe at the moment.
- ☐ The pain is the worst imaginable at the moment.

Section 2—Personal care (washing, dressing, etc.)

- ☐ I can look after myself normally without causing extra pain.
- ☐ I can look after myself normally but it causes extra pain.
- ☐ It is painful to look after myself and I am slow and careful.
- ☐ I need some help but manage most of my personal care.
- ☐ I need help every day in most aspects of self-care. I do
- ☐ not get dressed, I wash with difficulty and stay in bed.

Section 3—Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it gives extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently placed, eg. on a table.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift very light weights.
- ☐ I cannot lift or carry anything at all.

Section 4—Walking

- ☐ Pain does not prevent me walking any distance. Pain
- ☐ prevents me from walking more than 1 mile. Pain
- ☐ prevents me from walking more than ½ mile. Pain
- ☐ prevents me from walking more than 100 yards.
- ☐ I can only walk using a stick or crutches I am in bed most of the time.

Section 5—Sitting

- ☐ I can sit in any chair as long as I like.
- ☐ I can only sit in my favorite chair as long as I like.
- ☐ Pain prevents me sitting more than one hour.
- ☐ Pain prevents me from sitting more than 30 minutes.
- ☐ Pain prevents me from sitting more than 10 minutes.
- ☐ Pain prevents me from sitting at all.

Section 6—Standing

- ☐ I can stand as long as I want without extra pain.
- ☐ I can stand as long as I want but it gives me extra pain.
- ☐ Pain prevents me from standing for more than 1 hour.
- ☐ Pain prevents me from standing for more than 3 minutes.
- ☐ Pain prevents me from standing for more than 10 minutes.
- ☐ Pain prevents me from standing at all.

Section 7—Sleeping

- ☐ My sleep is never disturbed by pain.
- ☐ My sleep is occasionally disturbed by pain.
- ☐ Because of pain I have less than 6 hours sleep.
- ☐ Because of pain I have less than 4 hours sleep.
- ☐ Because of pain I have less than 2 hours sleep.
- ☐ Pain prevents me from sleeping at all.

Section 8—Sex life (if applicable)

- ☐ My sex life is normal and causes no extra pain.
- ☐ My sex life is normal but causes some extra pain.
- ☐ My sex life is nearly normal but is very painful.
- ☐ My sex life is severely restricted by pain.
- ☐ My sex life is nearly absent because of pain.
- ☐ Pain prevents any sex life at all.

Section 9—Social life

- ☐ My social life is normal and gives me no extra pain.
- ☐ My social life is normal but increases the degree of pain.
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests (e.g. sports).
- ☐ Pain has restricted my social life and I do not go out as often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have no social life because of pain.

Section 10—Travelling

- ☐ I can travel anywhere without pain.
- ☐ I can travel anywhere but it gives me extra pain.
- ☐ Pain is bad but I manage journeys over two
- ☐ hours. Pain restricts me to journeys of less than one hour.
- ☐ Pain restricts me to short necessary journeys under 30 minutes.
- ☐ Pain prevents me from travelling except to receive treatment.

Appendix Z: PEG-3: Pain Screening Tool

What number best describes your pain on average in the past week?

No Pain										Pain as bad as you can imagine
0	1	2	3	4	5	6	7	8	9	10

What number best describes how, during the past week, pain has interfered with your enjoyment of life?

Does not Interfere										Unable to carry on Any activities
0	1	2	3	4	5	6	7	8	9	10

What number best describes how, during the past week, pain has interfered with your general activity?

Does not interfere										Completely interferes
0	1	2	3	4	5	6	7	8	9	10

To compute the PEG score, add the three responses to the questions above, then divide by three to get a final score out of 10.

Final Score

The final PEG score can mean very different things to different patients. The PEG score, like most other screening instruments, is most useful in tracking changes over time. The PEG score should decrease over time after therapy has begun.

Reference: Krebs, E .E, Lorenz, K .A, Blair, M .J, et al. (2009). Development and initial validation of the PEG, a three-item scale assessing pain intensity and interference. Journal of General Internal Medicine, 24: 733-738.

