



BaylorScott&White
HEALTH

Pain Management & Opioid Prescribing Guidelines

A Provider and Community Resource



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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 may put your patient, or your patient’s family, or the community at large, at risk. Too many pills prescribed for a given situation may 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

Baylor Scott & White Health (BSWH)

Clinical Leadership at Baylor Scott & White Health is committed to educating our medical providers on the latest evidence regarding chronic pain physiology and therapy. These guidelines are provided as a resource for our physicians and other caregivers as they strive to treat our patients who have pain. In addition to these guidelines, which provide overall information about pain treatment, we have produced an educational video that offers continuing medical education credit for our providers. All of us need to understand the science that underlies current best-practice recommendations for treatment of pain, and to be able to communicate these to patients. Our hope is that all our providers will share common understanding, our patients will hear a consistent message, and the community at large will support these efforts.

The information contained in this document should not be considered standards of professional practice or rules of conduct or for the benefit of any third party. This document is intended to provide guidance and, generally, allows for professional discretion and/or deviation when the individual health care provider deems appropriate under the circumstances.



Institutional support for this project came from the Clinical Leadership Council, chaired by Robert Probe, MD, and the Central Texas Board of Directors, chaired by Alejandro Arroliga, MD. The Executive Sponsor was Glen Couchman, MD. Other leaders providing support for this project included Steven Sibbitt, MD, and Timothy Bittenbinder, MD. Tiffany Berry, MD, and Michael Massey, MD, along with Mae Centeno, DPN, provided assistance with overall institutional support and infrastructure for the project. Co-chairs Judy Embry, PhD, and Michael Reis, MD, provided leadership for a taskforce of expert practicing clinicians from the Baylor Scott & White Health system, which adapted these guidelines for use in the Baylor Scott & White Health system and produced a corresponding CME video. Members of that group included James Albers, MD; Chris Burnett, MD; Timothy Clark, PhD; Radha Kambhampati, MD; Glen Ledbetter, MD; Jason Sapp, DO, with Layne Stone as the project manager. This group developed the video content and, along with Emily Garmon, MD; Rodney Lange, MD; and Amber Whittenburg, MD, participated in the video, with Cinamon Romers, PhD, and Jae Ross, PsyD, as actors.

Oregon Pain Guidance Group (OPG)

The Guidelines on which the Baylor Scott & White Health guidelines are based, were authored by Oregon Pain Guidance (OPG), a group of physicians, nurse practitioners, physician assistants, nurses, pharmacists, medical directors, insurance providers, emergency room providers, pain medicine specialists, mental health counselors, substance abuse professionals, public health professionals, and others in Southern Oregon. The OPG group—and in particular the steering committee—promotes community education, an annual pain conference, the OPG website, and the original production of these guidelines.

Guidelines Authors and Contributors

With the release of the CDC guidelines,⁵ OPG focused their attention on operationalizing these nationally recognized best practices 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. The majority of the drafting and revisions 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.

These Baylor Scott & White Health guidelines are an adaptation of guidelines written by OPG. The BSWH taskforce, described above, added to the content of the OPG guidelines and adapted them for use in Texas and BSWH. In addition to this group, other Baylor Scott & White Health contributors included Aval-Na'Ree Green, MD; Tran Cassandra Huynh, MD; Javier Kane, MD; and Michael Ready, MD. We are grateful for all contributors to this effort. These guidelines are for all who work with patients with pain, including prescribers, behavioral health professionals, physical and occupational therapists, nurses, those who dispense pain medications, and those who pay for these services.



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 support and endorse these new guidelines. This is a summary of the 12 CDC recommendations.

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 strategies into their management plan to mitigate risk, including considering offering naloxone when factors are present 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.



9. Clinicians should review the patient’s history of controlled-substance prescriptions using state prescription monitoring program (PMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put the patient at high risk for overdose. Clinicians should review PMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every three months.
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 (examples include medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder.

Surgeon General

In August, 2016, current U.S. Surgeon General, Vivek H. Murthy, MD, M.B.A., sent notice to all physicians, asking each to take a pledge to “turn the tide” against opioid abuse. His message urged all prescribers to (1) become educated about treating pain safely and effectively, (2) screen patients for opioid use disorder and provide or connect them with evidence-based treatment, and (3) consider addiction to be a chronic illness, not a moral failing. Our guidelines are consistent with Dr. Murthy’s message and pledge; [Turn the Tide](#).

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 these help the practicing clinician by making appropriate pain management tools accessible and easy to follow.

Recommendations for 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.

Recommendations for chronic conditions with acute pain flares

- › Recommend against 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 [Texas Prescription Monitoring Program](#) (PMP) with any first opioid prescription.



Recommendations for subacute (6–12 weeks) opioid use and transition to chronic opioid therapy (>12 weeks)

- › Recommend against starting 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 such as non-opioid analgesics, graded exercise, cognitive behavioral therapy (CBT), 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 or suicidal history, PMP) 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, recommend recording total opioid dose using an [online calculator](#) and measures of pain and function using brief validated instruments.

Recommendations for chronic opioid use (>12 weeks)

- › Recommend against prescribing chronic opioids for non-specific musculoskeletal pain, headache or fibromyalgia.
- › Do not combine opioids with benzodiazepines, muscle relaxants, or sedative hypnotics.
- › Repeat PMP check and urine drug screen (UDS) periodically, based on risk.
- › Avoid exceeding 90 mg/day MED. For patients with one or more risk factors (e.g., history of substance-use disorder, tobacco users, mental health disorders, cannabis-use disorder), recommend limiting to no more than 50 mg/day MED.
- › Non-pharmacological alternatives to opioids can 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 and related therapies, that can effectively address psychosocial barriers to recovery (e.g., fear avoidance, catastrophizing, low expectations of recovery) and teach self-management of pain.
- › Periodically ask if the patient would like to consider trying a gradual opioid taper to reduce dose or discontinue use.

Recommendations for tapering chronic opioid therapy

- › Taper off opioids if patient has not achieved clinically meaningful improvement, had an overdose event, develops a serious adverse outcome (e.g., endocrine dysfunction, severe dependence or opioid use disorder), demonstrates aberrant behaviors or requests a taper.
- › Tapering to zero can be accomplished in most cases by reducing the dose up to 10% 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 [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.

Recommendations for perioperative opioid use

- › For patients on chronic opioid therapy, develop a coordinated treatment plan, including a timeline for tapering opioids post-operatively. By four to six weeks, doses should not exceed preoperative levels.
- › 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 should utilize behavioral, motivational and other ancillary modalities. Follow-up requires attention to safety monitoring such as PMP, UDS, and pill counts. Most experts agree that pain management is best accomplished in a team-based care model, not unlike the approach of the treatment of other chronic diseases such as diabetes, congestive heart failure, and the like.

Larger health care systems can access nurses, behavioral health specialists such as psychologists and therapists, OT/PT, and peers within their organization. Smaller medical practices should develop strong relationships with local specialists who have expertise in the treatment of pain.

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

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 Guidelines are divided into sections that can stand alone for quick reference. In this document, we tried to address the real-world situations non-pain-specialist practitioners face in daily patient care.

We encourage healthcare organizations large and small to use these tools along with other excellent resources, many of which are referenced in this document, to create treatment guidelines of their own. On request, Oregon Pain Guidance will provide a Microsoft Word version of this document. Email info@oregonpainguidance.org.

Treatment and tapering flow sheets

There are four flow sheets that can be used for quick reference for the most common situations encountered in treatment of pain. They are the treatment essentials for [Acute Pain](#), [Chronic Pain](#), [Opioid Tapering](#), and [Benzodiazepine Tapering](#). 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.



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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.

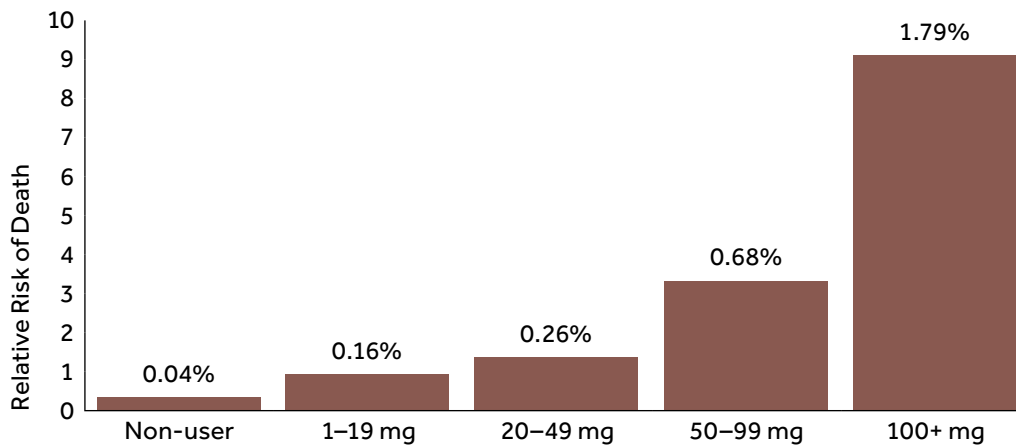
When using such calculators, be aware that methadone is a complex drug in terms of its metabolism. As the dose escalates, the MED escalates in a non-linear and accelerated fashion. It is critical to understand methadone's unique MED status to safely switch between methadone and other opioids, and vice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

The following chart illustrates the importance of keeping your patient's MED as low as possible. It also reveals the logic behind the CDC recommended 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



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

An electronic MED calculator is available at: [MED Calculator](#).

