

Pain Treatment Guidelines

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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 pill 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 manifest. 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.

- › What is the etiology of the pain, and would non-opioid treatment suffice?
- › Are there risk factors present that would make the use of opioids unsafe for this patient?
- › What is the usual expectation for pain for this condition? Is my patient’s response outside that expected range?
- › Is there a medical justification for this dose of opioid, for this length of time, for this condition, in this patient?

Practicing outside those parameters puts your patient, or your patient’s family, or the community at large, at risk. Too many pills prescribed for a given situation can create dependency in your patient, or if they are stolen or diverted, can feed the illicit habit of others.

This is an iatrogenic public health crisis, and all of us in the healthcare profession have to assume responsibility in fixing it.⁴

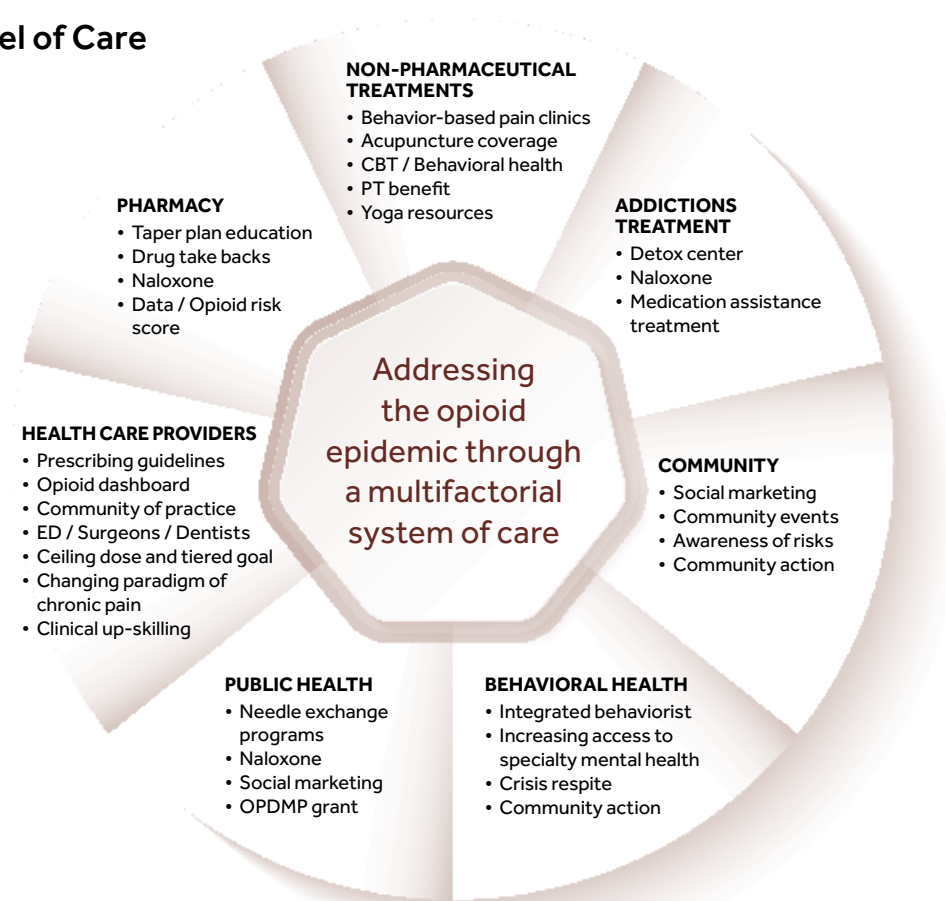
The Columbia Pacific Coordinated Care Organization Opioid Strategy

In Columbia, Clatsop, and Tillamook counties, we have been working on a community response to the opioid crisis for several years. We continue to adjust our recommendations as information concerning safe practice evolves. For example, we now advocate prescribing less than 50 mg/d MED (morphine equivalent dose) rather than the 120 mg/d MED mentioned in our previous guidelines. Likewise, we do not recommend methadone for the treatment of chronic pain, reflecting the increase in overdose deaths associated with methadone use for pain treatment.

To achieve genuine and lasting practice change, our entire community will be educated regarding our current understanding of the appropriate management of pain. The entire community needs to understand the science that underlies current best-practice recommendations; and our patients and families need to hear the same message. We felt the best approach would be to promote a coordinated, community-based effort to achieve regional broad support for these guidelines where providers share a common understanding, patients hear a consistent message, and the community at large supports and guides these efforts.

Led by the CPCCO Clinical Advisory Panel (CAP), the Columbia Pacific region has been working to address this issue for a few years. The CAP recommended in 2014 to start non-prescribing, behavior-based pain clinics as an alternative to treat patients' pain. In early 2016, the North Coast Opioid summit brought together over 200 community members consisting of providers, pharmacists, behavioral health specialists, law enforcement, general public, and public health professionals to discuss the epidemic and develop an action plan. The North Coast Opioid Steering Committee was subsequently formed to help move this work forward. The steering committee in partnership with the CAP is advising on regional action plans addressing: improving clinical prescribing (e.g., guidelines, provider education, OPDMP etc), decreasing pills in circulation, increasing naloxone access, increasing access to medication assistance treatments, and developing community education campaigns. Below is an overview of the multidisciplinary regional work that is helping to address the opioid crisis.

Regional Opioid Model of Care



OPG and CPCCO Guidelines Authors and Contributors

With the release of the CDC guidelines,⁵ Oregon Pain Guidance (OPG) focused their attention on operationalizing these nationally recognized best practices. The goal in the development of the OPG guidelines is to provide real-world tools and advice to practicing clinicians as they seek to comply with this excellent national guidance document. The OPG guidelines have been influenced by the work of the Washington State Medical Directors Group,⁶ the CDC, and many other leaders in the state of Oregon and nationally in the field of safe opioid prescribing. These guidelines have been debated and edited by our colleagues in OPG and elsewhere, and not every participant agrees with every component of this document. OPG created these guidelines for everyone who manages patients with pain: prescribers, behavioral professionals, those who dispense pain medications, and those who pay for them.

Credit for the creation of these guidelines belongs first to the members of the OPG group who developed a series of OPG guidelines over several years that reflected agreed community standards of care. The last major release was in 2014. Since that time, two major guidelines have been released, the Washington state AMDG guidelines (June 2015) and the CDC guidelines (March 2016). We have done our best to incorporate and be consistent with recommendations in both these guidelines.

The majority of the drafting and revisions of the OPG guidelines were done by three individuals: Jim Shames, MD, Medical Director and Health Officer of Jackson County Health and Human Services; John Kolsbun, MD, Medical Director of AllCare Health, and Mark Stephens, a healthcare consultant. Other significant contributors were Laura Heesacker, LCSW; Sara Smith, RN; Rachel Vossen, PharmD; Mark Kantor, RPh; and Paul Coelho, MD; as well as other members of the OPG group who added additional content. Other experts in “Pain” have reviewed and commented on these guidelines as well. OPG is very grateful for all the contributors who helped produce these guidelines.

For these updated CPCCO guidelines, credit belongs to the opioid task force members of the Clinical Advisory Panel: Katrina Mcpherson, MD; Dominique Greco, MD; Sarah Present, MD; and Christopher Laman, PharmD. The majority of the revisions were done by Melissa Brewster, PharmD, Ambulatory Care Clinical Coordinator for Columbia Pacific CCO and Safina Koreishi, MD, Medical Director for Columbia Pacific CCO. Special thanks also to the members of the North Coast Regional Opioid Steering Committee and Kelly White, MHA, for their help and guidance with the CPCCO regional opioid strategy. We would also like to thank all of our community and clinical partners who are working hard every day to address this issue and improve health in our communities.

CDC Guidelines

In March 2016, the CDC issued new guidelines on opioid prescribing.⁵ The importance of these guidelines cannot be overstated as they establish national recommendations for the use of opioids for treatment of chronic pain. We completely support and endorse these new guidelines. This is a summary of the 12 CDC recommendations. We have modified the OPG guidelines to ensure they are in compliance with and support these guidelines.

Determining when to initiate or continue opioids for chronic pain

1. 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.
2. 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.
3. 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

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

5. 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 (MED) per day, and should avoid increasing dosage to ≥ 90 MED/day or carefully justify a decision to titrate dosage to ≥ 90 MED/day.
6. Long-term opioid use often begins with 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.
7. 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

8. Before starting and periodically during 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 risk for opioid overdose, such as history of overdose, history of substance-use disorder, higher opioid dosages (≥ 50 MED/day), or concurrent benzodiazepine use are present.
9. Clinicians should review the patient's history of controlled-substance prescriptions using state prescription drug monitoring program (PDMP) 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 PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every three months.
10. 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 and illicit drugs.
11. Clinicians should avoid prescribing opioid pain medication and benzodiazepines (BZPs) concurrently whenever possible.
12. Clinicians should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid-use disorder.