Appendix AA: Additional Assessment Tools

Specific Psychosocial Assessment	Tools to Evaluate
Substance abuse history	ORT, CAGE, Audit, Dast. SOAPP-R
Psychiatric/Mental health history	PHQ, PMQ, DIRE, GAD-7, PCL-C
ADLs/self-care	Oswestry, SF-36 or 12, pain log/diary, ACPS QOL
Self-perception of disability	DIRE, COMM, SF-36 or 12
SI/SA history	Roland-Morris Low-Back Pain and Disability Questionnaire

ORT	Opioid Risk Tool. Very simple, evidence-based and widely used.
CAGE	Four-item self-test for identifying usage patterns that may reflect problems with alcohol.
PHQ	Patient Health Questionnaire, a 2-, 4-, or 9-item depression scale; tool for assisting in diagnosing depression.
DIRE	Diagnosis, intractability, risk, efficacy tool that assesses the risk of opioid abuse and the suitability of candidates for long-term opioid therapy.
COMM	Current Opioid Misuse Measure. A 17-item self-assessment to identify patients with chronic pain who are taking opioids and have indicators of current aberrant drug-related behaviors.
SBIRT	Screening, brief intervention, and referral to treatment. An effective, evidence-based method to intervene in alcohol and drug misuse.
OSWESTRY	The Oswestry Low-Back Pain Disability Questionnaire, a tool that researchers and disability evaluators use to measure a patient's permanent functional disability. The test is considered the gold standard of low back functional outcome tools.
SOAPP-R	The Screener and Opioid Assessment for Patients with Pain-Revised. Predicts possible opioid abuse in chronic pain.

Appendix AB: Opioid Withdrawal Attenuation Cocktail

Opioid Withdrawal Attenuation Cocktail

Acute Withdrawal

Clonidine 0 .1mg QID x anticipated length of withdrawal. (Check BP and watch for hypotension.)

Diarrhea: Loperamide 4mg then 2mg QID. May have opioid effects at high doses.
Alternatively, consider Hycosamine 0 .125mg q 4-6 hrs PRN

Myalgias: Ibuprofen 400mg po QID or Acetaminophen 325mg po Q6hrs

Anxiety: Hydroxyzine 25mg po TID

Insomnia: Trazodone 50-100mg po QHS

Nausea: Ondansetron 8mg po BID x anticipated length of withdrawal. (Check QTc)

Anticipated Withdrawal as a Part of a Planned Taper

Anxiety: Gabapentin Escalating Dose to 1200mg/day. Start loading one month prior to planned taper.

Clonidine 0 .1mg QID x anticipated length of withdrawal. (Check BP and watch for hypotension.)

Diarrhea: Loperamide 4mg then 2mg QID

Myalgias: Ibuprofen 400mg po QID or Acetaminophen 325mg po Q6hrs

Anxiety: Hydroxyzine 25mg po TID

Insomnia: Trazodone 50-100mg po QHS

Nausea: Ondansetron 8mg po BID x anticipated length of withdrawal. (Check EKG for QTc interval)

Appendix AC: Patient and Community Resources

Referral Options

A. If you are looking for substance abuse evaluation services: **Iowa Assessment/Evaluation for Drug and Alcohol Addiction**
B. If you are looking for treatment referral resources: **Iowa Assessment/Evaluation for Drug and Alcohol Addiction**, **Treatment resources look-up (SAMSHA)**, **NIDA Opioid Treatment Provider Directory**

Resources

A. CDC Patient Videos: **Even When Prescribed by a Doctor** raises general awareness about opioids, **Change the Conversation About Opioid Use Disorders**
B. National Institute on Drug Abuse: **Understanding Drug Use and Addiction Drugs of Abuse National Institute on Drug Abuse**
C. Foundation for a Drug-Free World: **The Truth About Prescription Drugs**
D. National Attorneys General Training & Research Institute Prescription Drug Abuse: **What Parents Need to Know Sometimes Pills Hurt More Than They Help**, **It's Up To Use – How to Combat Prescription Opioid Addiction Together Nebraska Family Helpline**

Appendix AD: 4 A's

Monitoring Prescription Opioid Therapy Using the "4 As"

Documentation	Analgesia	Is the patient's pain better controlled?	Administer (or re-administer) pain scale
	Activity	Is the patient better able to function?	Administer (or re-administer) pain scale
	Adverse Events	Are there any undesirable effects of the medication?	Ask patients if they are experiencing any new health issues (e.g., constipation, nausea, over sedation, itching since starting treatment or since the last visit.
	Aberrant Behavior	Are there any signs that the patient is misusing the prescription?	Review patient's medication use and adherence to treatment agreement. Recheck prescription drug monitoring system registry and consider repeat urine drug testing.

