Key Interventions:

1. Chronic Pain: Any pain persisting longer than the expected healing time, or at least 3 months or longer. All Chronic Pain Patients require:

- □ Pain Management Contract clearly documented in medication list
- □ Pain inventory and assessment at every visit
- □ Mental Health Screen (PHQ9) at least annually
- □ Opioid risk assessment at every visit (if on or considering Opioids)
- □ PMP Monitoring (every visit resulting in opioid prescription)
- □ Urine drug screen monitoring
  - □ Initial Visit
  - □ Random, at least once every 6 months

2. Use a Multimodal Approach with Non-Opioids First

- □ Avoid opioids when possible; opioids are rarely indicated for chronic pain
- □ Whenever possible, stabilize contributing conditions first:
  - □ Examples: Diabetes, depression, low vitamin D or iron levels, etc.
- □ Consider utilizing a multidisciplinary pain management care team including:
  - □ PT, OT, PharmD, Massage therapy, Alternative/Complementary therapies, etc.
- □ Utilize as many outpatient pain management options as necessary
  - □ Lifestyle Modifications
  - □ Physical Medicine and Rehabilitation
  - □ Alternative/Complementary Therapies
  - □ Interventional Pain Management Therapies
  - □ Topical, oral, and injectable medication options

3. Patient Education

- □ Provide patients with education and materials regarding chronic pain
  - □ KCN Educational Materials
  - □ Discuss realistic expectations for providers and patients
  - □ Discuss appropriate alternative pain treatment options
- □ Consider utilizing pain education and counseling, as available.

4. When Prescribing Opioids:

- □ Avoid opioids when possible; Opioids are rarely indicated for chronic pain
- □ Prescribe short-acting Opioids only
- □ Prescribe lowest effective dose, lowest quantity, and lowest day-supply required
  - □ Goal: < 50 MME/day; Max Dose: < 90 MME/day
- □ Opioid refills by Appointment Only, per clinic protocol
- □ Consider Naloxone for any patient with >50 MME/ day
  - □ Naloxone 4mg Nasal Spray-- Spray once into one nostril; may repeat every 2 to 3 minutes in alternating nostrils until medical assistance becomes available. For opioid overdose.
- □ Avoid co-prescribing benzodiazepines
- □ Opioid tapering plan should be part of every patients' treatment plan
  - □ Goal: Discuss tapering at least every 6 months
- □ Frequently assess for and treat addiction

5. Provider Continuing Education:

- □ Providers will receive approved continuing education (CME/CEU) opportunities to support their pain management practices.

Official Network Policy- Effective Date: 08/01/2018

Title: Chronic Pain Management Policy

Keywords: chronic pain; pain management

Policy Content Application: This policy applies to the following organizations-

- Kootenai Health Outpatient Services
- Kootenai Health Surgery Centers
- Kootenai Health Ambulatory Clinics
- Kootenai Care Network

Intent: The purpose of this policy is to provide an evidence based guideline for the treatment of chronic pain patients. It is our goal that this policy will:

- Improve patient safety
- Decrease the rate of opioid prescribing for adults (18 years or older) with diagnoses that do not warrant opioids.
- Decrease diversion of prescribed medication
- Promote evidence based, guideline adherent, and mechanisms cognizant pain management
- Promote prompt diagnosis, effective assessment and appropriate treatment of pain
- Facilitate discovery of comorbid conditions contributing to symptoms
- Improve standardization of pain treatment practices in order to make our expectations for our patients more transparent, improve accountability for patients, and increase consistency for staff protocols.

Patient Population: This policy provides the guidelines for management of chronic pain, defined as pain lasting greater than 90 days, and covers diagnoses including, but not limited to:

- Adult, non-cancer, Chronic pain (outpatient)
- Adult, non-cancer chronic pain patient experiencing unrelated acute pain, including withdrawal pain
- Adult, non-cancer chronic pain patient with Chronic pain exacerbation

Background: Misuse and abuse of prescription opioids is recognized second only to marijuana usage with opioid overdose now being recognized as the leading cause of accidental death in the United States. Opioids are also recognized to contribute to significant adverse effects such as respiratory depression, allodynia, and hyperalgesia. State governments, the Center of Disease Control (CDC), as well as third-party payer organizations have already begun to restrict and decrease the number of patients on high doses of opioids.