Axioms of 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 Drug Monitoring Program (PDMP) 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 (non-opioid analgesics, graded exercise, cognitive behavioral therapy, mindfulness, and relaxation techniques).
- › 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., UDS substance-use disorder, depression, PDMP, Opioid Risk Tool) 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 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 50 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 opioids chronically.
- › 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 (30% improvement on a standardized scale), 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% per week, with pauses as needed, with or without adjuvant medications (e.g., clonidine, buprenorphine)

- › 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 such as PDMP, 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, congestive heart failure, and COPD.

It is appropriate for most chronic pain patients to be treated by a team, which may include a provider, behavioral health specialist, MA, RN, and a pharmacist if available, that is centered in the office or medical home of their primary care physician, especially in the Columbia Pacific region where access to specialists is limited.

How to Use these Guidelines

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 CPCCO Guidelines are 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.

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 15](#)), Chronic Pain ([page 21](#)), Opioid Tapering ([page 41](#)), and Benzodiazepine Tapering ([page 45](#)). 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 printed directly from the website in the Tools section.

Website

Beyond the CPCCO guidelines, the website can serve as an up-to-date resource for you as well as your patients. Links to other guidelines, videos, scholarly articles, events, news stories, and more are all accessible through www.oregonpainguidance.org.

Permission for reprints

An electronic copy of these guidelines is available on the OPG/CPCCO website. We give permission for anyone to download the PDF and reprint copies.

Morphine Equivalent Dose (MED)

MED is referred to in this document frequently. MED calculators (not all of which agree with each other) can help you determine the dosage equivalency of one opioid when compared to another. It is wise to use MED calculations very conservatively and use 25 to 50% of the calculated dose when switching between opioids.

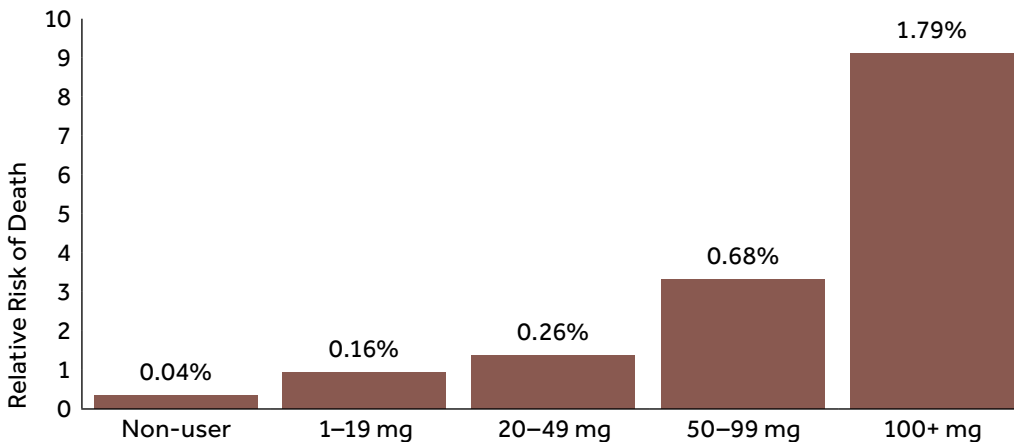
When using such calculators, be aware that methadone is a complex drug in terms of its metabolism. As the dose escalates, the MED escalates in an accelerated fashion. It is critical to understand methadone's unique MED status to safely switch between methadone and other opioids, and vice versa.

The following graph illustrates the importance of keeping your patient's MED as low as possible. It also reveals the logic behind CPCCO's opioid dose ceiling of 50 mg/d MED.

The Importance of MED

Significant Increment in Risk $p < 0.05$

Source: Dunn et al, Annals of Int Med, 2010



An electronic MED calculator is available at: www.agencymeddirectors.wa.gov/Files/DosingCalc.xls.

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 PDMP irregularities
- › Use of two or more psychoactive drugs
- › History of prior non-fatal overdose
- › Opioid Risk Tool (ORT) ≥ 8
- › History of current or active opioid or substance abuse
- › 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
- › Benzodiazepine use
- › Methadone use
- › Buprenorphine use
- › MED ≥ 90
- › Active alcohol misuse by AUDIT-3

Current patient red flags

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

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. This 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 PDMP
 - Increase the prescription refill frequency

TREATING ACUTE PAIN

(0–7 Days Following Trauma 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 suffice.^{7,8,9,10,11} 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.

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.

Non-Opioid Treatment

- › Help patients set reasonable expectations concerning recovery from the injury. Educate them about the healing process and the benefits of appropriate activity.
- › Reassure the patient that some pain is to be expected and that it will subside in time. Over-the-counter (OTC) medications will provide significant relief from pain in many situations and can be relied upon for ongoing pain relief after the acute period is over.
- › Patients should improve in function and pain and resume their normal activities in a matter of days to weeks, depending upon the diagnosis. Reevaluate those who do not follow the normal course of recovery.

Opioid Treatment

- › If the severity of the injury indicates that limited opioid treatment is appropriate, *before prescribing*, you:
 - Should perform a simple screen for substance abuse (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. Benzodiazepines have a synergistic effect with opioids.¹²
- Must inform the patient about the risks and side effects of opioids. Many young people who became dependent on opioids say they never were informed of its risks.
- May want to have the patient sign a treatment agreement if the patient returns requesting a refill of opioids. A urine drug screen and PDMP 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 percent) previously used prescription pain killers.¹³
- › 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, 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 pain and function, educate the patient on the importance of self-management and appropriate activity.

Patient Instructions

- › Dosage instructions need to 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 MED a day—a lot of medication for an opioid-naïve individual).
- › The number of pills you prescribe sets up “dosing expectations” for the patient. Prescribing #40 pills 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 ([Appendix A](#)), and SOAPP-R ([Appendix B](#))
- › Screening tools for function: Oswestry Disability Index (ODI) ([Appendix M](#)) and PEG-3 (Krebs et al 2009) ([Appendix N](#))
- › Screening tools for co-occurring mental health conditions: PHQ-4, GAD-7
- › Prescription Drug Monitoring Program (PDMP) (See http://www.orpdmp.com/PDMP_2015v02262015.pdf, page 15)

Acute Pain Flow Sheet

FOR THE EVALUATION AND TREATMENT OF ACUTE PAIN



TREATING CHRONIC PAIN (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.¹⁴ 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 “legacy patients,” those 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 addiction. When appropriate screening, safe monitoring, and dose reduction are instituted, some of these individuals will be found to have the true diagnosis of substance-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.¹⁵

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.

Categorization of Chronic Pain Patients

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

- › **Neuropathic pain:** Pain resulting from trauma to peripheral nerves. This pain may be responsive to pharmacotherapy.
- › **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, 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. While 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 and is often correlated with a history of childhood trauma.¹⁶

Central Pain or Central Sensitization (CS)

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.^{16,17,18}

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.

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 of course, history of childhood trauma.
 - Physical exam: A thorough exam will typically rule out undiagnosed nociceptive or neuropathic pain. Physical findings, imaging, and labs are typically unremarkable in controlled substance spectrum disorders.
- › A query of the PDMP.
- › 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, functional assessment to evaluate progress with treatment over time. (Oswestry, Low Back Pain Intensity, Visual Analog Scale, PEG 3-item scale for pain tracking).

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, as many patients will benefit from a dose reduction. If the patient presents with a total MED over 50 mg/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.
 - Co-prescribe a naloxone rescue kit. This will require a visit with the patient's loved ones. Most insurance will pay for this modality, and the drug comes as a nasal spray, is easy to use, carries no substantial risks, and has been proven to save lives. (See Naloxone, page 51.)
- › Ongoing monitoring should be instituted as clinic policy for *all* patients. Everyone is at increased risk with opioids, not just the ones you identify as problem patients or high-dose patients. Risk stratification (see elsewhere in this document) may have some, albeit limited, usefulness. Monitoring should include episodic evaluation of functional improvement, UDS, PDMP 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 should not be co-prescribed as they can produce a synergistic effect resulting in respiratory arrest.²⁰
- › Methadone use should be avoided for the treatment of pain. If prescribed, doses should be kept below 30mg/d because of its high lethality mg for mg.²¹ Other rapidly acting opioids, such as fentanyl, are highly addictive. Both methadone and transdermal fentanyl have unpredictable pharmacokinetics/dynamics and are particularly challenging for the treatment of pain.

- › 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. Past abuse 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.

Most non-cancerous chronic pain conditions should not be treated with opioid medications. These include but are not limited to:

- › Chronic low back pain
- › Fibromyalgia
- › Chronic headaches
- › Irritable bowel syndrome
- › Chronic pelvic pain

Non-Opioid Treatment^{22,23,24,25}

- › A pain rehabilitation program is strongly recommended as an adjunct to treating chronic pain patients. Such programs often include education, movement therapies, behavioral modalities, and peer-to-peer support. Patients should be educated about pain *management* techniques, rather than expecting pain elimination. This is a strategy common to all chronic disease states (diabetes, hypertension, etc.).
- › Attendance in a rehabilitation program can be effectively linked to a primary-care led dose-reduction regimen. Integrated behavioral health within primary or specialty care (separate from long-term mental health counseling) also can greatly help with behavior change and coping with and managing chronic pain symptoms. A patient agreeing to supportive treatments is likely to succeed with a slow opioid taper. Resistant patients may need to be tapered more rapidly to assure an appropriate risk/benefit balance in a timely manner.
- › Over-the-counter pain medications as well as intermittent, brief opioid regimens may be beneficial in selected patients when exacerbations of the chronic state occur.