Source: http://www.rethinkopioids.com/monitor-treatment

Appendix AE: DAST-20

Substance Abuse Screening Instrument (O4/05)

The Drug Abuse Screening Test (DAST) was developed in 1982 and is still an excellent screening tool. It is a 28-item self-report scale that consists of items that parallel those of the Michigan Alcoholism Screening Test (MAST). The DAST has "exhibited valid psychometric properties" and has been found to be "a sensitive screening instrument for the abuse of drugs other than alcohol.

The Drug Abuse Screening Test (DAST)

Directions: The following questions concern information about your involvement with drugs. Drug abuse refers to (1) the use of prescribed or "over-the-counter" drugs in excess of the directions, and (2) any non-medical use of drugs. Consider the past year (12 months) and carefully read each statement. Then decide whether your answer is YES or NO and check the appropriate space. Please be sure to answer every question.

		YES	NO
1.	Have you used drugs other than those required for medical reasons?	___	___
2.	Have you abused prescription drugs?	___	___
3.	Do you abuse more than one drug at a time?	___	___
4.	Can you get through the week without using drugs (other than those required for medical reasons)?	___	___
5.	Are you always able to stop using drugs when you want to?	___	___
6.	Do you abuse drugs on a continuous basis?	___	___
7.	Do you try to limit your drug use to certain situations?	___	___
8.	Have you had "blackouts" or "flashbacks" as a result of drug use?	___	___
9.	Do you ever feel bad about your drug abuse?	___	___
10.	Does your spouse (or parents) ever complain about your involvement with drugs?	___	___
11.	Do your friends or relatives know or suspect you abuse drugs?	___	___
12.	Has drug abuse ever created problems between you and your spouse?	___	___
13.	Has any family member ever sought help for problems related to your drug use?	___	___
14.	Have you ever lost friends because of your use of drugs?	___	___
15.	Have you ever neglected your family or missed work because of your use of drugs?	___	___
16.	Have you ever been in trouble at work because of drug abuse?	___	___
17.	Have you ever lost a job because of drug abuse?	___	___
18.	Have you gotten into fights when under the influence of drugs?	___	___
19.	Have you ever been arrested because of unusual behavior while under the influence of drugs?	___	___
20.	Have you ever been arrested for driving while under the influence of drugs?	___	___
21.	Have you engaged in illegal activities in order to obtain drug?	___	___
22.	Have you ever been arrested for possession of illegal drugs?	___	___
23.	Have you ever experienced withdrawal symptoms as a result of heavy drug intake?	___	___
24.	Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc.)?	___	___
25.	Have you ever gone to anyone for help for a drug problem?	___	___
26.	Have you ever been in a hospital for medical problems related to your drug use?	___	___
27.	Have you ever been involved in a treatment program specifically related to drug use?	___	___
28.	Have you been treated as an outpatient for problems related to drug abuse?	___	___

Scoring and interpretation: A score of "1" is given for each YES response, except for items 4,5, and 7, for which a NO response is given a score of "1." Based on data from a heterogeneous psychiatric patient population, cutoff scores of 6 through 11 are considered to be optimal for screening for substance use disorders. Using a cutoff score of 6 has been found to provide excellent sensitivity for identifying patients with substance use disorders as well as satisfactory specificity (i.e., identification of patients who do not have substance use disorders). Using a cutoff score of <11 somewhat reduces the sensitivity for identifying patients with substance use disorders, but more accurately identifies the patients who do not have a substance use disorders. Over 12 is definitely a substance abuse problem. In a heterogeneous psychiatric patient population, most items have been shown to correlate at least moderately well with the total scale scores. The items that correlate poorly with the total scale scores appear to be items 4,7,16,20, and 22.

Appendix AF: Sample Progress Note

Progress Note

Pain Assessment and Documentation Tool (PADT™)

Patient Name: _____ **Record #:** _____

Assessment Date: _____

Patient Stamp Here

Current Analgesic Regimen

Drug Name	Strength (eg, mg)	Frequency	Maximum Total Daily Dose

The PADT is a clinician-directed interview; that is, the clinician asks the questions, and the clinician records the responses. The Analgesia, Activities of Daily Living, and Adverse Events sections may be completed by the physician, nurse practitioner, physician assistant, or nurse. The Potential Aberrant Drug-Related Behavior and Assessment sections must be completed by the physician. Ask the patient the questions below, except as noted.

Analgesia

If zero indicates "no pain" and ten indicates "pain as bad as it can be," on a scale of 0 to 10, what is your level of pain for the following questions?