Recommendations from multiple organizations, such as the CDC and Mayo Clinic, have documented that the majority of patients can and should be treated with the lowest effective dose of opioids. They also state that a majority of these patients will require no more than 90 morphine milligram equivalencies (MME) per day. It is also well documented that there is an opioid crisis not only in our country but also in our own community. This policy is an attempt to begin to standardize pain management in our community and region. Multidisciplinary pain

management will be the central theme to the treatment of pain. Multimodal therapies, motivational interviewing, counseling and education will all be utilized as the primary treatment pathways. Opioids will be secondary and will only be a small component of patient's pain management.

Process:

I. Pain Management Contract: All chronic pain patients will be enrolled in the Multidisciplinary Pain Management Program and will be required to sign and abide by a pain management contract. Documentation of this contract will be located in the medication list or diagnoses section for transparency across healthcare sites. An example of this contract is located in Addendum 10. (Addendum 7)

II. Initial Assessment: A dedicated appointment be scheduled for chronic pain intake and assessment that allows adequate time to address this topic. When scheduling the initial chronic pain encounter, patients should be forewarned of the following by our schedulers:

1. New patients will not be provided Narcotics at first visit.
2. Chronic Pain patients already receiving opioid therapy who present for acute pain will not be prescribed additional opioid medications unless significant proof of necessity can be identified, documented, and proven safe for the patient.
3. Opioids should not be prescribed until records from previous treating physicians and available imaging is reviewed.
4. Pre-emptive records release should be encouraged when patients are scheduling their intake appointment in order to facilitate the patients transition of care.
5. New patients to the clinic with many comorbid conditions that seek to establish primary care at the clinic, as well as pain management, will need a separate visit to assess Chronic pain needs, review records, and develop a treatment plan.

The Chronic pain intake encounter will cover the following:

1. Review of records, if available, at the time of intake. If records are not yet obtained, get permission to release the records for review when they become available.

2. A set of resources to assist in the history taking on new pain management patients, or patients presenting with a new pain complaint, will be provided. This includes:

    a. **Prescription Monitoring Program (PMP) Screening for current or recent opioid use:** All physicians and NPs have the ability to sign up for both the Idaho and Washington Prescription Monitoring Program (PMP). In addition, CMAs can be given delegate access which in turn will promote a more effective workflow. Therefore, both the Idaho and Washington PMP database should be checked at all visits to ensure that prescriptions from other facilities are not being filled or that the patient is receiving early refills.
        i. Idaho PMP: https://idaho.pmpaware.net/login
        ii. Washington PMP: https://secureaccess.wa.gov/

b. **Pain Inventory and Assessment (See addendum 1):** The patient's self-report will be accepted as the most accurate measure of the current level of the patient's pain. Assessment of the patient's pain, function, and wellbeing will be performed by the provider. This will include:
    i. The Brief Pain Inventory questionnaire (See Addendum 1).
    ii. The Assessment and Management of Chronic Pain Algorithms will also be utilized to identify and treat the source of the patient's pain (See Addendum 4).
    iii. Assessment of Vitamin D and iron levels. Low vitamin D and/or iron levels can contribute to an increase in some types of pain.

c. **Mental Status Assessment such as PHQ-9 (See addendum 2):** Completion of a mental status assessment such as PHQ9 will be required at the initial and any follow up visits to identify any additional risks for the patient's treatment plan. This form may be completed by the patient either electronically or on paper before or upon arrival to the clinic. It will be reviewed by the provider and discussed with the patient during each visit to assess the appropriateness of the pain management plan.

d. **Opioid Risk Tool (See addendum 3):** The opioid risk tool will be used at the initial visit to identify the patient's risk for opioid addiction. If patient's risk score is high, score ≥8, no opioid therapy will be prescribed based on safety of the patient.

e. **Other Screenings: Urine Drug Screen:** A urine drug screen (UDS) should be performed initially and randomly at least once every 6 months. However, it is recommended that a UDS should be performed at every visit which results in a new opioid prescription, including refills and dosage changes.