Patient Instructions

- › Dose instructions need to clear. PRN 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. MED a day, even though each pill 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.

- Clinic policy regarding inappropriate behaviors. Many clinics have patients sign a patient contract. 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 (some providers do not allow).

Tapering

- › Many patients who have been on opioids for a long time 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.
- › 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 both opioids and benzodiazepines simultaneously. It is inappropriate to have patients on both of those drugs, 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 regarding overdose, and can be tapered more rapidly, we recommend starting your taper with opioids and then tapering the benzodiazepines; however, it may be appropriate to let patients choose which medication they prefer to taper first.
- › 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

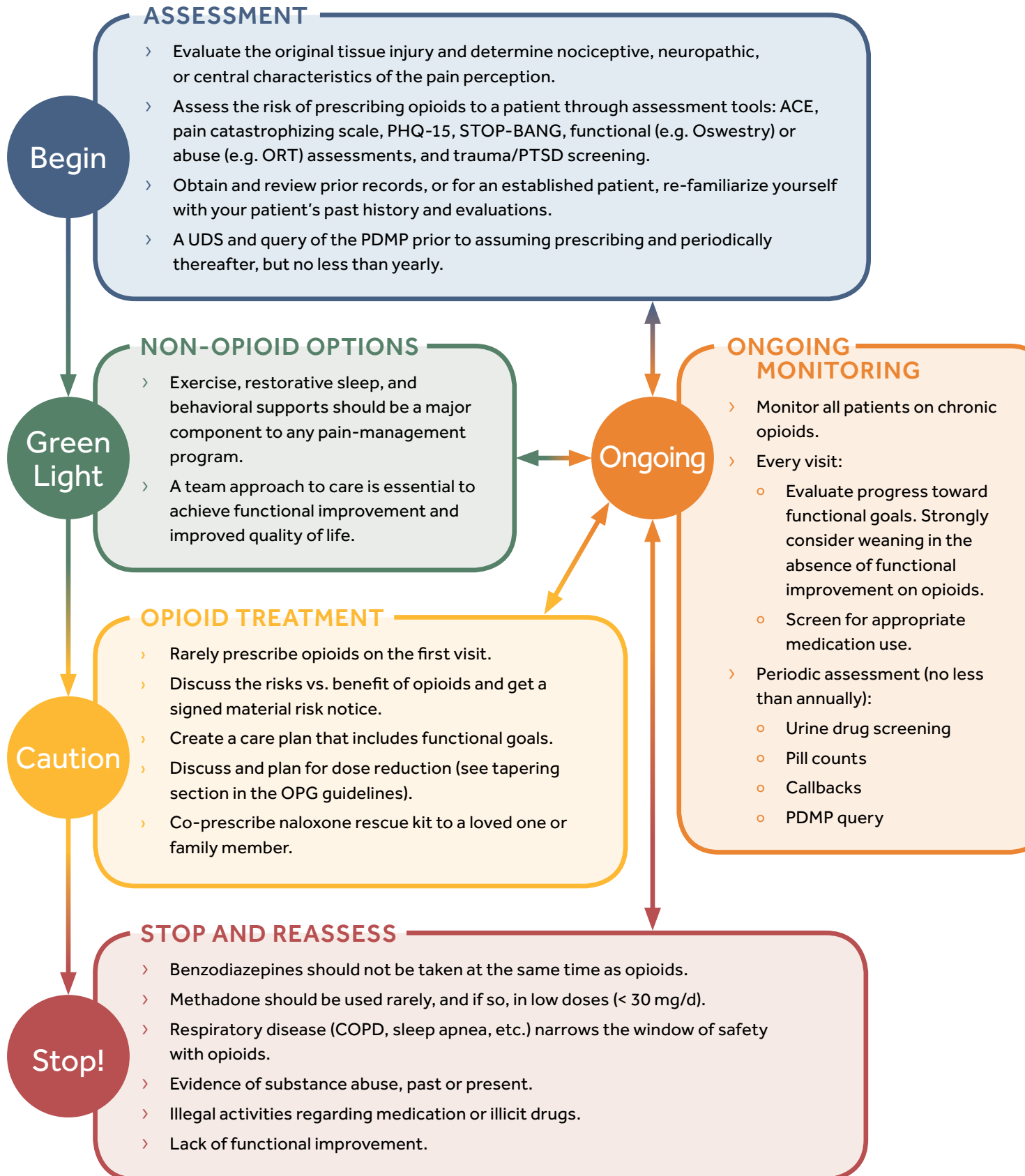
- › **Secondary Gain:** Disability payments, legal actions, and illicit financial incentives can complicate the treatment of pain. Practicing safe and appropriate medicine, with thorough documentation, will serve as a starting point, with specialty referral being necessary at times.
- › **Suicidality:** 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.
- › **Addiction (opioid-use disorder):** It is sometimes hard to distinguish between patients who take opioids to relieve pain and those who are taking medication obsessively 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 opioid-use disorder.

You may have patients to whom you were prescribing opioids for the treatment of pain, but who over time showed evidence of addiction. 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. 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 addiction services is an important component of chronic pain treatment.

Chronic Pain Flow Sheet

FOR THE EVALUATION AND TREATMENT OF CHRONIC NON-CANCER PAIN



NON-OPIOID OPTIONS

A patient's trauma history, mental health, family, and social situation all can affect the perception of pain. This is why chronic pain is described as a bio-psycho-social phenomenon. Without addressing those behavioral issues, opioid management of chronic pain will not provide the level of relief the patient is seeking, and dose escalation, with its concomitant morbidity and mortality, will often occur.

Studies show that opioids are only moderately successful in relieving pain and, in fact, are inferior to sleep restoration, mindfulness training, and physical exercise in providing long-term benefit.

Treatment Comparisons

Treatment	Reduction in Pain Intensity
Physical fitness	30–60%
CBT/Mindfulness	30–50%
Sleep restoration	30–40%
Opioids	<30%
Tricyclics	<30%
Anti-epileptics	<30%
Cannabis	10–30%
Acupuncture	>10%

Source: David Tauben, MD, Chief of Pain Medicine at the University of Washington.

The following table lists various non-opioid treatment options, including behavioral, movement, and pharmacological treatments. This is not meant to be an exhaustive list but, rather, is intended to show the many empowering ways our patients can use readily accessible resources to help manage their pain.

Non-Opioid Treatment Options

Patient Lifestyle	<ul style="list-style-type: none"> › Healthy sleep management › Weight reduction › Diet/Nutrition › Stress reduction › Exercise
Physiotherapy Interventions	<ul style="list-style-type: none"> › Functional therapies <ul style="list-style-type: none"> ◦ Physical therapy (PT) ◦ Occupational therapy (OT) ◦ Passive modalities
Behavioral Interventions	<ul style="list-style-type: none"> › Educational groups <ul style="list-style-type: none"> ◦ Preventive ◦ Support ◦ Peer-to-peer/Living Well workshops ◦ Shared medical appointments › Psychotherapy <ul style="list-style-type: none"> ◦ Individual counseling ◦ Group therapy ◦ Cognitive behavioral therapy › Supportive care <ul style="list-style-type: none"> ◦ Case management › Substance-abuse treatment <ul style="list-style-type: none"> ◦ Residential ◦ Outpatient ◦ Medication-assisted treatment referral › Trauma-informed care <ul style="list-style-type: none"> ◦ PTSD screening ◦ Domestic violence screening ◦ Child abuse screening
Medical Interventions	<ul style="list-style-type: none"> › Non-opioid medications that may aid in chronic pain management <ul style="list-style-type: none"> ◦ NSAIDS, acetaminophen ◦ Tricyclic antidepressants (neuropathic pain) ◦ Anti-epileptics (neuropathic pain) ◦ Antidepressants (treating underlying depression) ◦ Topical medications › Minimally invasive surgical procedures <ul style="list-style-type: none"> ◦ Nerve blocks, steroid injections ◦ Interventional treatments: ablations, restorative injections, stimulators, implantable devices ◦ Surgical treatment › Complementary and alternative treatments <ul style="list-style-type: none"> ◦ Manipulation therapy ◦ Acupuncture

Behavioral Treatment Options

Cognitive behavioral therapy (CBT)

- › **What is CBT?** CBT is a form of psychotherapy that emphasizes the importance of the causal relationship between our thinking and our feelings and behaviors. The cognitive, or thinking part of our experience, very much affects the behavioral, or action part of our experience. With training, we can change the way we think to affect the way we feel and behave, even if the situation has not changed. CBT has an educational focus and teaches rational self-counseling skills.
- › **What does the research say about CBT for the treatment of chronic pain?** Studies show that a patient's report of chronic pain intensity is far more about that individual's capacity to manage his or her pain than it is about stimulation of nociceptors.²⁶ Additional studies show that patients experience between 30% to 60% reduction in pain intensity by learning and applying CBT techniques. This compares favorably to the estimated efficacy of 30% for chronic opioids.
- › **What are some of the key components of CBT for patients with CNCP?** In general, CBT for chronic pain works to reduce patients' pain, distress, and pain behavior while improving their daily functioning. Components of CBT may include helping patients to decrease negative emotional responses to pain and perceptions of disability while increasing their acceptance of pain and orientation toward self-management. CBT helps patients change the way they relate to pain so they can experience life more fully.
- › **What is the goal of CBT for patients with CNCP?** Two fundamental concepts are at play. One is that a person must accept the aspects of the pain that cannot be changed, including all the difficult thoughts, feelings, and bodily sensations that come with it. The second is that this acceptance allows for the possibility of the patient opening to the pain and committing to acting in ways that make the patient feel vital and energized. Learning to accept pain to live life is often referred to as "victory by surrender."