1. What was your pain level on average during the past week? (Please circle the appropriate number)

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as it can be

2. What was your pain level at its worst during the past week?

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as it can be

3. What percentage of your pain has been relieved during the past week? (Write in a percentage between 0% and 100%.)

_____

4. Is the amount of pain relief you are now obtaining from your current pain reliever(s) enough to make a real difference in your life?

☐ Yes ☐ No

5. Query to clinician: Is the patient's pain relief clinically significant?

☐ Yes ☐ No ☐ Unsure

Activities of Daily Living

Please indicate whether the patient's functioning with the current pain reliever(s) is Better, the Same, or Worse since the patient's last assessment with the PADT.* (Please check the box for Better, Same, or Worse for each item below.)

	Better	Same	Worse
1. Physical functioning	☐	☐	☐
2. Family relationships	☐	☐	☐
3. Social relationships	☐	☐	☐
4. Mood	☐	☐	☐
5. Sleep patterns	☐	☐	☐
6. Overall functioning	☐	☐	☐

*If the patient is receiving his or her first PADT assessment, the clinician should compare the patient's functional status with other reports from the last office visit.

(Continued on reverse side)

Appendix AF: Sample Progress Note (Continued)

Progress Note

Pain Assessment and Documentation Tool (PADT™)

Adverse Events

1. Is patient experiencing any side effects from current pain reliever? ☐Yes ☐No

Ask patient about potential side effects:

	None	Mild	Moderate	Severe
a. Nausea	☐	☐	☐	☐
b. Vomiting	☐	☐	☐	☐
c. Constipation	☐	☐	☐	☐
d. Itching	☐	☐	☐	☐
e. Mental cloudiness	☐	☐	☐	☐
f. Sweating	☐	☐	☐	☐
g. Fatigue	☐	☐	☐	☐
h. Drowsiness	☐	☐	☐	☐
i. Other_____		☐	☐	☐
j. Other_____		☐	☐	☐

Potential Aberrant Drug-Related Behavior

This section must be completed by the physician

Please check any of the following items that you discovered during your interactions with the patient. Please note that some of these are directly observable (eg, appears intoxicated), while others may require more active listening and/or probing. Use the "Assessment" section below to note additional details.

- ☐ Purposeful over-sedation
- ☐ Negative mood change
- ☐ Appears intoxicated
- ☐ Increasingly unkempt or impaired
- ☐ Involvement in car or other accident
- ☐ Requests frequent early renewals
- ☐ Increased dose without authorization
- ☐ Reports lost or stolen prescriptions
- ☐ Attempts to obtain prescriptions from other doctors
- ☐ Changes route of administration
- ☐ Uses pain medication in response to situational stressor
- ☐ Insists on certain medications by name
- ☐ Contact with street drug culture
- ☐ Abusing alcohol or illicit drugs
- ☐ Hoarding (ie, stockpiling) of medication
- ☐ Arrested by police
- ☐ Victim of abuse
- ☐ Other: _____

_____

_____

2. Patients overall severity of side effects?

☐None ☐Mild ☐Moderate ☐Severe

Assessment: (This section must be completed by the physician.)

Is your overall impression that this patient is benefiting (eg, benefits, such as pain relief, outweigh side effects) from opioid therapy? ☐Yes ☐No ☐Unsure