III. Multidisciplinary Pain Management Program: It is extremely important to stress to the patient the goals of pain management. When possible, the root cause of the patient's pain should always be identified and optimally treated before opioids are initiated or dosages increased. Coaching and patient education will be a primary component of this program. Education regarding realistic expectations and multidisciplinary pain management options will be the starting point of the treatment program. The providers will work with the patient to establish agreed upon pain treatment goals. Based on goals and pain management options, an individualized pain treatment plan will be created with the patient which will assess for challenges and follow up schedule. Patients will be included as part of their care team and will be asked to participate in the decision making process of their care. Caregivers and/or powers of attorney may be included when appropriate.

Opioid therapy is one component of pain management. It focuses on the improvement of functional status and is only intended to be used short-term or in low dosages due to patient safety risks. Continuation of opioid therapy will be considered on a patient-by-patient basis and

such patient will be enrolled in the Multidisciplinary Pain Management Care Program. Opioid tapering will be included as part of each treatment plan as appropriate. This team will work together to provide a multimodal approach to pain management while utilizing the lowest effective dose of opioids as tolerated.

1. **Multidisciplinary Pain Management Care Team**: The Care Team includes but is not limited to the following types of healthcare providers:
   a. Doctors of Medicine (MD), Chiropractic (DC), Dentistry (DDS or DMD), Osteopathy (DO), Pharmacy (PharmD), Physical Therapy (DPT)
   b. Physician Assistants (PA), Nurse Practitioners (NP), Advanced Practice Registered Nurse (APRN)
   c. Certified Pharmacy Technicians (CPhT)
   d. Registered Nurses (RN), Certified Medical Assistant (CMA)
   e. Pain Educator/Pain Counselor
   f. Health Coach (INHC, CHC, etc.)
   g. Massage Therapist
   h. Occupational Therapist (OT)
   i. Others as Determined

2. **Non-Opioid therapy**: Therapies include but are not limited to: (See Addendum #8)
   a. Pain Education and Counseling
   b. Lifestyle Modifications
   c. Physical Medicine and Rehabilitation
   d. Alternative/Complementary Therapies
   e. Interventional Pain Management Therapies
   f. Topical, oral, and injectable medication options

3. **Opioid therapy**: Opioids are not recommended as first-line therapy for chronic pain. If opioid therapy is deemed necessary at the initial appointment, it should be a small component of the patient's treatment plan. Dosing will be based on morphine milligram equivalency (MME). Majority of opioid prescriptions should be ≤ 50 MME/day. However, patient specific prescribing will be utilized. A maximum dose of ≤ 90 MME/day is recommended. If ≥ 90MME/day is deemed appropriate, detailed documentation of proof of necessity will be required. If opioids are indicated, consider ordering pharmacogenomics testing to assess for risk of addiction based on genomics and precision-based therapy decision assistance.
   a. Diagnoses that are <u>inappropriate</u> for chronic opioid use:
      i. Fibromyalgia
      ii. Mechanical axial non-specific back pain
      iii. Idiopathic pain
      iv. Migraine headache
      v. Pain disproportionate to anatomical or laboratory findings
      vi. Flare of chronic pain
      vii. Temporomandibular Joint Disorders (TMJ)