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 patients may provide a false sense of security to the clinician. Here are some generally accepted guidelines:

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

Red flags upon intake

- › Evidence of PMP irregularities
- › Benzodiazepine use
- › Use of two or more psychoactive drugs
- › Methadone use
- › Buprenorphine use
- › MED \geq 90
- › History of prior non-fatal overdose
- › History of current or active opioid or substance abuse
- › Opioid Risk Tool ([ORT](#)) \geq 8
- › Active alcohol misuse by [AUDIT-C](#)
- › Patients with severe depression ([PHQ-9](#) \geq 15), anxiety ([GAD-7](#) \geq 12), or PTSD ([PC-PTSD](#) $>$ 2) (see Epic EHR for PHQ-9 and GAD-7)



- › Patients with a listed diagnosis in the medical record of bipolar disorder, personality disorder, or schizophrenia

Red flags during treatment

- › Losing prescriptions
- › Illicit use of prescription or use of illicit substances
- › Running out of medication early
- › Recurring ED visits
- › Demanding opioids
- › Obtaining opioids from multiple prescribers
- › Multiple pharmacies used
- › Unexpected UDS results
- › Non-compliance with clinic policies or [Controlled Substance Consent and Agreement](#)

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. The following measures may be useful:
 - Increasing the frequency of UDS
 - Instituting pill counts and/or “callbacks” (asking a patient to return to the clinic within 24 hours to evaluate and count remaining medication)
 - Frequent query of the PMP
 - 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. rest, 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 often will 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.
- › Perform 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*, recommendations are:
 - 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 overuse of opioids should be prescribed the least amount of medication necessary.



- Identify other prescribed medications or conditions that would preclude co-prescribing opioids. Benzodiazepines have a synergistic effect with opioids; they should not be used together.¹²
- 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.
- Have the patient sign a [Controlled Substance Consent and Agreement](#) (CSA) if the patient returns requesting a refill of opioids. A urine drug screen and PMP query should be performed prior to writing the second prescription.
- › 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 relievers.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, specialty referral, and an alternative treatment modality.
 - Ongoing pain may indicate that pain is becoming chronic and that non-opiate medications and treatments options need to be initiated. Assess and educate the patient
- › 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

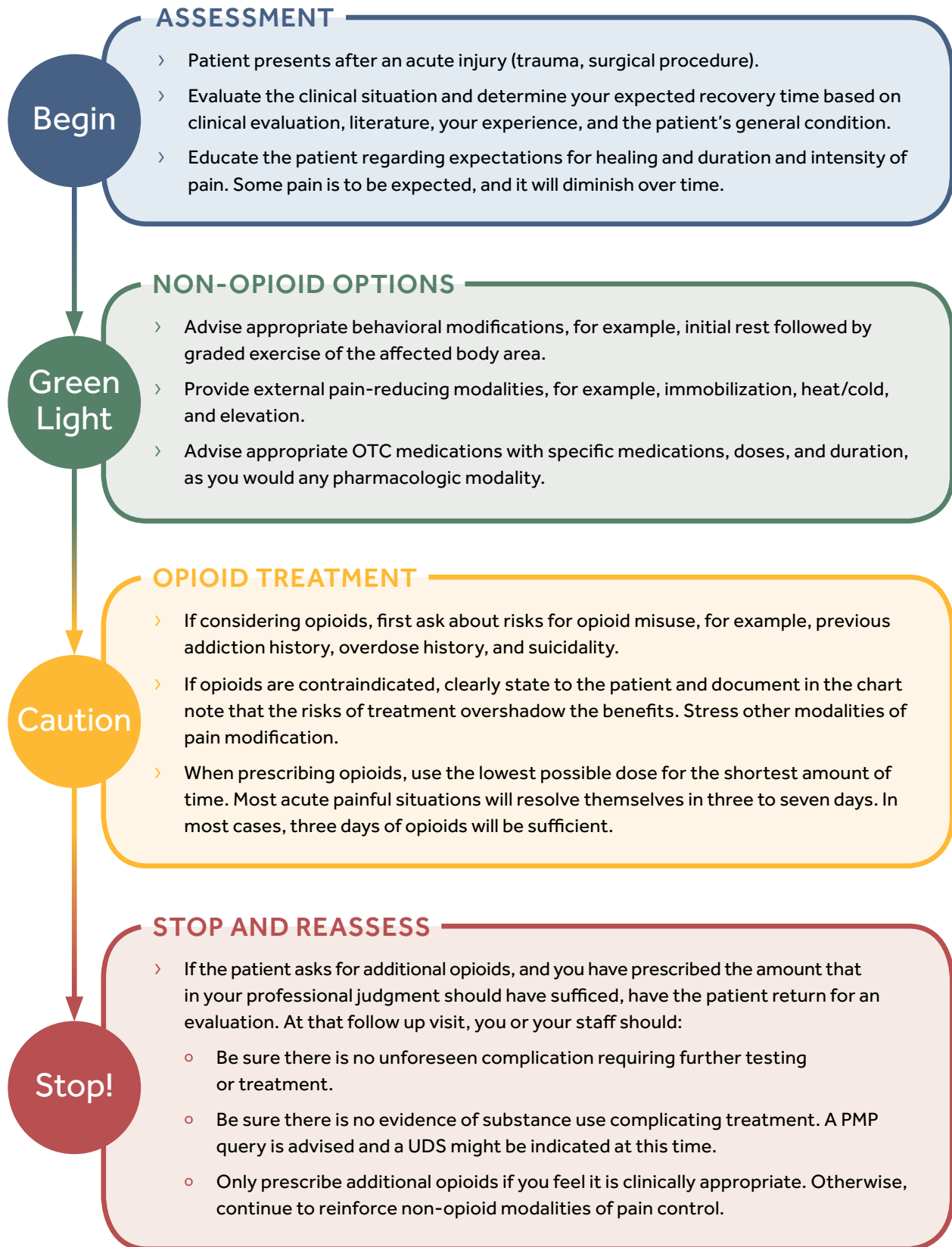
- › Dosage instructions need to be clear. PRN prescribing should be as conservative as possible, as it can lead to inadvertent large doses (e.g., hydrocodone/acetaminophen 5/325 one to two every three to six hours can be as much as 50 mg MED a day—a lot of medication for an opioid-naïve individual).
- › 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](#), and [SOAPP®-R](#)
- › Screening tools for function: [Oswestry Low Back Pain Disability Questionnaire](#) and [PEG-3: Pain Screening Tool](#) (Krebs et al 2009)
- › Screening tools for common co-occurring mental health conditions: [PHQ-9](#) and [GAD-7](#), for depression and anxiety respectively, are available in Baylor Scott & White Health Epic EHR
- › [Texas Prescription Monitoring Program](#) (PMP)

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 manage their pain with non-opioid modalities/strategies 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 (defined in [Specialty Care](#) section). 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 or both of the following broad categories: nociceptive and neuropathic.



- › **Nociceptive pain:** Pain that is due to actual or potential tissue damage or injury which initiates signals through peripheral nerves to the spinal cord and on to the brain. It involves direct stimulation of intact nociceptors along normal nerves and includes inflammatory pain. Arthritis and mechanical low back pain are examples. Nociceptive pain can be somatic, which is usually easy to describe and localize, or visceral, which is sometimes difficult to describe/localize. Nociceptive pain may respond to both opioid and other medications as well as to peripheral interventions.
- › **Neuropathic pain:** Pain resulting from trauma or dysfunction of peripheral or central nerves.
 - **Peripheral neuropathic pain** can come from diabetes or other metabolic disorders, peripheral nerve damage, or can be drug-induced. Peripheral neuropathic pain may respond to non-opioid medications.
 - **Central neuropathic pain*** can be due to head injury, stroke, or central nervous system disorders such as multiple sclerosis. Psychotropic and other non-opioid therapies, including behavioral therapies, can be beneficial for central neuropathic pain.

In chronic pain, patients usually have “mixed” pain, more than one type. All pain types may benefit from non-medication pain management strategies, including CBT, movement therapy, and education.

**Note: “Central neuropathic pain” is a distinct entity from “centralized pain” due to “central sensitization” – see below for more details.*

Nociceptive and Neuropathic Pain

Historically, almost all chronic non-cancer pain (CNCP) was thought to be either nociceptive or peripheral 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.

However, over the past decade, a body of evidence has accumulated to suggest that “centralized pain” is likely to be as prevalent as 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.¹⁶ Note that centralized pain can overlay nociceptive and/or neuropathic pain, making treatment planning more complex.

Centralized Pain or Central Sensitization (CS)

The prototypical centralized pain state is fibromyalgia syndrome. But current research suggests that centralization is a spectrum disorder, which includes a large family of common chronic non-cancer pain diagnoses. Chronic non-specific low back pain, chronic headaches, fibromyalgia and other pain disorders are highly associated with CS.^{16,17} These pain syndromes are believed to be the result of neuroplastic changes in function of the pain “neuromatrix” of the brain and/or changes in the ascending or descending pain pathways of the central nervous system. The result is hypersensitivity to pain-related stimuli. 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 exercise habits.

Assessment and Treatment of Chronic Non-Cancer Pain (CNCP)

We highly recommend that all providers thoroughly review [Texas Medical Board Rule 170.3](#) “Minimum Requirements for the Treatment of Chronic Pain” (effective July 7, 2016). This rule describes acceptable assessment, documentation, and ongoing monitoring, related to treatment of patients with chronic pain. These requirements should be understood prior to assuming responsibility for treatment.