Living Well with Chronic Pain

This program is one of a group of validated syllabus-based programs developed at Stanford University for the purpose of empowering individuals living with chronic pain. It is available in many communities around the country and teaches self-management skills concerning the management of chronic diseases, including pain.

Shared medical appointments

One approach for a busy practice to incorporate peer support, education, and behavioral treatment into the office visit is to use a shared medical appointment. The prescriber and a facilitator, often a nurse, can meet with patients as a group to discuss common issues, while simultaneously taking individual patients aside for brief patient-specific evaluations. Many insurance companies will pay for this treatment approach.

Peer-to-peer meetings

Trained peer educators can facilitate groups of pain patients to share successes, set goals, and help overcome common obstacles. Peer educators can work under the auspices of a licensed practitioner or enroll patients independently. Such programs can work in parallel with the other modalities mentioned in this section.

Community addiction services are an important component of chronic pain treatment.

Columbia Pacific Sponsored Behavior-Based Pain Clinics

As discussed above, these clinics are in each county and help to provide pain education, peer support, CBT, and movement therapy. See [Appendix S](#).

TRAUMA-INFORMED CARE

(Childhood Trauma, PTSD & Chronic Pain)

It is increasingly recognized that childhood trauma and PTSD affect not only the quality of life of many individuals but also their physical health. Research has increasingly demonstrated that trauma can lead to neurobiological dysregulation, altering the functioning of catecholamine, hypothalamic-pituitary-adrenocorticoid, endogenous opioid, thyroid, immune, and neurotransmitter systems. It is not surprising, therefore, that exposure to traumatic stress is associated with increased health complaints, health-services utilization, morbidity, and mortality.

Trauma and Chronic Pain

The prevalence of trauma is substantially elevated in patients with chronic pain. A current PTSD prevalence of 35% was seen in a sample of chronic pain patients,²⁹ compared to 3.5% in the general population.³⁰ In a study of patients with chronic low back pain, 51% of the patients evidenced significant PTSD symptoms.³¹ Daniel Claw and others have found a strong association between trauma, childhood sexual abuse in particular, and central sensitization (CS) syndromes.³¹ Emotional pain can amplify physical pain perception, and pain itself can actually serve as a reminder of the traumatic event, and thus put the patient at risk for dose escalation.

Screening and Referral Overview

- › PTSD symptom screening is an important addition to routine preventive health screening in primary healthcare settings because:
 - Patients are unlikely to report trauma history or symptoms unless directly asked.
 - Trauma exposure is associated with many problems—emotional and physical—that affect health.
 - In patients with long-lasting PTSD, significant improvements in symptoms are unlikely to occur without treatment.
- › Gather a thorough bio-psycho-social history and assess the individual for medical and psychiatric problems. Do a risk assessment for suicidal and homicidal ideation. Also ask about substance abuse.
- › Assess for PTSD symptoms. There are a number of screening tests that have been designed for use in primary care and other medical settings. See PTSD Screening and Referral: For Health Care Providers for more information.
- › Make appropriate referrals for PTSD, depression, other psychiatric disorders, or significant spiritual issues. Likewise, help build up or stabilize the patient's social support network, as this will act as a buffer against the stress they are experiencing.
- › Consider implementing universal Adverse Childhood Experience screening protocols within your organization.

Trauma-Informed Treatment

- › Research suggests that providing CBT treatments to address PTSD symptoms in patients with chronic pain may lead to improvements in pain-related functioning.³³
- › Other useful treatment methods include behavioral regulation methods (imagined or actual exposure to feared activities or circumstances) and physiological strategies (relaxation-response training; movement therapy) that overlap substantially with many aspects of cognitive behavioral therapy used in the treatment of chronic pain.
- › Multimodal pain programs, which are trauma informed, also provide a good referral resource for those suffering from PTSD and persistent pain.
- › Consider providing in-depth trauma informed care training to all staff and becoming a trauma-informed organization.

What Can Healthcare Providers Do

Healthcare providers can increase the chances of improved health outcomes for their patients by following these steps:

- › Identify a PTSD consultant in your community
- › Screen for trauma
- › Discuss the results openly with your patient
- › Provide a referral when appropriate
- › Provide educational materials
- › Follow up with the patient

Further information can be found on the U.S. Department of Veterans Affairs website: <http://www.ptsd.va.gov/professional/co-occurring/chronic-pain-ptsd-providers.asp>.

Tools

See Primary Care PTSD Screen (PC-PTSD) in [Appendix D](#).

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

- › Review medical history, including records from previous providers, when available. Be sure to elicit family history of chronic pain syndromes.
- › 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 (see Acute Pain section in this document).

Non-Opioid Treatment

- › 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 activity and exercise can often provide some pain relief and may improve healing.
- › Explain that OTC or over-the-counter 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

- › 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 to fewer than seven days.

- › Opioids may be indicated for some chronic conditions where there is no definable endpoint (like osteogenesis imperfecta or epidermolysis bullosa) or for end-of-life care. Such patients are best treated in a specialty-care setting.
- › 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 Adolescents

- › Screening tools for substance abuse: ORT, SOAPP-R
- › Screening tools for co-occurring mental health conditions: PHQ-9, GAD-7
- › Prescription Drug Monitoring Program
- › Age and developmentally appropriate screening tools for children such as NIPPS, FLACC, or Bieri-Modified

PAIN CONTROL IN THE ELDERLY AND INDIVIDUALS WITH DEMENTIA

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.

Because chronic non-cancer pain can be reduced but not eliminated, ongoing pain reporting is common in patients with dementia.

Chronic Pain in the Elderly Population

- › Persistent pain (three to six months) is present in 25–50% of older adults, and increases with age. Nursing home patients may have prevalence as high as 45–80%.³⁴
- › 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.
- › In a patient with complicated emotional issues, they 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 are more sensitive to medication side effects.³⁵

Goals of Treatment

- › 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.³⁶

- › Persistent pain is multifactorial. It is a treatable but not curable condition. Let the patient know that although pain cannot be eliminated, substantial improvement in function is a realistic goal.

Non-Pharmaceutical Approach

- › Often beneficial, with low cost and 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 (positioning, hot/cold).
- › Behavioral – Cognitive behavioral therapy and meditation along with patient education.
- › Localized therapy – Joint injections and trigger-point injections.
- › Continue these treatments when introducing medications to minimize medications and their side effects.

Pharmaceutical Approach

Non-opioids

Non-opioids are preferred over opioids. Used 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 so, therefore, 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.
- › Antidepressants-for chronic neuropathic pain (postherpetic neuralgia, neuropathic back pain, polyneuropathy, trigeminal neuralgia). All have increased side effects in the elderly.³⁷
 - 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 interactions.
 - SNRIs – Selective noradrenalin 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.³⁸
 - 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.
- › 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 used for continuous pain. Breakthrough pain should be identified and treated by the use of fast-onset, short-acting preparations.
- › Elderly are 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 pills. 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% to 50% of the recommended starting dose at the same dosing intervals, and then titrate doses upward in 25% 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

- › Because chronic, non-cancer pain can be reduced but not eliminated, ongoing pain reporting is common.
- › 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.³⁹
- › Patients may also exhibit striking out, refusing 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 from palliative care onto hospice, 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 MEDs 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 Is Palliative Care 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. This benefits everyone.

Palliative Care Approaches

- › 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, page 32.
- › 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.⁴⁰ 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.⁴¹
- › 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.⁴²
- › 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.⁴³
- › 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

The Oregon Chapter of the American College of Emergency Physicians has created a set of guidelines regarding the use of opioids in a hospital emergency department (ED). The following is a modified summary of those guidelines. Emergency medical providers (EMPs) should be supported and should not be subject to adverse consequences by any regulating bodies when respectfully adhering to these guidelines.