b. **Dosing**: Short-acting opioids are preferred when opioid therapy is required. Long-acting opioids will be reserved for patients in whom providers are confident of their patient's medication adherence.
    i. **Tolerance**: Increasing doses of opioids with no or little improvement in pain and/or function may indicate central sensitization and/or tolerance to opiate effect, and an opiate holiday should be considered. After opiate holiday, treatment with tolerance resistant medication such as Tramadol or Buprenorphine should be considered.
    ii. **Addiction**: Patients on opioid therapy should be frequently assessed for addiction. A comprehensive definition of addiction can be found in the Diagnostic and Statistical Manual, Edition 5. It should be noted that pain patients often manifest a pseudoaddiction syndrome when managed with opiates that arises out of the expected biological activity of narcotics. This syndrome is separate from addiction and does not imply misuse or problematic behavior. Nonetheless it should be managed with kindness and sensitivity to the individual circumstances of the individual. Occasionally patients managed with narcotics may develop full-fledged addiction that results in dysfunction in one or many facts of their lives. In this case the patient should be considered for discussion with other Multidisciplinary chronic pain management providers in order to develop an appropriate plan of action.

c. **Opioid Refills**: It should be stressed to the patient that refills on opioid therapies will not be provided without a clinic visit and re-assessment.

d. **Naloxone**: Consider offering naloxone for patients receiving ≥50 MME/day and who are at risk for overdose or respiratory depression. Frequency of follow-up appointments may also be increased.

e. **Avoid**: Avoid co-prescribing opioids with benzodiazepines when possible. If required, a maximum dose of opioids should be ≤ 50 MME.

2. **Treatment Algorithm:** (Addendum 4) The Assessment and Management of Chronic Pain Algorithms will be used to identify and treat the source of the patient's pain. The algorithm is based on the Institute for Clinical Systems Improvement's assessment and management of chronic pain algorithms.

IV. Follow-up Assessment: All assessments, Addendums 1-3, should be repeated at each follow-up visit. In addition, surveillance for comorbid conditions affecting pain should be continued. Appropriate treatment for these problems should be optimized as part of the Multidisciplinary pain management program. These comorbid conditions may include, but are not limited to, sleep disturbances, depression, PTSD, diabetes, and muscle imbalances.

Patients with comorbid or chronic conditions may not tolerate multimodal therapy. Therefore, non-medication alternatives should be assessed at each visit. If opioid therapy dosing changes

were prescribed, follow up needs to be performed within 3-5 days in order to assess their pain management regimen as well as appropriate use of their pain medication. This follow-up may be done telephonically or face-to-face. Patients with uncontrolled pain should be seen monthly until their pain is controlled. Once their pain is controlled, patients can then be seen every 3 months.

V. Tapering Opioids: (Addendum 6 Opioid Taper Example) Patient's will be required to work with the Multidisciplinary Chronic Pain Care Team for a comprehensive approach to their pain management. A plan to taper opioid therapy to the lowest effective dose or complete discontinuation of opioid therapy should be included in every patient's pain management plan and offered at least every 6 months.

1. **Education**: Patient education based on the patient empowerment model should be the primary focus when working to taper opioids.

2. **Tapering Methodology:** Tapering methods will be patient specific. Current guidelines suggest that a 10% decrease per week is reasonable. Adjust the rate and duration of the taper according to the patient's response. Do not reverse the taper; adjust rate or pause the taper while monitoring and managing withdrawal symptoms.
    a. Immediate Discontinuation: Immediate discontinuation is appropriate in the following situations: life threatening adverse drug reactions, known diversion, and a serious breach of the pain contract. It is also appropriate for a patient maintained on low-dosages of opioids to completely discontinue their opioid therapy.

3. **Adjunctive Therapy:** Adjunctive therapies should be considered to help the patient manage symptoms of withdrawal. These may include: nutrition support through diet and/or vitamin supplementation, hydration, hydrotherapy, NSAIDS, anti-nausea medication, topical analgesics, natural sleep supplements, antidiarrheal medications, and replacement medications, including methadone and buprenorphine.

4. **Support:** Make sure patients receive appropriate psychosocial support. Patients are expected and required to communicate openly and honestly with the care team as part of the program.

5. **Encourage**: Let patients know that most people have improved function without worse pain after tapering opioids. In order to minimize and manage withdrawal symptoms, encourage patients to continue to work with their care team.