In addition to, or in support of, TMB requirements, we recommend you obtain 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, and any 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 substance use spectrum disorders and disorders that are primarily due to central sensitization.
- › A query of the PMP.
- › UDS (see [Urine Drug Screenings \(UDS\) FAQ](#) for specifics)
- › Substance-abuse risk screening. See [ORT](#) and [SOAPP®-R](#)
- › Mental health screening, for example, [Primary Care PTSD Screen](#), anxiety ([GAD-7](#); Epic EHR), and depression ([PHQ-9](#); Epic EHR)
- › Respiratory disease risk screening; see [STOP BANG](#).
- › Pain and, most important, functional assessment to evaluate progress with treatment over time. Examples of tools include [Graded Pain and Function Scale](#), [Oswestry Low Back Pain Disability Questionnaire](#), [PEG-3: Pain Screening Tool](#).

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 [Controlled Substance Consent and Agreement](#) (CSA) and obtain a signature, scanning the signed document into the patient chart.
 - If the patient is already taking an opiate, 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 90mg, 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.
 - Consider co-prescribing a naloxone rescue kit. Some [Texas pharmacies](#) now dispense naloxone without prescription. See more on [naloxone](#) in Other Considerations section.



- › Ongoing monitoring is recommended 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, PMP query, callbacks with pill counts, and/or 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.¹²
- › Tramadol is a weak opiate and, as such, has many of the same limitations and risks as other opioids
- › Methadone use should be avoided for pain, and, if prescribed, doses should be kept below 30mg/d because of its high lethality mg for mg.¹² Other rapidly acting opioids, such as fentanyl, are highly addictive and should be avoided as well.
- › 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 substance abuse, even if in remission currently, requires increased scrutiny if any prescribing is undertaken, to help prevent relapse.
 - Illegal activities regarding medications.
 - Lack of functional improvement while taking opioids.
 - Violation of an opioid treatment agreement with another prescriber in the previous 12 months (documented).

Non-Opioid Treatment^{19,20,21,22}

- › Behavioral therapies and exercise/movement have been shown to be highly effective for management of chronic pain and will be discussed in a separate section.
- › Referral to interventional pain medicine or substance abuse specialties may be needed; these will be discussed in the [Specialty Care](#) chapter.
- › A pain rehabilitation program is strongly recommended for treatment of complex chronic pain patients who have not responded to other treatments and who are disabled from the pain. Such programs often include education, movement therapies, behavioral modalities, and peer-to-peer support. See more about these programs in the [Specialty Care](#) chapter of these guidelines.

Patient Instructions

- › Patients should be educated about pain management techniques, such as exercise/movement, CBT, medications and other strategies, to reduce expectation of pain elimination. This is common to all chronic disease states (diabetes, hypertension, etc.).
- › Dose instructions need to be 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.)
- › When prescribing a psychotropic medication, it is helpful to designate them as “for pain” or “for sleep” when prescribed in the absence of a psychiatric disorder. This practice may make these medications more acceptable to patients and families.



- › The following should be a part of patient/family education concerning opioids:
 - Safe storage to prevent children and others from obtaining the medication.
 - Contact local police department or visit [DEA Take-Back website](#) about safe disposal when medications are no longer needed.
 - Clinic policies. Consider overall clinic policies concerning early refills, lost or stolen prescriptions, Friday and weekend refill requests, use of illicit drugs including marijuana, and alcohol use/abuse.

Tapering

- › Many legacy patients 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 accompany tapering. Learn what local community resources are available to you or refer to appropriate professionals.
- › 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. In collaboration with other prescribers, 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; recommendation is to start with opioids and then taper the benzodiazepines.
- › When patients are exhibiting active addiction behaviors (e.g., use of illicit drugs like heroin) an immediate cessation of prescribing may be indicated and accompanied by an addiction treatment referral.

Additional Concerns

- › **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 health support. Be sure to ask about suicidal thoughts and provide referrals 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.

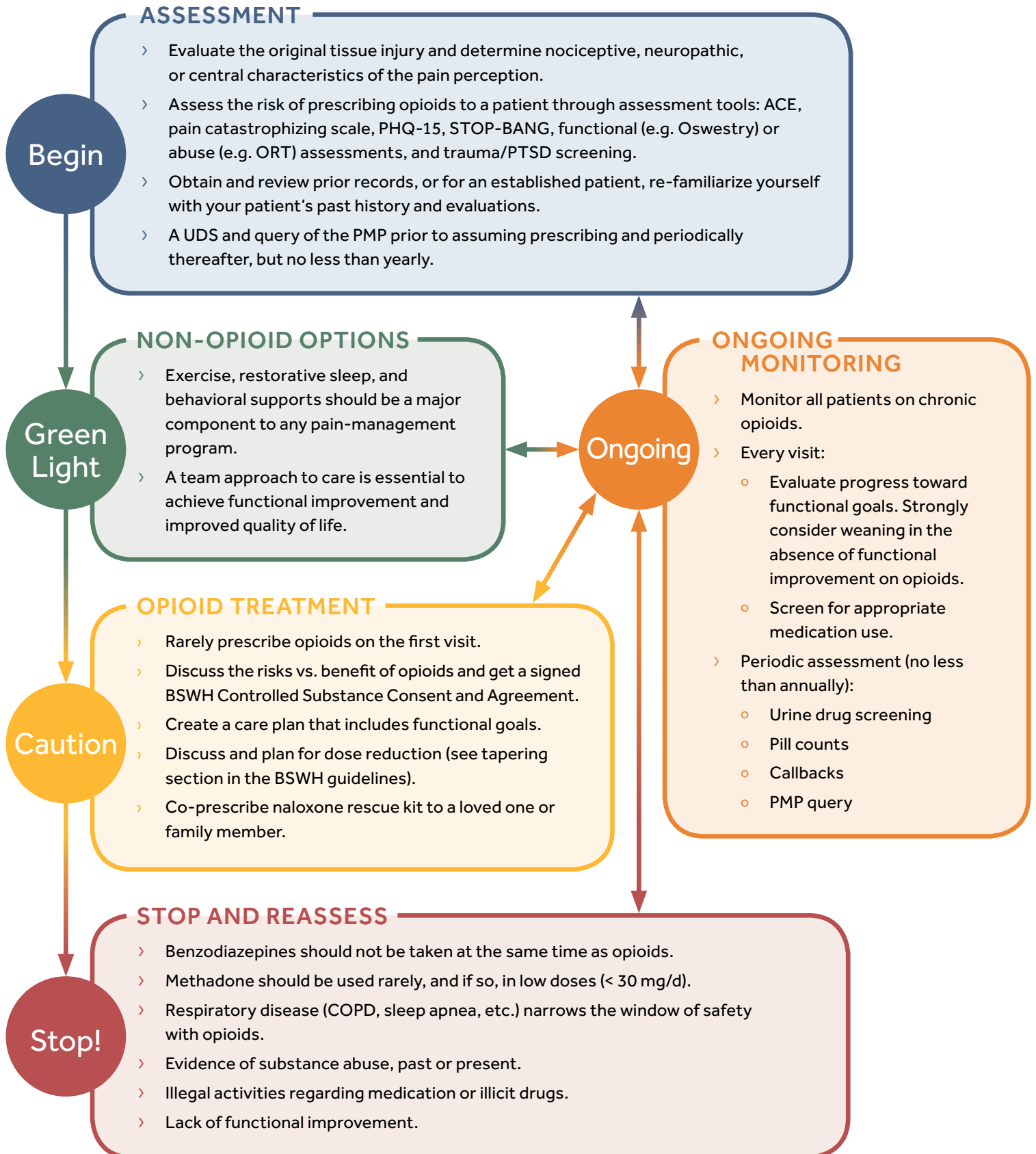
You may have patients to whom you were prescribing opioids for the treatment of pain, but who over time showed evidence of addiction. Ideally, if you prescribe opioids for chronic pain, you also have the capability to prescribe buprenorphine (or can refer to others with that capability) for your patients who you believe have a substance-use disorder. Regardless of the terminology you use, some patients would be safer being prescribed buprenorphine rather than full mu agonists such as hydrocodone.

An in-depth knowledge of both community and healthcare system addiction services is an important component of chronic pain treatment. Baylor Scott & White Health social workers are good resources for this information.



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%
Acupuncture	>10%

Adapted from: Tauben D. Nonopioid medications for pain. *Phys Med Rehabil Clin N Am* 2015;26(2):219-248.

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 options and strategies our patients can use to help manage their pain.



Non-Opioid Treatment Options

Patient Lifestyle	<ul style="list-style-type: none"> › Weight reduction › Diet/Nutrition › Stress management › Exercise › Sleep and sleep hygiene
Physiotherapy Interventions	<ul style="list-style-type: none"> › Functional therapies <ul style="list-style-type: none"> ○ Physical therapy (PT) ○ Occupational therapy (OT) ○ Passive and active modalities
Behavioral Interventions	<ul style="list-style-type: none"> › Educational groups <ul style="list-style-type: none"> ○ Preventive ○ Support ○ Shared medical appointments › Psychotherapy <ul style="list-style-type: none"> ○ Individual counseling ○ Group therapy ○ Cognitive behavioral therapy (CBT) ○ Acceptance and commitment therapy (ACT) ○ Relaxation training/mindfulness meditation ○ Cognitive behavioral therapy for insomnia (CBTi) › Supportive care <ul style="list-style-type: none"> ○ Case management › Substance-abuse treatment <ul style="list-style-type: none"> ○ Inpatient ○ Outpatient ○ 12-step groups ○ Medication-assisted treatment › Trauma-informed care <ul style="list-style-type: none"> ○ PTSD screening ○ Domestic violence screening ○ Child abuse screening



Medical Interventions

NOTE: Current literature suggests combinations of these classes of medications are more effective than just one class.²³

- › Non-opioid medications that may aid in chronic pain management
 - NSAIDs, acetaminophen
 - Tricyclic antidepressants (neuropathic and centralized pain)
 - Anti-epileptics (neuropathic and centralized pain)
 - Antidepressants; SNRIs for neuropathic or centralized pain and/or depression; SSRIs for depression
 - Topical medications, prescription and over-the-counter
- › Minimally invasive surgical procedures
 - Interventional treatments: Nerve blocks, steroid injections, ablations, restorative injections, stimulators, implantable devices
 - Surgical treatment
- › Complementary and alternative treatments
 - 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. It can be conducted for individuals or for groups of patients. 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.²⁴ 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. There now is fMRI evidence that positive results of CBT likely are due to changes in brain processing of neural input.²⁵
- › **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 as well as orientation toward self-management. CBT helps patients change the way they relate to pain so they can experience life more fully. Other techniques, such as mindfulness and relaxation training, teach patients to relax and decrease tension.
- › **A related strategy, Acceptance and Commitment Therapy or ACT, can be beneficial.** Two fundamental concepts are at play in this strategy. One is that a person must accept any 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."