1. Only one medical professional should provide all opioids to treat a patient's chronic pain, to the extent possible.
2. The administration of intravenous and intramuscular opioids in the ED for the relief of acute exacerbations of chronic pain is discouraged.
3. EMPs should not provide replacement prescriptions for controlled substances that were lost, destroyed, or stolen.
4. EMPs should not provide replacement doses of methadone for patients in a methadone treatment program.
5. Long-acting or controlled-release opioids (e.g., oxycodone, fentanyl patches, and methadone) should not be prescribed by EMPs.
6. EMPs are encouraged to access EDIE (emergency department information exchange) and/or the state PDMP.
7. EMPs should exercise caution when considering prescribing opioids for patients who present to the ED without a government-issued photo ID.
8. Primary care and pain-management physicians should make patient pain agreements accessible to local EDs and work to include a plan for pain treatment in the ED.
9. EDs should coordinate the care of patients who frequently visit the ED, using an ED care coordination program, to the extent possible.
10. The administration of meperidine in the ED is discouraged.
11. ED prescriptions for opioid pain medication for acute injuries should be no more than 10 pills. 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 20 tablets.
12. 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.
13. 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.

1. Prescribe opioids cautiously to those with a substance-abuse history. Be aware that such use can trigger relapse behaviors in susceptible individuals.
2. Ask if patients are getting medications from other doctors, and use the PDMP prior to prescribing opioids whenever possible.
3. Do not prescribe opioids to patients in substance-abuse treatment programs without consulting the program's medical staff.
4. Do not offer prescriptions with refills. Use caution if replacing prescriptions that were lost, destroyed, or stolen.
5. Prescribing over the phone is discouraged, especially with patients you have not met, except in rare cases involving known invasive surgery.
6. The use of non-combination opioids is discouraged.
7. Prescribe opioid pills only in small dosages, which in most cases should not exceed three days or 10 tablets.
8. When prescribing an antibiotic with the opioids, stipulate that the narcotic must be filled with the antibiotics at the pharmacy.
9. Inform patients how to secure medication against diversion and how to dispose of leftover medication.
10. 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.
11. 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.
12. 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.
13. Prolonged pain management (while awaiting specialty care) should be managed by and/or coordinated with the patient's primary care provider.

TAPERING

Opioid Taper/Discontinuation

Though rare exceptions will exist, opioid therapy should be tapered down or discontinued if any of the following situations occur:

- › The medication fails to show significant analgesia despite incremental dose increases.
- › The medication fails to show functional improvement over time.
- › MED is in excess of 50 mg/d or methadone dose is in excess of 30mg/d.

It is highly recommended not to treat chronic pain with methadone. If a patient is on methadone, it is recommended to taper to 30 mg/day and then change to alternative opioid and/or taper off

- › 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. Use unexpected urine drug screen results and PDMP irregularities to improve patient safety (e.g., change in pain management strategy, tapering or discontinuation of opioids, more frequent re-evaluation, offering naloxone, or referral for treatment for substance use, all as appropriate).

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 or buprenorphine) may be a safer and more appropriate treatment consideration under these circumstances.

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."

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/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 withdrawal 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 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, 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, 90, or any number, represent a dose 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 individuals quality of life improves as the dose approaches or reaches zero.

Symptoms of Opioid Withdrawal

Early Symptoms	Late Symptoms
› Agitation	› Abdominal cramping
› Anxiety	› Diarrhea
› Muscle aches	› Dilated pupils
› Increased tearing	› Goose bumps
› Insomnia	› Nausea
› Runny nose	› Vomiting
› Sweating	
› Yawning	

Initial steps

1. Calculate the MED, 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).

Slow-taper protocol

1. Long-acting opioids: Decrease total daily dose by 5–10% of initial dose per week.
2. Short-acting opioids: Decrease total daily dose by 5–15% 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% of the total dose is reached, the rate of taper can be slowed to 5% 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:
 - Antidepressants to manage irritability, sleep disturbance (e.g., trazodone)
 - Hydroxyzine for insomnia and anxiety
 - Anti-epileptics for neuropathic pain
 - Clonidine for autonomic withdrawal symptoms such as rhinorrhea, diarrhea, sweating, tachycardia, hypertension
 - NSAIDs for myalgia (e.g., ibuprofen)
 - Anti-diarrheal agents for diarrhea
 - Opioid Withdrawal Attenuation Cocktail ([Appendix R](#))

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.

Opioid Tapering Flow Sheet

START HERE

Consider opioid taper for patients with opioid MED > 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 rate of taper based on 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. See OPG guidelines.

OPIOID TAPER

Opioids

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

- 1 Use an MED calculator to help plan your tapering strategy. Methadone MED 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% of initial dose per week.
Short-acting opioids: Decrease total daily dose by 5–15% per week.
- 3 See patient frequently during process and stress behavioral supports. Consider UDS, pill counts, and PDMP to help determine adherence.
- 4 After ¼ to ½ of the dose has been reached, with a cooperative patient, you can slow the process down.
- 5 Consider adjuvant medications: antidepressants, gabapentin, NSAIDs, clonidine, anti-nausea, anti-diarrhea agents.

MED for Selected Opioids

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

Morphine Equivalent Dosing (MED) Calculator:
agencymeddirectors.wa.gov/mobile.html

Benzodiazepine Taper/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 withdrawal 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 withdrawal 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 quite 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

Here are two strategies that can be used to taper off of benzodiazepines:

1. Switching to a long-acting benzodiazepine (e.g., diazepam) and slower taper.
2. Simultaneous treatment with an anti-epileptic drug during taper (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 = within 15 min.

Intermediate = 15–30 min.

Slow = 30–60 min.

Benzodiazepine Tapering Flow Sheet

START HERE

Consider benzodiazepine taper for patients with aberrant behaviors, behavioral risk factors, impairment, 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% 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% per week in divided doses.
- 4 After $\frac{1}{4}$ to $\frac{1}{2}$ 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.

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 safeguards (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.

Benzodiazepine Equivalency Chart

Drug	Half-life (hrs)	Dose Equivalent
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	30 mg

OTHER CONSIDERATIONS

Prescription Drug Monitoring Program (PDMP)

The PDMP is an online tool available to all prescribers, pharmacists, and patients in Oregon. Once a prescriber is registered with the program, he or she can learn exactly which prescription medications a patient has taken and is taking. 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. Prescribers can now delegate “look-up authority” to their support staff. Go to www.orpdmp.com for details.

Concomitant Benzodiazepine and Opioid Use

Most experts advise against concomitant use of BZPs and opioids because of the synergistic effect of those drugs in combination exacerbating respiratory depression. As many as 50% 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 BZP use by UDS, PDMP 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 BZPs have a difficult time abstaining from other sedative hypnotic substances (such as alcohol, barbiturates, and carisoprodol), and these drugs have similar risks for overdose when combined with opioids.

Concomitant Marijuana and Opioid Use

Many patients in Oregon may be using medical marijuana to treat chronic pain. Currently, 60,324 (90%) of 66,880 medical marijuana card holders have severe pain as one of their qualifying conditions. With the state’s recent legalization of recreational use of marijuana, its use for both medical and recreational reasons is likely to increase. Current data on the interactions between opioids and marijuana are lacking, and there is little evidence for making recommendations to patients about the use of marijuana to treat chronic pain, or for advising about potential consequences of interaction with opioids. We do not dispute the possibility that marijuana may have some benefit for pain, but due to the lack of clinical evidence supporting its use, CPCCO does not support patient use of marijuana for the treatment of pain.

Given the reality of increasing medical and recreational use of marijuana in Oregon, we encourage providers and clinics to carefully consider the implications of marijuana use in clinical care. When ordering urine drug screening, providers should include THC in the screening, and make time for discussions with patients who use marijuana to help avoid negative impacts on pain treatment or patient safety. Clinics should develop policies that address whether or not they will sign medical marijuana forms, THC positive urine drug screens, and using opioids and marijuana concomitantly. These policies should be implemented at a clinic level, rather than being left to the discretion of individual providers.

Marijuana Recommendations

1. Health care providers should conduct a full assessment of medications, physical and mental health status, and drug use, including marijuana, alcohol and other substances. Consider both self-report and urine drug screen.
2. If assessment of use is positive for marijuana, conduct further assessment to detail spectrum of use (frequency, amount), reasons for use, drug effects, and potential interactions with mental health comorbidities and polysubstance use.
3. For patients with mental health conditions such as Post-Traumatic Stress Disorder, and/or indication of substance use disorder, or history of Adverse Childhood Experiences (ACES) consider consultation with or referral to a specialist or peer consultation if a specialist is unavailable.
4. Conduct patient education about marijuana, to include: harms of smoking vs. other forms of delivery, safe storage, the potential variation in chemical content and dosage levels, heterogeneity of strains, CBD and THC content, effects of higher concentrations of THC on psychoactive properties, and variability of effect due to mode of use. Providers should explore level of knowledge with patients.
5. Include discussions with patients about the need for multiple modalities and approaches to treat pain as well as patient's level of motivation/willingness to engage in treatment modalities, including the possible use of Cognitive Behavioral Therapy (CBT), exercise therapy, and complementary and alternative therapies such as mindfulness, massage and acupuncture.
6. If a patient is regularly using marijuana in conjunction with opioids for pain, the clinician and patient should monitor functional status and quality of life and carefully assess for adverse outcomes; if there is no evidence of improvement, or evidence of potential harms with the combination, the clinician should consider tapering the opioids.
7. Clinics should develop organizational policies addressing medical marijuana, THC positive urine drug screens, and marijuana and opioid use concomitantly. These decisions should be made at a clinic level rather than being left to the discretion of an individual provider.