VI. Special Populations:

1. **Treatment of Opioid Use Disorders:** If appropriate, referrals to inpatient treatment facilities or recovery centers will be utilized as appropriate. Medication Assisted Therapy (MAT) will also be utilized as appropriate to help patients manage their pain symptoms. Opioids should be avoided or maintained ≤ 50MME in patients with substance or opioid use disorders.

2. **Legacy Patients:** Patients new to this community and who have been on large doses of opioids should not be managed any differently than those within our own community. They should be managed as part of team-based care and should be expected to attempt opioid dose tapering as described above. These individuals should be enrolled in the Multidisciplinary Pain Management Program to receive pain education counselling and support via care managers to help provide a strong support system to aid them in this process.

VII. Provider Resources and Support:

1. **Provider Education:** Providers will be provided with continuing education (CME/CEU) opportunities to support their chronic pain management practice.

2. **Pharmacy Consults:** Providers will be provided with a KCN clinical pharmacist who can assist them with developing a plan for their complex and/or chronic pain patients.

VIII. References:

- CDC Opioid Prescribing Guidelines
- Mayo Clinic Acute and Chronic Pain Guidelines
- Academy of Multidisciplinary Pain Management
- Institute for Clinical Systems Improvement
- UpToDate: Treatment of Chronic Non-Cancer Pain
- UpToDate: Treatment of Acute Non-Cancer Pain
- Bonica's Management of Pain, 4th Edition
- Department of Health and Human Services
- The Office of the Surgeon General
- Turn The Tide Rx
- Moving Beyond Medications Program: Academic Collaborative for Multidisciplinary Health; Academic Consortium for Multidisciplinary Medicine and Health; Academy of Multidisciplinary Health and Medicine; Multidisciplinary Health Policy Consortium
- American Addiction Centers

IX. Addendum

- Addendum 1: Brief Pain Inventory
- Addendum 2: Mental Status Assessment: PHQ9
- Addendum 3: Opioid Risk Tool
- Addendum 4: Assessment and Management of Chronic Pain Algorithm
- Addendum 5: Non-Opioid Treatment Options
- Addendum 6: Opioid Taper Example
- Addendum 7: Chronic Pain Management Contract
- Addendum 8: Pain Etiology-Based Treatment Options Reference Chart

Compliance Criteria

List Departments affected by this document and which Committees approved this document (including your own service line committee).

Departments Affected	Approved by:	Date Approved
Kootenai Care Network	KCN Director, Quality and Care Management KCN Pharmacy Clinical Supervisor	7/18/2018
Kootenai Care Network	KCN Chronic Pain Workgroup	7/18/2018
Kootenai Care Network	KCN Quality Committee	7/18/2018
Kootenai Care Network	KCN Board Meeting	08/01/2018

Official Network Pathway and Policy, Effective as of:
08/01/2018

☐ NO REVISIONS, reformatted with new template

☒ New Document

☐ Replacement of existing document

If a replacement, title of document being replaced: _____

☐ Revision

☐ If an organizational document exists, explain why this document is still necessary:

_____

_____

☐ Archive Specify reason for archival _____

Shelly Rutledge, PharmD, INHC | KCN Pharmacy Clinical Supervisor

Document Owner Title

KootenaiCareNetwork

Addendum 1:

Brief Pain Inventory

1903

Date: ☐☐ / ☐☐ / ☐☐
(month) (day) (year)