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 or behavioral health specialist, can meet with patients as a group to discuss common issues, while simultaneously taking individual patients aside for brief patient-specific evaluations. Insurance companies may 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.



SPECIALTY CARE FOR TREATING CHRONIC PAIN

Pain, in all its manifestations, is an aspect of most illnesses, as well as a normal part of the aging process. As such, its treatment is an essential component of primary care. The treatment of pain, especially acute pain, may at times require the use of opioids, which have significant risks in addition to their benefits. After years of misguided provider education, millions of patients in our healthcare system are on opioids for inappropriate diagnoses and at inappropriate doses (legacy patients or the lost generation). Many of these patients have not responded to care, are disabled, and/or have significant psychosocial issues. Even the most skilled providers may at times need specialty care to assist in the management of these complex patients. This section of the guidelines will address the following questions as related to Interventional Pain Medicine, Chemical Dependency Services, and Interdisciplinary Pain Management Program:

What kinds of patients are most appropriate for this type of specialty care?

What is the screening and evaluation expected for these patients?

What kinds of services are provided by specialists?

What are the expectations and long-term goals for patients treated in specialty care?

Pain Specialty Care – Interventional Pain Medicine

For patients with chronic pain, interventional pain management should be one part of a multimodal treatment plan.

Referral criteria

- › Patients with significant functional limitations due to pain, despite non-invasive multimodal, multidisciplinary treatment.

Pre-referral

- › Complete appropriate diagnostics and imaging

Services

- › Interventions to temporarily or permanently interrupt the flow of signals along specific nervous system pathways (injections, blocks, ablations)
- › Diagnostic blocks and injections
- › Neuromodulators such as spinal cord stimulators
- › Intrathecal infusions, “pain pumps”
- › Multimodal treatment planning

Possible goals of treatment

- › Improved function, possibly reduced pain
- › Permanent relief of pain
- › Temporary relief of pain in order for patient to participate in a full treatment plan.

Expectations

- › Once interventions are successful or have failed, patients will return to the care of their PCP.
- › Patients may return for resurgence of pain or for new pain.

Exclusion criteria

- › Patients needing opiate tapers or with substance use disorders should not be referred. Patients with predominant centralized pain will have best outcomes from a multidisciplinary approach that includes behavioral health and movement therapies.

Pain Specialty Care – Chemical Dependency Services

For patients with comorbid chronic pain and substance use disorders, chemical dependency services should be one part of a multimodal pain treatment plan.

Referral criteria

- › Patients with known or suspected opioid or other substance use disorder, the essential feature being cognitive, behavioral, and/or physiological symptoms indicating the patient continues to use the substance despite associated problems. These patients should have a desire to be substance free.

Pre-referral

- › Assess whether patient has tolerance/dependence only vs. Opioid (or other) Use Disorder. See [DSM V Checklist for Opioid Use Disorder](#).
- › Communicate with the patient regarding concerns and reasons for referral.
- › Address plans for management of pain that will be necessary moving forward.

Services

- › Assessment and treatment planning
- › Education and referral
- › Detoxification (inpatient)
- › Education and Referral
- › Medication Assisted Treatment/Tapering

Goals of treatment

- › Active Recovery
- › Acquisition of coping skills and strategies
- › Relapse prevention



Expectations

- › Individuals will return to the care of their referring physician for further management of continued pain.
- › Patients will remain susceptible to relapse into their substance use disorder. Any medications that are potentially addictive should be prescribed only if no other treatment options are available and in small amounts with the understanding that active addiction can be triggered.

Referral exclusion criteria

- › Patients who are opiate dependent only, that is, showing tolerance and withdrawal without other symptoms of a Substance Use Disorder.
- › Patients who need tapers due to other reasons such as side effects, lack of progress, violation of a CSA, personal preference or any other reasons outside addiction should be tapered by the prescribing physician.
- › Note that undiagnosed substance abuse disorders may surface during a taper.

Pain Specialty Care – Interdisciplinary Pain Programs

Interdisciplinary pain programs provide tertiary care for patients with chronic pain with other complex problems who have failed more conservative treatments.

Referral criteria

- › Patients with chronic pain who have failed other treatments, have impaired function, are on high doses of opiates, or have higher levels of emotional distress.
- › Must be independent and willing to actively participate.
- › Must be able to attend multiple hours/days/weeks of a treatment program.

Pre-referral

- › Evaluate for possible unforeseen sources of nociception.
- › Assess whether patient's emotional and medical stability are sufficient to attend several weeks of treatment.
- › Determine whether there are geographical or other factors that prohibit attending program.

Services

- › Individual and group education and treatment
- › Interdisciplinary care, usually by physician, psychologist and physical therapist. May include occupational therapy, nursing, pharmacy, clergy, or others.
- › Focus is on increasing overall function and teaching self-management skills and strategies.

Possible goals of treatment

- › Improved function, possibly reduced pain
- › Reduced reliance on or discontinuation of opiates
- › Improved self-management of pain
- › Improved quality of life



Expectations

- › Once program is completed, patients will return to the care of the referring physician.
- › (Some programs have after-care support groups.)

Referral exclusion criteria

- › Patients with medical or emotional instability that would prohibit attending a multi-week program, or those who are otherwise unable to attend such a program, should not be referred.

“Pain Clinics”

It is clear from the latest research that chronic pain is often, if not largely, a disorder of nociceptive perception and dysregulation.²⁶ Chronic pain patients often represent a subset of the population with specific bio-psycho-social characteristics. This means that a pain specialty clinic needs to have a foundation of understanding and resource accessibility to care for individuals with historical trauma, substance-use disorder, and catastrophic thinking patterns. There should be good understanding of the pharmacodynamics of opioids. Chronic pain is often best viewed through the lens of chronic disease management rather than cure. Therefore, clinics that treat chronic pain should:

- › Provide multimodal treatment, rather than pain medications alone.
- › Work closely with behavioral health specialists and physical therapists.
- › Be able to identify and treat, or refer for treatment, patients with substance use disorders.
- › Communicate regularly with primary care physician and help establish common treatment goals.
- › Return patient to care of PCP once an optimal care plan is established.



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 catecholamines, the hypothalamic-pituitary-adrenocorticoid axis, endogenous opioids, thyroid and immune function, 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,²⁷ compared to 3.5% in the general population.²⁸ In a study of patients with chronic low back pain, 51% of the patients evidenced significant PTSD symptoms.²⁹ Daniel Claw and others have found a strong association between trauma, childhood sexual abuse in particular, and central sensitization (CS) syndromes.²⁹ 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.
 - Patients with long-lasting PTSD are unlikely to achieve significant improvement in symptoms without behavioral health treatment.
- › Gather a thorough bio-psycho-social history and assess the individual for medical and psychiatric problems. Perform a risk assessment for suicidal and homicidal ideation. Assess for substance abuse.
- › Assess for PTSD symptoms (see [Tools](#) below). There are a number of screening tests that have been designed for use in medical settings. See [Primary Care PTSD Screen](#) 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.



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.³¹
- › 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 (CBT) used in the treatment of chronic pain.
- › Interdisciplinary pain programs, which are trauma informed, also provide a good referral resource for those suffering from PTSD and persistent pain.

What Can Healthcare Providers Do

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

- › Identify behavioral health professionals in the healthcare system or community who work with patients who have PTSD
- › 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: [PTSD for Professionals](#).

Tools

See [Primary Care PTSD Screen](#) (PC-PTSD). The PTSD Checklist for DSM-5 (PCL-5) can be found in Epic EHR (NTX only).



TREATING HEADACHES

When an individual has presented with headache as a medical issue, the first question to be asked is whether it is a primary headache or a secondary headache. A primary headache is a condition to be treated. A secondary headache is a symptom of another condition; the headache goes away when the condition that caused it is diagnosed and treated.

Signs and Symptoms of Secondary Headache

Evaluation may determine the headache is primary, but secondary headache should be ruled out before headache specialist referral when any of these are present:

- › Systemic signs such as fever and rash
- › Neurological symptoms (deficits or abnormalities)
- › Onset to maximum pain <1 minute
- › New onset, or distinct pattern change, in an individual >50
- › Presence of postural component or papilledema
- › Precipitated by Valsalva or physical exertion

Primary Headaches

- › Migraine is the most common;
 - Migraine is due to CNS hypersensitivity or central sensitization (see [Treating Chronic Pain](#) chapter).
 - Any disabling headache can be considered migraine until proved otherwise.
 - Incidence is 6% of males, 18% of females (33% during child-bearing years).
 - According to WHO, 30% of worldwide disability and 50% of neurological disability is due to migraine.
- › Primary headaches other than migraine are:
 - **Tension-type.** Not disabling, not throbbing, not localized. Typically holocephalic.
 - **Cluster.** Intense unilateral, often felt behind one eye, duration 15 minutes to two hours. Unilateral autonomic signs such as tearing or rhinorrhea.
 - **Hemicrania Continua.** Continuous unilateral headache that may vary in intensity. Autonomic signs may be present.
 - **Cough-associated.** Intense pain associated with cough.
 - **Stabbing.** “Ice pick” headache. Sharp jabs of intense pain lasting seconds to several minutes. Moves around head. ~ 40% of migraine patients have this.
 - **New daily persistent.** Onset of a continuous daily headache from one point forward for over three months. Migraine characteristics are often present.