Disposal

The overprescribing of opioids can lead to the accumulation of unused pills in the medicine cabinet. This is true, especially for acute pain situations, when 30 pills may be prescribed for a time-limited situation and only five pills are taken. Those unneeded medications can pose a risk to children or can inadvertently provide a source of illicit opioids through theft or sharing. The ability to safely dispose of unused medication is an important strategy in the fight to reduce unnecessary opioids in circulation.

Drug take-back programs: The Drug Enforcement Administration promotes national drug-take back day on May 8. Many law enforcement agencies have drug drop boxes in their communities. Some pharmacies may also take unused medications as the laws have been relaxed allowing for medication return in some states. The FDA and DEA have useful hints on their websites for disposal, including how to dispose of unwanted medication safely.

Medication-Assisted Treatment (MAT)

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 significant risks associated with abuse 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 PDMP 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 physician in an office setting can prescribe buprenorphine, after taking a brief educational course and getting an “X” waiver added to their DEA number.⁴⁴ 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 waived, a switch to buprenorphine treatment.
- › Naltrexone-injectable Vivitrol can be another useful tool for the patient motivated enough to begin treatment after total opioid abstinence. It also can be provided in a practitioner’s office. Columbia Pacific CCO is dedicated to increasing access and availability to medication-assisted treatment within primary care and behavioral health organizations, as well as providing educational opportunities for clinicians and clinical teams to provide these services.

Heroin

There has been a rise in heroin use, heroin overdoses, and heroin treatment admissions in the U.S. over the past decade.⁴⁵ 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 addict 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 pills increase the risk of overdose.

The most effective treatment for heroin addiction (as well as all opioid substance-use disorder) is medication-assisted treatment (see the MAT section in this document). 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 all patients prescribed opioids for chronic use who have any risk factor for overdose, including:

- › Dose \geq 50 mg/day MED
- › Sleep-disordered breathing, including sleep apnea
- › Renal or hepatic dysfunction
- › Mental illness
- › Substance use disorder
- › Concomitant benzodiazepine or other sedating medication
- › Recent period of abstinence (e.g. release from incarceration or treatment program)
- › Previous history of non-fatal overdose

Naloxone has a short half-life, having an effect for 30 to 60 minutes. After naloxone wears off, the opioid 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.

Many states allow lay-person use of naloxone, many insurance companies will pay for the drug, and in Oregon, a simple online training course will suffice to allow dispensing of the drug.

In 2014, 52 people died every day in the United States from prescription-opioid-related overdoses. Cities and states with naloxone distribution programs have seen 37–90% reductions in overdose deaths. Co-prescribing naloxone with medications is an important component of opioid therapy. Patients and their providers commonly underestimate the chance of experiencing an overdose. “Risky drugs, not risky people” is a useful phrase to use when explaining the necessity of naloxone co-prescribing to patients.

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

- › Videos demonstrating use of naloxone: <http://tinyurl.com/oregonoverdose>
- › Oregon naloxone law: <http://tinyurl.com/oregonODlaw>
- › Oregon training materials: <http://tinyurl.com/naloxonetrainer>
- › Film and resources for advocates, families and providers: www.reach4me.org
- › Prescribing information and guidelines: 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

MEDICATIONS THAT WARRANT SPECIAL ATTENTION

Sleeping Pills (Z Drugs and Others)

The Z drugs—zolpidem, zaleplon, eszopiclone—are indicated for the short-term treatment of insomnia. These medications are not benzodiazepines, but they do act on the same receptors and yet have a somewhat different risk profile (reduced seizure risk with withdrawal, for example). Many of the adverse effects of BZPs are true for the Z drugs, as well: drowsiness, memory impairment, reduced coordination, depression, and sleep disturbances. Benzodiazepines are also commonly prescribed for insomnia, namely temazepam and lorazepam. As noted, there are many adverse effects associated with use, with little long-term efficacy.

There is an increase in all of these effects with elderly and pediatric patients. Using any of the Z drugs, BZPs, alcohol, or opiates in any combination increases the risks of impairment and overdose. It is easy to become dependent on these medications, and it can be difficult to return to normal, unaided sleep when discontinuing use. There are safer medical alternatives as well as non-pharmacological options that can be explored.

When considering prescribing these medications for insomnia:

- › Avoid combinations of Z drugs, BZPs, opioids, or stimulants
- › Use the lowest dose possible:
 - Avoid prescribing these for children and adolescents
 - Use cautiously and at the lowest doses in the elderly
- › Prescribe for only short intervals (7–10 days)
- › Consider alternatives:
 - Trazodone
 - Amitriptyline

Tramadol and Tapentadol

These are opiate-like analgesics used to treat moderate to severe pain. In addition to binding to mu opioid receptors, tramadol weakly inhibits norepinephrine and serotonin reuptake and tapentadol inhibits norepinephrine reuptake. Many of the risks associated with opioids are true for tramadol and tapentadol. Tramadol is now a Schedule IV drug and has been shown to increase the risk of precipitating a seizure. Both of these medications can cause physical and psychological dependency.

We recommend that tramadol be treated as other true opioids when evaluating risks and benefits of opioid treatment.

Carisoprodol

Carisoprodol is a muscle relaxant with properties and risks similar to benzodiazepines, with similar habit forming properties. This medication should be avoided, especially in combination with opioids. It has been removed from the market in a number of countries worldwide, and the EU recommends it not be used for the treatment of low back pain. In patients experiencing severe pain from spasticity, consider alternatives such as tizanidine or baclofen.

Meperidine

Meperidine is a narcotic analgesic with sedative properties and is not recommended for outpatient treatment of acute or chronic pain. Additionally, meperidine is included in the 2015 AGS Beers Criteria as a potentially inappropriate medication to be avoided in patients 65 years and older because of potentially higher risk for delirium (neurotoxic metabolite), and lack of analgesia when taken orally. Furthermore, the American Pain Society does not recommend its use as an analgesic.

Long-Acting Opioids

Long-acting opiates consist of ER/LA formulations such as oxycodone, morphine ER, fentanyl patches, and methadone, among others.

Long-acting opiates carry the same risks as short-acting formulations. However, the risks of addiction, abuse, misuse, overdose and death are much greater, especially in opiate-naïve patients. For this reason, the use of long-acting opiates should be reserved for the management of pain severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative modalities (both pharmacologic and non-pharmacologic) have been maximally tried and subsequently failed.

Methadone

Methadone has unique metabolic properties making it particularly dangerous to prescribe outside of a closely managed methadone clinic. Overdoses are greatly increased with methadone compared to other opioids. Most guidelines recommend dosing at fewer than 30 mg/day or not at all.

You will notice in the table below, as the dose of methadone increases, the potency of the drug in relation to other opioids increases in an exponential fashion. This will assist in making safe medication switches from methadone to other opioids and vice versa.

Morphine Equivalents	Methadone Factor
100 mg	4:1
100 – 300 mg	8:1
300 – 500 mg	12:1
500 – 1000 mg	15:1
1000 – 2000 mg	20:1
> 2000 mg	30:1

Gabapentin

Gabapentin and pregabalin have a role in the treatment of neuropathic pain, but also have potential for misuse and abuse. These agents are perceived on the street as a substitute for most common illicit drugs. Overdoses have been fatal because of CNS depression, especially when combined with opioids, alcohol, or other CNS depressants.

Gabapentin and pregabalin are structurally related to GABA. They reduce the release of excitatory neurotransmitters as well as increase the effects of the dopaminergic reward system. This is responsible for the sedative and dissociative/psychedelic effects that can occur at higher doses. Pregabalin is a Schedule V controlled substance in the U.S. It may have a higher addiction potential than gabapentin resulting from its rapid absorption, faster onset of action, and a greater affinity for binding sites. The bioavailability of pregabalin does not decrease with higher doses, while bioavailability of gabapentin decreases by nearly 50% when the dose is increased from 900 mg/day to 3,600 mg/day. Doses greater than 1,800 mg/day of gabapentin don't appear to provide additional neuropathic pain relief.

Gabapentin may help attenuate withdrawal symptoms from alcohol or opioids, and abusers will often “bridge” with gabapentin until they can obtain a supply of illicit drugs. However, it is important to note that individuals may also experience withdrawal symptoms from gabapentin itself. Consider alternatives such as tricyclics (TCAs) for neuropathic pain as an alternative to high-dose gabapentin.

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 may 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. Pain 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.

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 way, this indicates that 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, and 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 much 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.

Resources

Difficult Conversations: Real life examples, Helpful Hints, and Tools – www.oregonpainguidance.org/clinical-tools
Motivational Interviewing Resources – www.motivationalinterviewing.org

TOOLS

There are various tools that can assist you in evaluating and managing your chronic pain patients. The following is a brief overview, while the tools themselves can be found in the Appendices. The following is a brief overview, while the tools themselves can be found in the Appendices. These tools are available online at www.oregonpainguidance.org/clinical-tools.

Assessment Tools

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 A](#). 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 B](#).

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 C](#).

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 D](#).