Subject's Initials : _____

Study Subject #: ☐☐☐☐

Study Name: _____

_____

Protocol #: _____

PI: _____

Revision: 07/01/05

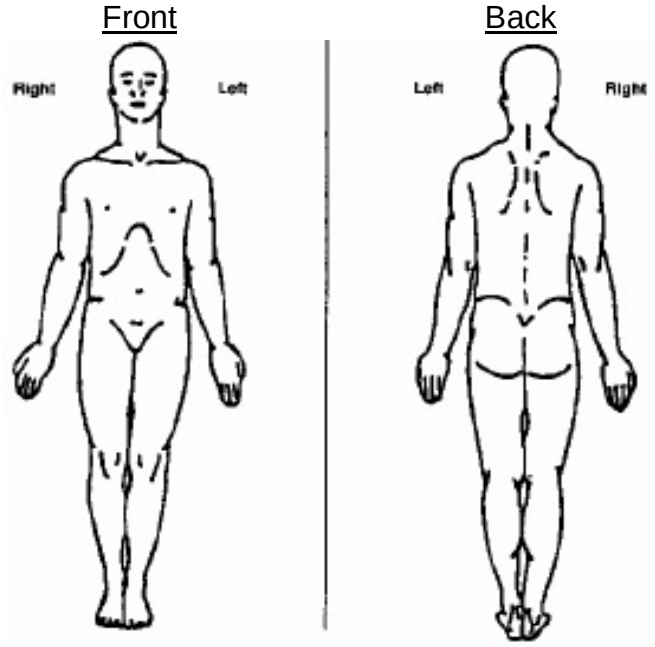
PLEASE USE BLACK INK PEN

Brief Pain Inventory (Short Form)

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

☐ Yes ☐ No

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



3. Please rate your pain by marking the box beside the number that best describes your pain at its worst in the last 24 hours.

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

No Pain — Pain As Bad As You Can Imagine

4. Please rate your pain by marking the box beside the number that best describes your pain at its least in the last 24 hours.

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

No Pain — Pain As Bad As You Can Imagine

5. Please rate your pain by marking the box beside the number that best describes your pain on the average.

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

No Pain — Pain As Bad As You Can Imagine

6. Please rate your pain by marking the box beside the number that tells how much pain you have right now.

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

No Pain — Pain As Bad As You Can Imagine

1903

Date: ☐☐ / ☐☐ / ☐☐
(month) (day) (year)

Subject's Initials : _____

Study Subject #: ☐☐☐☐

Study Name: _____

Protocol #: _____

PI: _____

Revision: 07/01/05

PLEASE USE BLACK INK PEN

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

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

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

9. Mark the box beside the number that describes how, during the past 24 hours, pain has interfered with your:

A. General Activity

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Does Not Interfere — Completely Interferes

B. Mood

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Does Not Interfere — Completely Interferes

C. Walking ability

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Does Not Interfere — Completely Interferes

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

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Does Not Interfere — Completely Interferes

E. Relations with other people

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Does Not Interfere — Completely Interferes

F. Sleep

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Does Not Interfere — Completely Interferes

G. Enjoyment of life

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Does Not Interfere — Completely Interferes

PEG: A Three-Item Scale Assessing Pain Intensity and Interference

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

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

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

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

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

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

From Krebs et al., 2009.

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Addendum 2:

Mental Status Assessment-PHQ9

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

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

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

10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

A2663B 10-04-2005

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Addendum 3:

Opioid Risk Tool

Opioid Risk Tool (ORT)

Questionnaire developed by Lynn R. Webster, MD to assess risk of opioid addiction.

MARK EACH BOX THAT APPLIES	FEMALE	MALE
FAMILY HISTORY OF SUBSTANCE ABUSE		
Alcohol	☐ 1	☐ 3
Illegal drugs	☐ 2	☐ 3
Rx drugs	☐ 4	☐ 4
PERSONAL HISTORY OF SUBSTANCE ABUSE		
Alcohol	☐ 3	☐ 3
Illegal drugs	☐ 4	☐ 4
Rx drugs	☐ 5	☐ 5
AGE BETWEEN 16–45 YEARS	☐ 1	☐ 1
HISTORY OF PREADOLESCENT SEXUAL ABUSE	☐ 3	☐ 0
PSYCHOLOGIC DISEASE		
ADD, OCD, bipolar, schizophrenia	☐ 2	☐ 2
Depression	☐ 1	☐ 1
SCORING TOTALS		