Treatment of Primary Headaches

- › Neither opioids nor barbiturates (such as butalbital-containing medications) are first-line treatments for recurring primary headaches.
- › Medication Overuse Headaches (“rebound”) can occur with even OTC pain medications. Use of analgesics more than 8 times per month can inhibit headache prevention

Migraine Treatments

- › Acute: Mild to moderate—NSAIDs; moderate to severe—triptans or polypharmacy; severe—parenteral medications
- › Known provocation (menstruation, travel): Scheduled NSAIDs or triptans
- › Clinical effectiveness of an acute therapy may be enhanced by metoclopramide or prochlorperazine.
- › As a migraine attack intensifies or goes beyond the 1st day, parenteral medications will likely be required secondary to migraine-associated gastroparesis.
- › Outpatient rescue treatment for acute migraine in established patients can minimize emergency room or urgent care visits and limit exposure to unnecessary radiation and laboratory testing.
- › Preventive: Started when patient is ready or when ≥ 6 migraines/month. Includes behavioral interventions such as exercise, relaxation skills, and sleep; pharmacological interventions such as supplements, TCAs, SNRIs, and/or anticonvulsant medications; and procedural interventions such as injections.
- › For more details, see *Discussing Migraines with Your Patients*, [Migraines – Michael Ready, MD](#), available for free download from a Baylor Scott & White Health computer (look for: Click here!).



Treatment of Headache Other Than Migraine

Headache Type	Treatment
Migraine	<p>Acute: NSAID, combo analgesics, triptans (oral, intranasal, parenteral); augment with neuroleptics.</p> <p>Preventive: Behavioral interventions; Mg⁺⁺, CoQ10, Vitamin B-2; TCAs, β blocker, candesartan, anticonvulsants, SNRIs; injections</p>
Tension Type	<p>Acute: NSAID</p> <p>Preventive: TCA, SNRI</p>
Cluster	<p>Acute: High flow O₂ @ 10–15 LPM by non-rebreather mask; parenteral or intranasal triptans or ergots.</p> <p>Preventive: Steroid burst therapy (prednisone 60–80 mg, 5 to 7 days); instant release verapamil, 80 to 120 mg BID increasing to TID, titrating up every 5 to 7 days as needed until attacks abate or adverse events become intolerable. EKGs should follow increasing verapamil doses.</p>
Hemicrania Continua	Indomethacin sensitive
Cough-associated	Tends to respond well to indomethacin
Stabbing	<p>Tends to respond well to indomethacin.</p> <p>Melatonin 10 to 20 mg with evening meal;</p> <p>If no improvement in 7 – 10 days, add Boswellia 250 mg TID with meals;</p> <p>If no improvement start indomethacin 50 mg BID with meals, increasing to TID and titrating upwards to 225 mg a day.</p> <p>Use PPI for gastric protection and monitor renal function.</p> <p>Continue melatonin as this has been shown to reduce clinical indomethacin dose requirements.</p>
New Daily Persistent	Steroid burst or taper therapy (prednisone 60–80mg for 5 to 7 days or taper down over several weeks). Aggressively intervene with migraine rescue therapies such as intravenous dihydroergotamine.

American Headache Society

Choosing Wisely, Five Things Physicians and Patients Should Question

1. Don't perform neuroimaging studies in patients with stable headaches that meet criteria for migraine.
2. Don't perform computed tomography (CT) imaging for headache when magnetic resonance imaging (MRI) is available, except in emergency settings.
3. Don't recommend surgical deactivation of migraine trigger points outside of a clinical trial.
4. Don't prescribe opioid or butalbital-containing medications as first-line treatment for recurrent headache disorders.
5. Don't recommend prolonged or frequent use of over-the-counter (OTC) pain medications for headache.



TREATING PAIN IN CHILDREN AND ADOLESCENTS

The use of opioids to treat pain in infants and children presents challenges. 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.

General Facts

- › *NOTICE: Use of codeine or tramadol is contraindicated in children under the age of 12 due risk of death from high metabolism and resulting effects. Codeine and tramadol also are contraindicated for children ages 12 to 18 after surgery to remove the tonsils and/or adenoids. In addition, they are not recommended for children under 18 who are obese or who have sleep apnea or lung disease. (FDA; May 20, 2017)*
- › Effective assessment and management of pain in children is an ethical imperative.
- › Pain in pediatrics comes from diagnostic and medical procedures, accidents, injuries and chronic diseases or conditions, and is found in medically fragile children with intellectual and developmental disabilities.
- › Pain pathways are present at 20 weeks gestation, but pathways that ameliorate pain develop much later. Severe pain in infancy is associated with attachment disorders in later life.
- › Teenagers who are interviewed remember chronic pain from toddler years. Increased peripheral nerve endings at the site of pain predisposes to more pain later in life.
- › Changes in spinal cord and perceptual cortex predisposes to permanent and difficult-to-treat pain syndromes in children. This is important for patients requiring multiple invasive procedures; if a first procedure is painful, achieving comfort during future procedures will be more difficult
- › For neonates, the use of a pacifier with sucrose combined with distraction techniques is an effective tool that can have synergistic effects with medications and is recommended for procedure-related pain.
- › Except for very young children, there is no increased risk of respiratory depression due to opiates. Smaller doses are recommended for children under 3–6 months old.
- › Children under one year old often develop anticipatory fear behaviors. They may also withdraw the affected body part. Comfort measures are less effective than with older children.
- › Children 1–3 years old may be assessed through play. They may play despite pain, but may avoid social interactions. As a comfort measure, physicians should not separate them from parents.
- › Older children, ages 6–12 years, may initially perceive pain as punishment until they gradually learn to understand cause-and-effect and can utilize cognitive coping skills.
- › Adolescents over 12 years old need privacy and independence, some sense of control, and full explanations by care providers. They can use cognitive coping skills and need to be able to participate in decision-making regarding pain control.



Assessment

Principles for the assessment of pain in children are the same as for adults.

- › Review medical history, including records from previous providers, when available. Be sure to elicit family history of chronic pain syndromes.
- › Interrogate the child using age-appropriate language (i.e. Do you have any “ouchies” today?) and the child’s parent or guardian. Become familiar with pain assessment tools appropriate for children.
- › Perform a physical exam to determine diagnosis, baseline function, location, and type of 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).

Treatment

- › There is a broad therapeutic arsenal for the management of pain in children, including behavioral techniques, distraction, sucrose, adjuvants, non-opioids and opioids, patient controlled analgesia, epidural analgesia and nerve blocks.
- › Pain management should be individualized and provided by mouth and by the clock whenever possible. Avoid IM dosing and rectal administration.
- › 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. Acetaminophen is widely used, as are certain NSAIDS (ibuprofen, naproxen or ketorolac).
- › Patients who experience pain extending beyond the expected time of recovery should be reevaluated.
- › Behavioral health referrals can be helpful to promote self-management of pain, as even younger children can learn some coping strategies. Such a referral also can be helpful for the parents or guardians of a child or adolescent with chronic pain.
- › 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.
- › In seriously ill or medically fragile children, a trial of oral opioids may be appropriate when pain is severe enough to affect quality of life. For children with progressive and incurable illness, symptomatic long-term treatment with acetaminophen, NSAIDS, and/or opiates may improve quality of life.
- › 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

Adolescents

- › Assessment of Pain: Numeric Pain Scale (0–10)
- › Screening tools for substance abuse: [ORT](#), [SOAPP®-R](#)
- › Screening tools for co-occurring mental health conditions: [PHQ-9](#), [GAD-7](#) (available in Epic EHR)
- › [Texas Prescription Monitoring Program](#)

Children

- › Screening tools for pain (see [Additional Screening Tools](#)):
 - Neonates: PIPP (preterm neonates); NIPS, NFCS, N-PASS, CRIES, and COMFORT (term neonates)
 - Under 5 years, or older children with cognitive limitations: FLACC
 - Ages 3–5: Poker Chip Tool
 - Ages 5–7 years: Faces Pain Scale, Oucher, Color Scale
 - Intellectual and developmental disabilities: NCCPC, PPF, INRS



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 may not be 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%.³²
- › 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.³³

Goals of Treatment

- › The goals of treatment are modulated pain; ability to perform valued activities; improved function; to feel well enough to socialize; to have additional freedom from chronic, painful conditions; and enhanced quality of life.³⁴
- › Persistent pain is multifactorial. It is a treatable but not curable condition. Let the patient know that although pain may not 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 (CBT) and meditation/relaxation 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. Involve a pharmacist for help in reviewing side effects and concomitant medications (including supplements) for drug-drug/supplement interactions.