Comments: _____

_____

Specific Analgesic Plan: Comments: _____

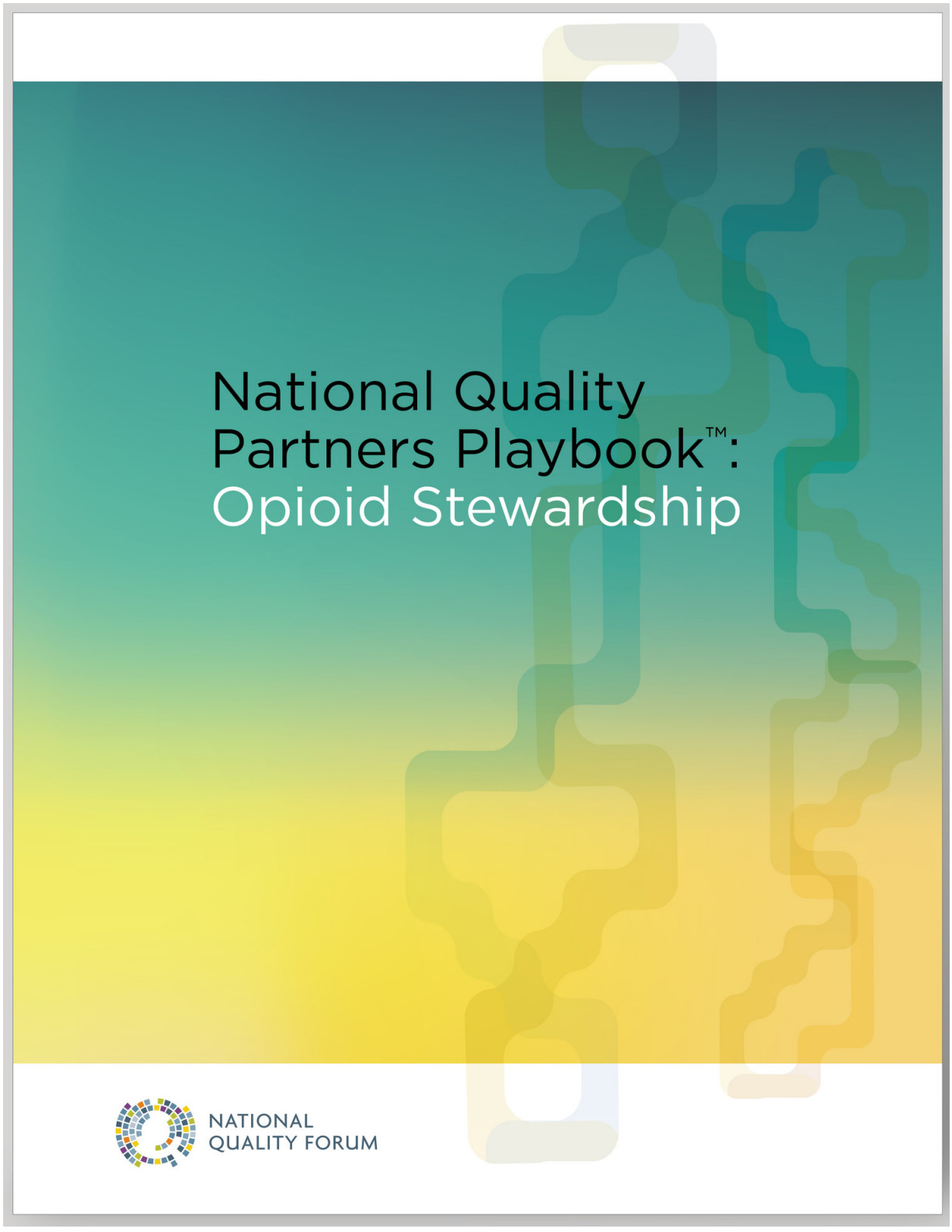
- ☐ Continue present regimen
- ☐ Adjust dose of present analgesic
- ☐ Switch analgesics
- ☐ Add/Adjust concomitant therapy
- ☐ Discontinue/taper off opioid therapy

Date: _____ Physicians Signature: _____

Provided as a service to the medical community by Janssen Pharmaceutica Products, L.P.

Appendix AG: National Quality Partners Playbook: Opioid Stewardship

The NQF Playbook: Opioid Stewardship is available for purchase on the **NQF website**.



Appendix AH: Additional Tools and Resources

Tools to Use in Evaluation and Monitoring

- **Pain Management Evaluation Tool**
- **Patient Pain and Medication Tracking**
- **Sheehan Disability Scale**
- **Brief Pain Inventory Form**
- **Treatment Plan for Prescribing**
- **SF-12**

Tools to Screen for Risk of Complications

- Iowa Prescription Monitoring Program
- **Current Opioid Misuse Measure (COMM)**
- **Urine Drug Testing Devices**
- **Signs of Substance Misuse**
- **Checklist for Adverse Effects, Function and Opioid Dependence**

Informational Tools

- **United States Food and Drug Administration (FDA) Guidelines on Proper Disposal of Prescription Drugs**
- **Non-opioid Pain Management Tool**
- **Absolute Contraindications to Opioid Prescribing**
- **Strategies for Tapering and Weaning**
- **Information for Patients-Opioid Analgesics for Non-Cancer Pain**
- **The Role of Methadone in the Management of Chronic Non-Malignant Pain**
- **Dosing Guidelines**
- **Electronic MME Dosing Calculator**
- **Osteopathic Rules on Prescribing for Intractable Pain (OAC 510:5-9-1 et. seq.)**
- Iowa Board of Medicine Rules on Opioid Prescribing