STOP BANG

STOP BANG 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 **STOP BANG** assessment is provided in [Appendix E](#).

Chronic pain 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 F](#).

Laboratory Screening

Urinary drug screen (UDS)

UDS helps monitor for unexpected licit and illicit drugs that may be present in your patient's urine. UDSs should be used with every chronic pain patient as a standard part of your office policy. There are two basic types of UDS: POC testing (in office) and confirmatory (laboratory based). See [Appendix G](#) for UDS 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. Some examples:

- Hydrocodone often is not detected on the POC opioid strip.
- 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 H](#).

Patient-Provider Communication

Patient 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 I](#).

Material risk notice

The Oregon Medical Board states that a material risk notice needs to be signed by the patient whenever opioids are prescribed chronically. A Material Risk Notice is provided in [Appendix J](#).

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 K](#).

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 L](#).

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 M](#).

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 N](#).

Other Tools

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 P](#).

Behavioral health risks screening tool for pregnant women and women of child-bearing age

Women and their children's health can be affected by emotional problems, alcohol, tobacco, other drug use and violence. This screening tool can help guide referrals to tobacco cessation programs, addictions and recovery programs, domestic violence prevention and mental health programs. See [Appendix Q](#).

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 R](#).

Patient and community resources

This is a local Columbia Pacific resource guide which includes residential services, populations served, and information regarding non-prescribing pain treatment modalities including physical therapy, acupuncture, and chiropractic. This listing is located in [Appendix S](#).

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These tools are available online at www.oregonpainguidance.org/clinical-tools.

OPIOID RISK TOOL (ORT)

		Mark each box that applies	Item score if FEMALE	Item score if MALE
1	Family history of substance abuse	Alcohol <input type="checkbox"/>	1	3
		Illegal drugs <input type="checkbox"/>	2	3
		Prescription drugs <input type="checkbox"/>	4	4
2	Personal history of substance abuse	Alcohol <input type="checkbox"/>	3	3
		Illegal drugs <input type="checkbox"/>	4	4
		Prescription drugs <input type="checkbox"/>	5	5
3	Age (mark box if 16–45)	<input type="checkbox"/>	1	1
4	History of preadolescent sexual abuse	<input type="checkbox"/>	3	0
5	Psychological disease	Attention deficit disorder <input type="checkbox"/>	2	2
		Obsessive compulsive disorder <input type="checkbox"/>	2	2
		Bipolar <input type="checkbox"/>	2	2
		Schizophrenia <input type="checkbox"/>	2	2
		Depression <input type="checkbox"/>	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):432–442. Used with permission.

The ORT and other tools are available online at www.oregonpainguidance.org/clinical-tools.

SCREEN AND OPIOID ASSESSMENT FOR PATIENTS WITH PAIN—REVISED (SOAPP®-R)

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?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. How often have you felt a need for higher doses of medication to treat your pain?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. How often have you felt impatient with your doctors?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. How often have you felt that things are just too overwhelming that you can't handle them?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. How often is there tension in the home?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. How often have you counted pain pills to see how many are remaining?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. How often have you been concerned that people will judge you for taking pain medication?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. How often do you feel bored?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. How often have you taken more pain medication than you were supposed to?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. How often have you worried about being left alone?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11. How often have you felt a craving for medication?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12. How often have others expressed concern over your use of medication?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
13. How often have any of your close friends had a problem with alcohol or drugs?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14. How often have others told you that you had a bad temper?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
15. How often have you felt consumed by the need to get pain medication?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
16. How often have you run out of pain medication early?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
17. How often have others kept you from getting what you deserve?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
18. How often, in your lifetime, have you had legal problems or been arrested?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
19. How often have you attended an AA or NA meeting?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
20. How often have you been in an argument that was so out of control that someone got hurt?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
21. How often have you been sexually abused?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
22. How often have others suggested that you have a drug or alcohol problem?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
23. How often have you had to borrow pain medications from your family or friends?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
24. How often have you been treated for an alcohol or drug problem?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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

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PHQ-4: THE FOUR-ITEM PATIENT HEALTH QUESTIONNAIRE FOR ANXIETY AND DEPRESSION

Over the last two weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
Feeling nervous, anxious or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Feeling down, depressed or hopeless	0	1	2	3
Little interest or pleasure in doing things	0	1	2	3
TOTALS				

Total score is determined by adding together the scores of each of the 4 items.

Scores are rated as normal (0–2), mild (3–5), moderate (6–8), and severe (9–12).

Total score ≥ 3 for first 2 questions suggests anxiety.

Total score ≥ 3 for last 2 questions suggests depression.

Reprinted with permission from Kroenke K, Spitzer RL, Williams JB, Löwe B. An ultra-brief screening scale for anxiety and depression: the PHQ-4. *Psychosomatics*. 2009;50(6):613-21. From *Principles of Neuropathic Pain Assessment and Management*, November 2011.

The PHQ-4 and other tools are available online at www.oregonpainguidance.org/clinical-tools.

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?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
2. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
3. Were constantly on guard, watchful, or easily startled?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
4. Felt numb or detached from others, activities, or your surroundings?	<input type="checkbox"/> YES	<input type="checkbox"/> 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 than 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.

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.

Source: <http://www.ptsd.va.gov>

The PC-PTSD screen and other tools are available online at www.oregonpainguidance.org/clinical-tools.

STOP BANG

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.

STOP BANG and other tools are available online at www.oregonpainguidance.org/clinical-tools.

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)?

URINE DRUG SCREENINGS (UDS) FAQ

Using UDS 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 UDS 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 11) 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 UDS 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 UDSs. Creating a UDS 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 maintained on opioid therapy and 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. UDS enables us to identify individual risks related to your medications and avoid problems.”
- › “Our clinic uses ‘universal precautions’ in opioid prescribing, which includes UDS. 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. UDS 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 ultrarapid metabolizers. They metabolize specific drugs more rapidly than typical patients. It would be rare to take an opioid as prescribed and have a totally negative UDS. 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 UDS 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 UDS?

- 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. Short-acting opioids can be detected if the lab removes the cutoff concentration so that the presence of lower concentrations is detected. 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.

Risk Category	UDS Frequency	Recommended Drug Panel to Test
LOW RISK by ORT (1 or more/year)	Periodic (e.g. up to 1/year)	Drug you are prescribing if not listed
MODERATE RISK by ORT (2 or more/year)	Regular (e.g. up to 2/year)	Amphetamines Opiates Cocaine Benzodiazepines
HIGH RISK by ORT (3 or more/year) or opioid doses >120 mg MED/d	Frequent (e.g. up to 2+/year)	Alcohol Barbiturates Oxycodone Methadone
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)	Fentanyl Marijuana <i>Testing for all drug classes may not be necessary, depending on clinical situation.</i>

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.

UDS Results

Interpreting UDS 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 UDS results. The following UDS 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

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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UDS FAQs and other tools are available online at www.oregonpainguidance.org/clinical-tools.

METABOLISM DATA FOR COMMON MEDICATIONS

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 in the urine. Also, morphine may metabolize to produce a small amount (<10%) of hydromorphone.
Morphine (Avinza, Embeda, MS Contin, Kadian)	1–3 days		Opiates Immunoassay – positive GC/MS or LC/MS/MS – morphine, possibly 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).
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	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.
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	

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, Methamphetamine 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 intermediate-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 benzoyllecgonine	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.

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.
- › 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.

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** _____

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 prescriptions. 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 to 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 pill 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 a 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.

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 | _____ Lose weight |
| _____ Increased ability to participate in family activities | _____ Able to go shopping |
| _____ Increased ability to do housework | _____ 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.

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 _____

Sample patient treatment agreements are available online at www.oregonpainguidance.org/clinical-tools.

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.

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 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.

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.

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.

PATIENT SIGNATURE

DATE _____

Explained by me and signed in my presence.

PHYSICIAN SIGNATURE

DATE _____

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.

GRADED PAIN AND FUNCTION SCALE

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

The Graded Pain and Function Scale and other tools are available online at www.oregonpainguidance.org/clinical-tools.

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)

$$50 \text{ (total possible score)} \times 100 = 32\%$$

If one section is missed or not applicable, the score is calculated:

16 (total scored)

$$45 \text{ (total possible score)} \times 100 = 35.5\%$$

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.

Reference: Fairbank JC, Pynsent PB. The Oswestry Disability Index. Spine 2000 Nov 15;25(22):2940-52; discussion 52.

The Oswestry Disability Index and other tools are available online at www.oregonpainguidance.org/clinical-tools.

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.

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.

The PEG-3 and other tools are available online at www.oregonpainguidance.org/clinical-tools.

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.

This information and other tools are available online at www.oregonpainguidance.org/clinical-tools.