- › **Acetaminophen** is the first-line approach to mild, persistent pain:
 - Acetaminophen lacks inflammatory activity; therefore it's effects 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.
- › **Topicals and Transdermals**
 - Before prescribing oral NSAIDs, try topical NSAIDs or over-the-counter analgesic creams such as diclofenac gel or trolamine salicylate cream.
 - Transdermal lidocaine can be useful in the elderly to treat neuropathic and localized, nociceptive pain and has a low incidence of side effects.
- › **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, renal, and GI risk factors.
 - For those at risk for GI complications, add a gastro-protective agent.
 - There is a 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.³⁵
 - 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. Tolerance improves over time. Side effects and potential for drug-drug interactions limit their utility in older adults.³⁶
 - 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. Use caution when prescribing long acting and short acting opioids of the same name due to the risk of confusion between the two preparations by patients and their caregivers (example: Morphine IR and Morphine SR).
- › Elderly are more sensitive to the effects of the opioids, due to age-related physiologic changes (e.g., decreased renal or hepatic function and altered body-fat distribution) as well as 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.
- › Consider whether the patient (or caregiver) is likely to manage use of the opioid responsibly.
- › Patients may require 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. A stool regimen should be initiated along with opiates, to help prevent obstipation/constipation.
 - 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 opioid dosing. Always consider constipation as an underlying cause. Addressing constipation may remedy nausea without the addition of another medication.
 - 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 is more likely to be reduced than 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.³⁷
- › 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. Also consider inadequate pain control as a potential underlying cause of delirium or acute decline in a demented patient.
- › Demented patients will not be able to adequately communicate the need for PRN medications; therefore, scheduling of empiric doses of pain medications is warranted if there is good reason for pain. 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.



OPIOID USE DURING PREGNANCY

There are many factors that make opioid use in pregnancy a unique issue, requiring special understanding and careful treatment.³⁸ Beyond the obvious—that you are treating two patients, the fetus and the mother—there are other considerations.

- › *NOTICE: Breast-feeding mothers should not use codeine or tramadol due to possible harm to their infants. (FDA; May 20, 2017)*
- › These are by definition younger 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.³⁹
- › 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.⁴⁰
- › 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.⁴¹
- › 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.



TAPERING

Opioid Taper/Discontinuation

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 90 mg/d or methadone dose is in excess of 30mg/d.
- › Significant physical risk factors are present (sleep apnea, prolonged QT, pulmonary disease, etc.).
- › Side effects of medication are interfering with quality of life.
- › Patient request.
- › Evidence of misuse, abuse, diversion, or other behavioral/psychological dysfunction.
- › Other violations of opioid agreement.

Opioids should be weaned, rather than abruptly stopped, after chronic use (30 days or greater). When opioids are being sold, injected, used in a dangerous or clearly illegal fashion, immediate discontinuation should be undertaken for patient safety and compliance with the law. Referral to a medication-assisted treatment program (methadone 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, and 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 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.
- › Behavioral health specialists 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. Even 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.
- › We tend to associate “ceiling dose” with the concept that there is a dose at which the risks of the medication outweigh the benefits. However, medication dependence, side effects, and other physical and behavioral changes experienced with chronic opioid use, are related to dose also; 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 current daily MED, review the ORT (or other risk-screening assessments), and assess patient progress in treatment, including UDS, PMP, 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 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 these 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 groups, support groups, CBT, and other counseling/therapy 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](#)

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 BSWH 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 PMP to help determine adherence.
- 4 After $\frac{1}{4}$ to $\frac{1}{2}$ 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](#)

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 inpatient 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. Even 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 (or to phenobarbital) and then start 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-b](#) 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: ([Benzodiazepine Table](#)). 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

*Action Onset

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 BSWH 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

Texas Prescription Monitoring Program (PMP)

The PMP is an online tool available to prescribers. Once registered with the program, a prescriber can learn which prescription medications a patient has taken and is taking. We strongly encourage its regular use as an assessment and management tool. Without question, a query of the PMP should be completed for each patient prior to prescribing. Go to [Texas PMP](#) for details.

Concomitant Benzodiazepine and Opioid Use

Most experts advise against concomitant use of benzodiazepines 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 benzodiazepine use by UDS, PMP query, as well as observing for impairment or sedation. Psychotherapy is often helpful as an adjunct to tapering (see [Tapering](#) chapter in this document). Some individuals may require inpatient treatment to successfully discontinue use. Many patients who are dependent on benzodiazepines have a difficult time abstaining from other sedative hypnotic substances (such as alcohol, barbiturates, and carisprodol), and these drugs have similar risks for overdose when combined with opioids.

Concomitant Marijuana and Opioid Use

Although medical and recreational marijuana is legal in some states, it is illegal in Texas. Therefore, opiates should not be prescribed for patients who use it. Marijuana is clearly a mind-altering drug, and though it may provide mild to moderate pain relief, it does have associated risks and side effects, such as altered response times, perceptual changes, and mood changes. In some circumstances, marijuana use may be associated with other illicit or risky drug use.

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.

To dispose of medications appropriately, contact local law enforcement or go to this [DEA website](#) for information.



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 PMP query. The use of high-dose methadone in such circumstances does not carry the same degree of risk as it would in a primary-care setting.
- › Any physician in an office setting can prescribe buprenorphine, after taking a brief educational course and getting an “X” waiver added to their DEA number.⁴² 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.
- › Injectable naltrexone 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.

Heroin

There has been a rise in heroin use, heroin overdoses, and heroin treatment admissions in the U.S. over the past decade.⁴³ 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 cannot stop using pain medications because of dependency or addiction, and whose demand exceeds their supply, turn 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 above). Since discontinuation of opioids leads to reduced opioid tolerance, relapse is associated with an 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 considering naloxone for the families and loved ones of patients prescribed opioids for chronic use.

Naloxone displaces other opioids off the mu receptor sites, but has a short half-life, having an effect for 30 to 90 minutes. After the drug wears off, the agonists may again reattach to the receptors. Anyone requiring naloxone treatment should be transported to an emergency department for further evaluation since return to the overdose state is possible with the passage of time after the initial naloxone treatment.

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

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

Everyone taking opioids on a daily basis should have their friends or loved ones trained in naloxone use. Consider naloxone as a part of a routine prescribing protocol along with opiates. It communicates your concerns about safety to your patient.

Beginning September 1, 2016, naloxone is available at many pharmacies in Texas without a prescription. Under a standing order, pharmacists who have completed training can dispense this medication to patients who take opiates or to their friends/family. Some insurers will pay for naloxone if prescribed by a medical provider.

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. 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 naloxone to patients and their families.

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. For example, a sudden increase in opioid dosing or a new source of heroin that is stronger than the user expected could result in overdose.
- › Someone who has previously overdosed is at risk of overdosing again.

Further resources

- › Texas Pharmacy Association: [Naloxone TX](#)
- › Overdose prevention training: [San Antonio Council on Drugs & Alcohol: Overdose Prevention](#)
- › Film and resources for advocates, families and providers: [Reach For Me](#)
- › Prescribing information and guidelines: [Prescribe to Prevent](#)
- › Provider guide to prescribing naloxone: [Provider Guide: Naloxone](#)
- › Naloxone brochure for patients: [Patient Brochure: Naloxone](#)



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 though they have a somewhat different risk profile (reduced seizure risk with withdrawal, for example) they share many of the adverse effects of benzodiazepines such as 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, benzodiazepines, 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, benzodiazepines, 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
 - Melatonin
 - Cognitive Behavioral Therapy for Insomnia (CBTi)

Tramadol and Tapentadol

These are weak opiate 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 including similar habit-forming properties. This medication should be used cautiously, if at all, 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 table can 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 change with higher doses, but bioavailability of gabapentin decreases by nearly 50% when the dose is increased from 900 mg/day to 3,600 mg/day. As a result, gabapentin doses greater than 1,800 mg/day 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 consent and agreement.
- › 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 help 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](#)

[Pain Management: Discontinuing Opioids – YouTube](#)

Baylor Scott & White Health CME Video – Available at BSWQA website

[Motivational Interviewing Resources](#)



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.

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 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.

Patient health questionnaire (PHQ-9)

The correlation between mental health issues and opioid misuse is well established. The [PHQ-9](#) is a tool to help 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-9 are especially useful when used in the context of behavioral health evaluation and/or physical exam. A positive score on the PHQ-9 or other tests, the presence of suicidal ideation, and/or your clinical judgment may indicate that further assessment is warranted. The PHQ-9 can be found in Epic EHR.

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](#), as well as PTSD Checklist for DSM-V (PCL-5) in Epic EHR (NTX only).

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. See [STOP BANG](#).



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 [Chronic Pain Treatment Checklist](#).

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 [Urine Drug Screenings \(UDS\) FAQ](#) 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 which drugs are, and are not, picked up on a particular test is 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 (Gas Chromatography–Mass Spectrometry) and LC/MS/MS (Liquid Chromatography–Tandem Mass Spectrometry) 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 [Metabolism Data for Common Medications](#).



Patient-Provider Communication

Controlled Substance Consent and Agreement

The Baylor Scott & White Health [Controlled Substance Consent and Agreement for Chronic Pain](#).

Medical risks of long-term opioid use

A patient education handout, outlining risks of opiates, is provided in [Medical Risks of Long-Term Opioid Use](#).

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. See [Graded Pain and Function Scale](#).

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 [Oswestry Low Back Pain Disability Questionnaire](#).

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 [PEG-3: Pain Screening Tool](#).

Other Tools

Additional screening tools

Descriptions of other commonly used screening tools for alcohol and drug abuse, opioid risk, functional assessment, and pain assessment for children can be found here: [Additional Screening Tools](#).

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 [Behavioral Health Risks Screening Tool](#).

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 [Opioid Withdrawal Attenuation Cocktail](#).



Texas Medical Board

A copy of the TMG RULE §170.3 “Minimum Requirements for the Treatment of Chronic Pain” can be found here: [Texas Medical Board - Chronic Pain](#).



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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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SCORING INSTRUCTIONS FOR SOAPP[®]-R

Add the numbers in each column together for a total SOAPP-R score. Research suggests 18 is a conservative cutoff score, with 18 and above being predictive of aberrant medication-related behavior.

SOAPP-R Cutoff Score	Sensitivity	Specificity
Score 17 or above	.85	.47
Score 18 or above	.79	.52
Score 19 or above	.74	.62



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

Chung F, Yang Y, Brown R, Liao P. Alternative scoring models of STOP-BANG questionnaire improve specificity to detect undiagnosed obstructive sleep apnea. *Journal Of Clinical Sleep Medicine: JCSM: Official Publication of the American Academy of Sleep Medicine*. September 15, 2014;10(9):951-958.

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.

- History and physical with assessment of baseline function and pain.
- Review all relevant prior records.
- Have there been sufficient trials of non-opioid modalities?
- Is opioid treatment evidence-based for diagnosis?
- Psychosocial and risk assessment: Risk of medication abuse ([ORT](#)), psychiatric co-morbidity ([PHQ-9](#) or other validated tools), evidence of existing abuse (PMP).
- Are there co-prescribed drug interaction risks? Benzodiazepines are a contraindication.
- Sleep risk assessment ([STOP BANG](#) or equivalent).
- UDS: Any unexpected results?
- Have you checked the PMP for prescriptions of which you were unaware?
- Create a treatment plan that emphasizes patient self-management.
- Make 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 [BSWH Controlled Substance Consent and Agreement for Chronic Pain](#).
- Establish treatment goals with periodic review of goals over time.
- Monitor compliance (UDSs, pill counts, PMP, call-backs).
- Monitor improvement in pain and function, including overall well-being.
- Establish an exit plan: When and how to taper down or off opioids.
- Obtain consultation as needed: behavioral health, substance abuse, pain management, other specialty care.
- Have you considered partnering with a behavioral health specialist (psychologist, therapist, or counselor offering CBT and/or group support; 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 described in this document such as [ORT](#). 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 Since use of marijuana is illegal in Texas, opioids should not be prescribed to patients with chronic pain who use cannabis.



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/MS) to verify a presumptive positive result. *In addition, confirmatory testing is required to verify a presumptive negative result that might suggest a patient is not taking a particular medication, since initial testing may not detect lower-than-therapeutic levels of an opioid.*

Contact the laboratory director in your area for questions about drug testing or results.

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 [Metabolism Data for Common Medications](#) 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 discontinuing or tapering the opioid, 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.

References

- Heltsley R, Zichterman A, Black DL, et al. Urine drug screening of chronic pain patients. II. Prevalence patterns of prescription opiates and metabolites. *Journal of Analytical Toxicology*. 2010;34(1):32-38.
- Moeller KE, Lee KC, Kissack JC. Urine drug screening: practical guide for clinicians. *Mayo Clinic Proceedings*. 2008;83(1):66-76. doi: 10.4065/83.1.66.
- Standridge JB, Adams SM, Zotos AP. Urine drug screening: a valuable office procedure. *American Family Physician*. 2010;81(5):635-40.

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 ¹	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 ¹	Urine Drug Screening to Order	Expected Results	Consideration
Opioids – Synthetic (man-made) – continued				
Methadone (Methadose)	3–7 days	Methadone Immunoassay + GC/MS or LC/MS/MS Methadone	Methadone Immunoassay – positive GC/MS or LC/MS/MS – methadone & EDDP	
Propoxyphene (Darvon, Darvocet)	1–3 days	Propoxyphene Immunoassay + GC/MS* or LC/MS/MS** Propoxyphene	Propoxyphene Immunoassay – positive GC/MS or LC/MS/MS – propoxyphene & norpropoxyphene	
Others				
Alcohol	Up to 8 hours	Alcohol	Alcohol – see Consideration	Additional testing for alcohol metabolites, ethyl glucuronide (EtG) or ethyl sulfate.
Amphetamines	2–3 days	Amphetamines, Methamphetamines or MDMA Immunoassay + GC/MS or LC/MS/MS Amphetamines	Amphetamines, methamphetamines or MDMA Immunoassay – see Consideration GC/MS or LC/MS/MS – amphetamine, methamphetamine or MDMA	Amphetamines immunoassays are highly cross-reactive so results should be interpreted cautiously, and may require consultation with the lab. They may detect other sympathomimetic amines, such as ephedrine, pseudoephedrine or selegiline. Confirmatory testing can identify which amphetamine is present.
Barbiturates	1–3 days w/ short-acting; up to 30 days w/ long acting	Barbiturates Immunoassay	Barbiturates Immunoassay – see Consideration	The clearance half-life of intermediate-acting barbiturates averages 24 hours. It takes about 5 to 7 half-lives to clear 98% of a drug dose. Thus, the presence of an 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 benzoylcegonine	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.

¹Agency Medical Directors Group, Interagency Guideline on Opioid Dosing for Chronic Non-Cancer Pain, 2010.

*GC/MS is Gas Chromatography–Mass Spectrometry

**LC/MS/MS is Liquid Chromatography–Tandem Mass Spectrometry

**BAYLOR SCOTT & WHITE HEALTH
CONTROLLED SUBSTANCE CONSENT AND AGREEMENT FOR CHRONIC PAIN**

I voluntarily request Dr. _____ to treat my chronic pain. I understand this condition may be long-term and complete pain relief may not be possible. I understand the goal of treatment is to manage my condition and help me function as well as possible. My treatment plan may include physical therapy and/or behavioral therapies (a type of psychological counseling) to teach self-management.

As part of my treatment plan, I will be taking _____.

I understand these medications may be harmful if taken without medical supervision. I will work with my doctor to manage side effects.

Possible side effects of these medications include:

- *Brain and Nerves:* Confusion, poor decision-making, sleepiness, impaired judgment, new or worse depression, impairment when operating vehicles and machinery, sleep problems
- *Heart:* Irregular heartbeats, low blood pressure
- *Lungs:* Slow breathing, wheezing, shortness of breath
- *Stomach and Intestines:* Very bad constipation, nausea, vomiting
- *Skin:* Itching, rash
- *Sexual:* Low sex drive, impotence
- *Kidneys and Bladder:* Difficulty urinating
- *Death*

Taking these medications can cause tolerance, dependence, addiction, and/or death.

- *Tolerance:* Needing more of the medication over time to get the same effect.
- *Dependence:* Stopping the medication quickly causes withdrawal. Withdrawal can cause increased pain, aches, sweating, runny nose, agitation, restlessness, nausea, vomiting, stomach cramps, diarrhea, and abnormal heartbeats.
- *Addiction:* Looking for ways to get or use the medication other than how it is prescribed.

I understand and agree to the following:

1. I will partner with my doctor and participate fully in my treatment plan. I will take my medications as prescribed. My doctor may decrease or stop my medications if the medications do not improve my ability to function, if I do not follow our treatment plan, or if I miss scheduled appointments. In addition, my doctor may discharge me from care if I violate this agreement. I understand I can withdraw from this plan and stop these medications at any time.
2. I will get all my prescriptions for this condition from my doctor and their direct care team ONLY. I will not get medications for this condition from anyone else, including other health care professionals, family, friends or any others.
3. I will use only one (1) pharmacy to fill all prescriptions for these medications.
4. My doctor will check my information in the prescription monitoring database for controlled substances managed by the Texas State Board of Pharmacy.

BAYLOR SCOTT & WHITE HEALTH



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CONTROLLED SUBSTANCE CONSENT AND AGREEMENT FOR CHRONIC PAIN

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**BAYLOR SCOTT & WHITE HEALTH
CONTROLLED SUBSTANCE CONSENT AND AGREEMENT FOR CHRONIC PAIN**

5. I agree to medical tests and examinations before and during my treatment. Tests may include scheduled and random (without notice) blood or urine tests for drug levels, pill counts, and psychological evaluations.
6. My doctor may stop my prescription if I use illegal substances, alcohol or other medications.
7. I consent to be searched for any medications, drugs, and drug paraphernalia when I am on any Baylor Scott & White Health property.
8. I will tell my doctor about all my other treatments, procedures and medications.
9. I will keep my medication(s) in a secure place so they do not get lost, stolen, or used by others. I will not give or sell my medication(s) to anyone else.
10. I understand that my doctor will limit how many refills I get and how often I can get refills. I will not ask for refills before the scheduled refill date, even if my medication runs out or gets lost or stolen. Requests for refills may take as long as 5 days.
11. I allow my doctor to talk to other healthcare professionals about my diagnosis and treatment and to share copies of this agreement with them.
12. I will not use any intravenous (IV) site or port for any medications in different ways than my doctor prescribes.
13. Female Patients Only: (_____) As far as I know, I am not pregnant. I will use birth control during my treatment because this medication may harm an unborn baby.

I understand that no warranty or guarantee has been made to me about the results of my treatment plan. I am reading and signing this document while I am of sound mind. I am not under the effect of any drug or alcohol that might impair my judgment.

I have been given the chance to ask my doctor questions about my condition, my treatment plan, other forms of treatment, risks of no treatment, the medications prescribed to me, and the risk and dangers involved. I am satisfied I have enough information to make an informed decision. I am comfortable consenting to this treatment.

DATE: _____ TIME: _____ A.M. / P.M.

PATIENT/OTHER LEGALLY RESPONSIBLE PERSON:

Signature

Print Name

Relationship to Patient

WITNESS/PHYSICIAN:

Signature

Print Name

Address

City, State, Zip Code

BAYLOR SCOTT & WHITE HEALTH



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CONTROLLED SUBSTANCE CONSENT AND AGREEMENT FOR CHRONIC PAIN

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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

Note: This tool can be used to monitor treatment progress and outcomes.