BEHAVIORAL HEALTH RISKS SCREENING TOOL



For Pregnant Women and Women of Childbearing Age

Patient/Client Name _____ Date _____

Screener Name _____ Date _____

Reviewed by Qualified Provider _____ Date _____

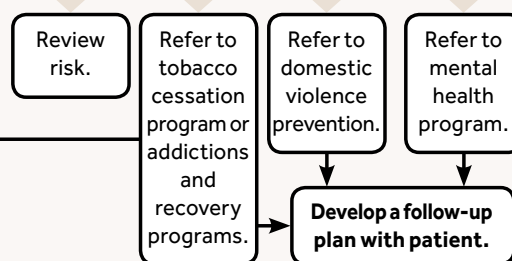
Women and their children's health can be affected by emotional problems, alcohol, tobacco, other drug use and violence. Women and their children's health are also affected when these same problems are present in people who are close to them. Alcohol includes beer, wine, wine coolers, liquor and spirits. Tobacco products include cigarettes, cigars, snuff and chewing tobacco.

1. Have you smoked any cigarettes or used any tobacco products in the past three months?	TOBACCO	<input type="checkbox"/> YES	<input type="checkbox"/> NO
2. Did any of your parents have a problem with alcohol or other drug use?	PARENTS	<input type="checkbox"/> YES	<input type="checkbox"/> NO
3. Do any of your friends have a problem with alcohol or other drug use?	PEERS	<input type="checkbox"/> YES	<input type="checkbox"/> NO
4. Does your partner have a problem with alcohol or other drug use?	PARTNER	<input type="checkbox"/> YES	<input type="checkbox"/> NO
5. In the past, have you had difficulties in your life due to alcohol or other drugs, including prescription medications?	PAST	<input type="checkbox"/> YES	<input type="checkbox"/> NO
6. Check YES if she agrees with any of these statements. – In the past month, have you drunk any alcohol or used other drugs? – How many days per month do you drink? _____ – How many drinks on any given day? _____ – How often did you have 4 or more drinks per day in the last month? _____	PRESENT	<input type="checkbox"/> YES	<input type="checkbox"/> NO
7. Over the last few weeks, has worry, anxiety, depression, or sadness made it difficult for you to do your work, get along with other people, or take care of things at home?	EMOTIONAL HEALTH	<input type="checkbox"/> YES	<input type="checkbox"/> NO
8. Are you feeling at all unsafe in any way in your relationship with your current partner?	VIOLENCE	<input type="checkbox"/> YES	<input type="checkbox"/> NO

PROVIDER USE ONLY

Brief Intervention/Brief Treatment

	Y	N	NA
Did you State your medical concern?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did you Advise to abstain or reduce use?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did you Check patient's reaction?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did you Refer for further assessment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did you Provide written information?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



Moderate drinking for non-pregnant women is one drink per day. Women who are pregnant or planning to become pregnant should not use alcohol, tobacco, illicit drugs or prescription medication other than as prescribed.

Developed by the Institute for Health and Recovery (IHR), Massachusetts, February, 2007. Adapted by the Southern Oregon Perinatal Task Force in partnership with AllCare Health, Oregon, May 2013.

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)

This information and other tools are available online at www.oregonpainguidance.org/clinical-tools.

PATIENT AND COMMUNITY RESOURCES

COMMUNITY MENTAL HEALTH AND ADDICTIONS TREATMENT SERVICES

Community Mental Health and Addictions Treatment Services are available in Clatsop, Columbia, and Tillamook counties. The agencies provide a full range of outpatient individual and group mental health services for children, families, and adults. Substance use treatment services are available for adolescents and adults. The centers also provide crisis services, Assertive Community Treatment teams and psychiatric medical services. All agencies have satellite offices in outlying communities in their counties. These are accessed through the main number provided.

	Phone	Services	Populations served	Chronic Pain Services	Sliding scale	Payment options
Clatsop Behavioral Healthcare						
65 N. Highway 101, Ste.204; Warrenton www.clatsopbhc.org	503-325-5722	Outpatient counseling, crisis services, child wrap around and Intensive services, and residential crisis respite services	All	North Coast Pain Clinic	✓	OHP, commercial insurance
Columbia Community Mental Health						
58646 McNulty Way; St. Helens www.ccmh1.com	503-397-5211	Outpatient, mobile crisis, addictions residential, detox, supported housing	All	Revitalize Clinic	✓	OHP, commercial insurance
Tillamook Family Counseling						
906 Main Avenue; Tillamook www.tfc.org	503-842 8201	Outpatient mental health and substance use counseling, Intensive and WRAP children's services. crisis services	All	Ivy Street Clinic	✓	OHP, commercial insurance

MEDICATION-ASSISTED TREATMENT FACILITIES

	Phone	Services	Populations served	Chronic Pain Services	Sliding scale	Payment options
OHSU Scappoose						
51377 SW Old Portland Rd., Scappoose	503-418-4222	Outpatient	All, including pregnant women wanting MAT services through the referral process. Requirement: Must be established with a PCP in ANY clinic. See CPCCO website for referral process.	Only if seen for primary care	✓	OHP, commercial insurance
CODA						
Fax: 503-239-8407	1-855-733-2632	Outpatient residential	Adults	(none)	(none)	OHP, commercial insurance

NON-PHARMACOLOGICAL INTERVENTION PROVIDERS

Service	CPCCO Provider		
Acupuncture	Mackenzie Champ, ND, LAc Nourish Natural Family Medicine 35890 7th St. Nehalem, OR 97131 503-368-4312	Katherine Delleney, LAc Tillamook Natural Health Center 309 Laurel Ave. Tillamook, OR 97141 503-842-6532	Alfred Thieme, LAc Vital Health Center 440 Columbia Blvd. St Helens, OR 97051 503-481-0283
Chiropractic Care	Stano Chiropractic, LLC 58147 Columbia River Hwy, Ste B St. Helens, OR 97051 503-438-4733	Barry K Sears 2935 Marine Dr Ste B Astoria, OR 97103 503-325-3311	
Physical Therapy	Astoria Physical Therapy 2120 Exchange St. Astoria, OR 97103 Phone: 503-325-7711 Fax: 503-325-7143 Email: administration@astoriapt.com	Therapeutic Associates – St. Helens Physical Therapy 58147 Columbia River Hwy. St. Helens, OR 97051 Phone: 503-397-1914 Fax: 503-366-0422 Email: sthe@taiweb.com	Bayshore Physical Therapy & Fitness Center 38505 Brooten Rd. Pacific City, OR 97135 Phone: 503-965-6400 Fax: 503-965-9555 Email: lcpt1@hotmail.com
	Therapeutic Associates – Scappoose Physical Therapy 51577 Columbia River Hwy. Scappoose, OR 97056 Phone: 503-543-0254 Fax: 503-543-0259 Email: scappoose@taiweb.com		
Wellness Centers Focusing on Pain	North Coast Pain Clinic 65 North Highway 101, Ste 208 Warrenton, OR 97146 Phone: 503-501-4774 Fax: 503-861-0807	Ivy Avenue Wellness Center 1105 Ivy Ave. Tillamook, Oregon 97141 503-815-2704	Revitalize Wellness Center 51577 Columbia River Hwy Ste C Scappoose, OR 97056 503-396-4807

DETOX

Detox Providers	www.oregon.gov/oha/amh/docs/Detox-Provider-Directory.pdf
Bridges to Pathways	Columbia Community Mental Health PO Box 1234; St. Helens, OR 97051; Phone: 503-397-5211
Oregon Substance Use Disorder Directory	www.oregon.gov/oha/amh/publications/provider-directory.pdf

PRESCRIPTION TAKE-BACK LOCATIONS

County	Prescription Drop-Off Site		
Clatsop	Astoria Police Department 555 30th St., Astoria 503-338-6411	Columbia Memorial Hospital 2111 Exchange St., Astoria	Seaside Police Department 1091S. Holladay, Seaside *Lobby drop box 503-738-6311
	Cannon Beach Police Dept. 163 E Gower St., Cannon Beach Monday–Friday: 8am–5:30pm 503-436-2811	Providence Health & Services 725 S. Wahanna Rd., Seaside	Warrenton Police Department 225 S. Main Ave., Warrenton Monday–Friday: 8am–5pm 503-861-2235
Columbia*	St. Helens Police Department 150 S 13th St, St. Helens	Peace Health St. John Medical Center 1615 Delaware St., Longview WA	Providence Health and Services 18610 NW Cornell Rd., Hillsboro
Tillamook	Garibaldi City Hall 107 Sixth St., Garibaldi Monday: 12pm–5pm & Tuesday–Friday: 8am–5pm	Rinehart Clinic-Pharmacy 230 Rowe St., Wheeler	Tillamook Police Department 207 Madrona Ave., Tillamook Monday–Friday: 8am–4pm
	Manzanita Police Department 165 S. Fifth St., Manzanita Monday–Sunday: 8am–4pm Call 503-368-7229 before coming in	Tillamook County Sheriff's Office 5995 Long Prairie Road, Tillamook Monday–Sunday: 8am–5pm	

*Only one known location available in Columbia County. The nearest locations in neighboring counties are listed.

OTHER SERVICES

Dual Diagnosis of Oregon	http://www.ddaoforegon.com/pdf%20docs/Meeting%20Directory.pdf
Jordan's Hope for Recovery	www.jordanshope.org



OREGON PAIN GUIDANCE

www.oregonpainguidance.org



Columbia Pacific CCO

Creating Health Together



Produced by Oregon Pain Guidance (OPG)

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