OSWESTRY LOW BACK PAIN DISABILITY QUESTIONNAIRE

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

Scoring instructions

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

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

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

16 (total scored)
45 (total possible score) x 100 = 35.5%

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

Interpretation of scores

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

Instructions

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

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 SCREENING TOOLS

Specific Assessment	Tools to Evaluate
Alcohol & Drug Abuse	AUDIT, CAGE, DAST, SBIRT
Opioid Risk	COMM, DIRE, PMQ
Quality of Life/Functional Status	SF-36, Roland-Morris Low-Back Pain and Disability Questionnaire
Pain in Children	Preterm Neonates: PIPP Neonates: NIPS, NFCS, N-PASS, CRIES, and COMFORT <5 or cognitively impaired: FLACC Age 5–7: Faces Pain Scale, Oucher, NCCPC, PPF, INRS

- AUDIT** Ten-item screen for alcohol related problems.
- CAGE** Four questions used to screen for alcohol use problems.
- DAST** Screen for drug abuse, 20-items.
- 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.
- DIRE** Diagnosis, Intractability, Risk, Efficacy. A 7-item tool that assesses the risk of opioid abuse and the suitability of candidates for long-term opioid therapy.
- PMQ** Pain Medicine Questionnaire, 26-item self-report assessment to screen for potential opioid misuse.
- Roland-Morris** 24-items that assess functional status related to low back pain. Can be used to assess treatment outcomes.
- SBIRT** Screening, Brief Intervention, and Referral to Treatment identify and intervene for alcohol and drug misuse.
- SF-36** 36-item self-report assessment of functional health and well-being.

Pain in Children

- PIPP** Premature Infant Pain Profile
- NIPS** Neonatal Infant Pain Scale. Birth to one year.
- NFCS** Neonatal Facial Coding System
- N-PASS** Neonatal Pain, Agitation, and Sedation Scale
- CRIES** Assesses crying, oxygenation, vital signs, facial expression, and sleeplessness.
- COMFORT** Observer scale for children or cognitively impaired adults.
- FLACC** Face, Legs, Cry, Consolability Scale
- Faces** For cognitively-intact children.
- Oucher** In poster form, with a number scale for older children and picture scale for younger children.
- NCCPC** Non-Communicating Children's Pain Checklist
- INRS** Individualized Numeric Rating Scale, observation scale for non-verbal children with cognitive impairment.

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 _____

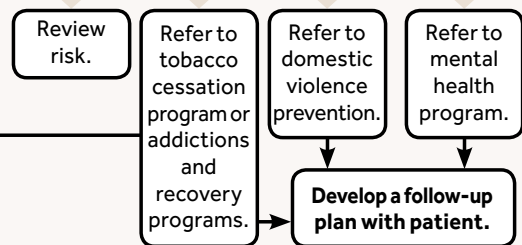
Reviewed by Qualified Provider _____ Date _____

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.



TEXAS ADMINISTRATIVE CODE – CHRONIC PAIN

TITLE 22	EXAMINING BOARDS
PART 9	TEXAS MEDICAL BOARD
CHAPTER 170	PAIN MANAGEMENT
RULE §170.3	Minimum Requirements for the Treatment of Chronic Pain

A physician's treatment of a patient's pain will be evaluated by considering whether it meets the generally accepted standard of care and whether the following minimum requirements have been met:

1 Evaluation of the patient

- A A physician is responsible for obtaining a medical history and a physical examination that includes a problem-focused exam specific to the chief presenting complaint of the patient.
- B The medical record shall document the medical history and physical examination. In the case of chronic pain, the medical record must document:
 - i the nature and intensity of the pain;
 - ii current and past treatments for pain;
 - iii underlying or coexisting diseases and conditions;
 - iv the effect of the pain on physical and psychological function;
 - v any history and potential for substance abuse or diversion; and
 - vi the presence of one or more recognized medical indications for the use of a dangerous or scheduled drug.
- C Prior to prescribing dangerous drugs or controlled substances for the treatment of chronic pain, a physician must consider reviewing prescription data and history related to the patient, if any, contained in the Prescription Drug Monitoring Program described by §§481.075, 481.076, and 481.0761 of the Texas Health and Safety Code and consider obtaining at a minimum a baseline toxicology drug screen to determine the presence of drugs in a patient, if any. If a physician determines that such steps are not necessary prior to prescribing dangerous drugs or controlled substances to the patient, the physician must document in the medical record his or her rationale for not completing such steps.

2 Treatment plan for chronic pain

The physician is responsible for a written treatment plan that is documented in the medical records. The medical record must include:

- A How the medication relates to the chief presenting complaint of chronic pain;
- B dosage and frequency of any drugs prescribed;
- C further testing and diagnostic evaluations to be ordered, if medically indicated;
- D other treatments that are planned or considered;
- E periodic reviews planned; and
- F objectives that will be used to determine treatment success, such as pain relief and improved physical and psychosocial function.



3 Informed consent

It is the physician's responsibility to discuss the risks and benefits of the use of controlled substances for the treatment of chronic pain with the patient, persons designated by the patient, or with the patient's surrogate or guardian if the patient is without medical decision-making capacity. This discussion must be documented by either a written signed document maintained in the records or a contemporaneous notation included in the medical records. Discussion of risks and benefits must include an explanation of the:

- A diagnosis;
- B treatment plan;
- C anticipated therapeutic results, including the realistic expectations for sustained pain relief and improved functioning and possibilities for lack of pain relief;
- D therapies in addition to or instead of drug therapy, including physical therapy or psychological techniques;
- E potential side effects and how to manage them;
- F adverse effects, including the potential for dependence, addiction, tolerance, and withdrawal; and
- G potential for impairment of judgment and motor skills.

4 Agreement for treatment of chronic pain

A proper patient-physician relationship for treatment of chronic pain requires the physician to establish and inform the patient of the physician's expectations that are necessary for patient compliance. If the treatment plan includes extended drug therapy, the physician must use a written pain management agreement between the physician and the patient outlining patient responsibilities, including the following provisions:

- A the physician may require laboratory tests for drug levels upon request;
- B the physician may limit the number and frequency of prescription refills;
- C only the primary pain management physician or another physician covering for the primary pain management physician in compliance with Chapter 177, Subchapter E of this title (relating to Physician Call Coverage Medical Services), may prescribe dangerous and scheduled drugs for the treatment of chronic pain. For any prescriptions issued for medications to treat acute or chronic pain by a person other than the primary pain management physician or covering physician, the terms of the agreement must require that at or before the patient's next date of service, the patient notify the primary pain management physician or covering physician about the prescription(s) issued. The terms of the agreement must require that such notice include at a minimum the name and contact information for the person who issued the prescription, the date of the prescription, and the name and quantity of the drug prescribed;
- D only one pharmacy designated by the patient will be used for prescriptions for the treatment of chronic pain, with an exception for those circumstances for which the patient has no control or responsibility, that prevent the patient from obtaining prescribed medications at the designated pharmacy under the agreement. For such circumstances, the agreement's terms must require that at or before the patient's next date of service, the patient notify the primary pain management physician or covering physician of the circumstances and identify the pharmacy that dispensed the medication; and
- E reasons for which drug therapy may be discontinued (e.g. violation of agreement).

5 Periodic review of the treatment of chronic pain

- A The physician must see the patient for periodic review at reasonable intervals in view of the individual circumstances of the patient.



- B Periodic review must assess progress toward reaching treatment objectives, taking into consideration the history of medication usage, as well as any new information about the etiology of the pain.
- C Each periodic visit shall be documented in the medical records.
- D Contemporaneous to the periodic reviews, the physician must note in the medical records any adjustment in the treatment plan based on the individual medical needs of the patient.
- E A physician must base any continuation or modification of the use of dangerous and scheduled drugs for pain management on an evaluation of progress toward treatment objectives.
 - i Progress or the lack of progress in relieving pain must be documented in the patient's record.
 - ii Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, and/or improved quality of life.
 - iii Objective evidence of improved or diminished function must be monitored. Information from family members or other caregivers, if offered or provided, must be considered in determining the patient's response to treatment.
 - iv If the patient's progress is unsatisfactory, the physician must reassess the current treatment plan and consider the use of other therapeutic modalities.
 - v The physician must periodically review the patient's compliance with the prescribed treatment plan and reevaluate for any potential for substance abuse or diversion. In such a review, the physician must consider reviewing prescription data and history related to the patient, if any, contained in the Prescription Drug Monitoring Program described by §§481.075, 481.076, and 481.0761 of the Texas Health and Safety Code and consider obtaining at a minimum a toxicology drug screen to determine the presence of drugs in a patient, if any. If a physician determines that such steps are not necessary, the physician must document in the medical record his or her rationale for not completing such steps.

6 Consultation and Referral

The physician must refer a patient with chronic pain for further evaluation and treatment as necessary. Patients who are at-risk for abuse or addiction require special attention. Patients with chronic pain and histories of substance abuse or with co-morbid psychiatric disorders require even more care. A consult with or referral to an expert in the management of such patients must be considered in their treatment.

7 Medical records

The medical records shall document the physician's rationale for the treatment plan and the prescription of drugs for the chief complaint of chronic pain and show that the physician has followed these rules. Specifically the records must include:

- A the medical history and the physical examination;
- B diagnostic, therapeutic and laboratory results;
- C evaluations and consultations;
- D treatment objectives;
- E discussion of risks and benefits;
- F informed consent;
- G treatments;
- H medications (including date, type, dosage and quantity prescribed);
- I instructions and agreements; and
- J periodic reviews.

Source Note: The provisions of this §170.3 adopted to be effective January 4, 2007, 31 TexReg 10798; amended to be effective August 4, 2015, 40 TexReg 4898; amended to be effective July 7, 2016, 41 TexReg 4824.