ADMINISTRATION

- On initial visit
- Prior to opioid therapy

SCORING (RISK)

0–3: low

4–7: moderate

≥8: high

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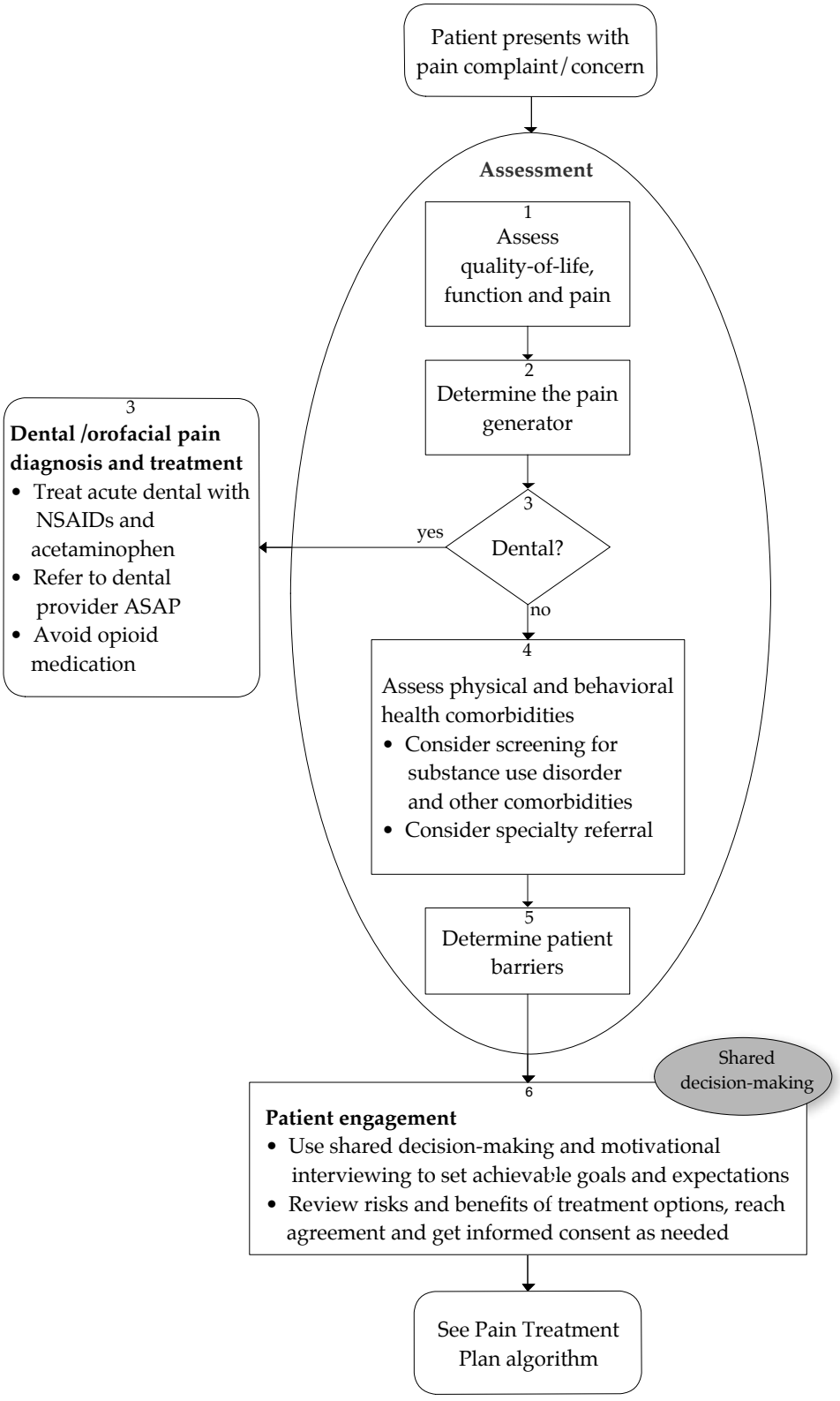
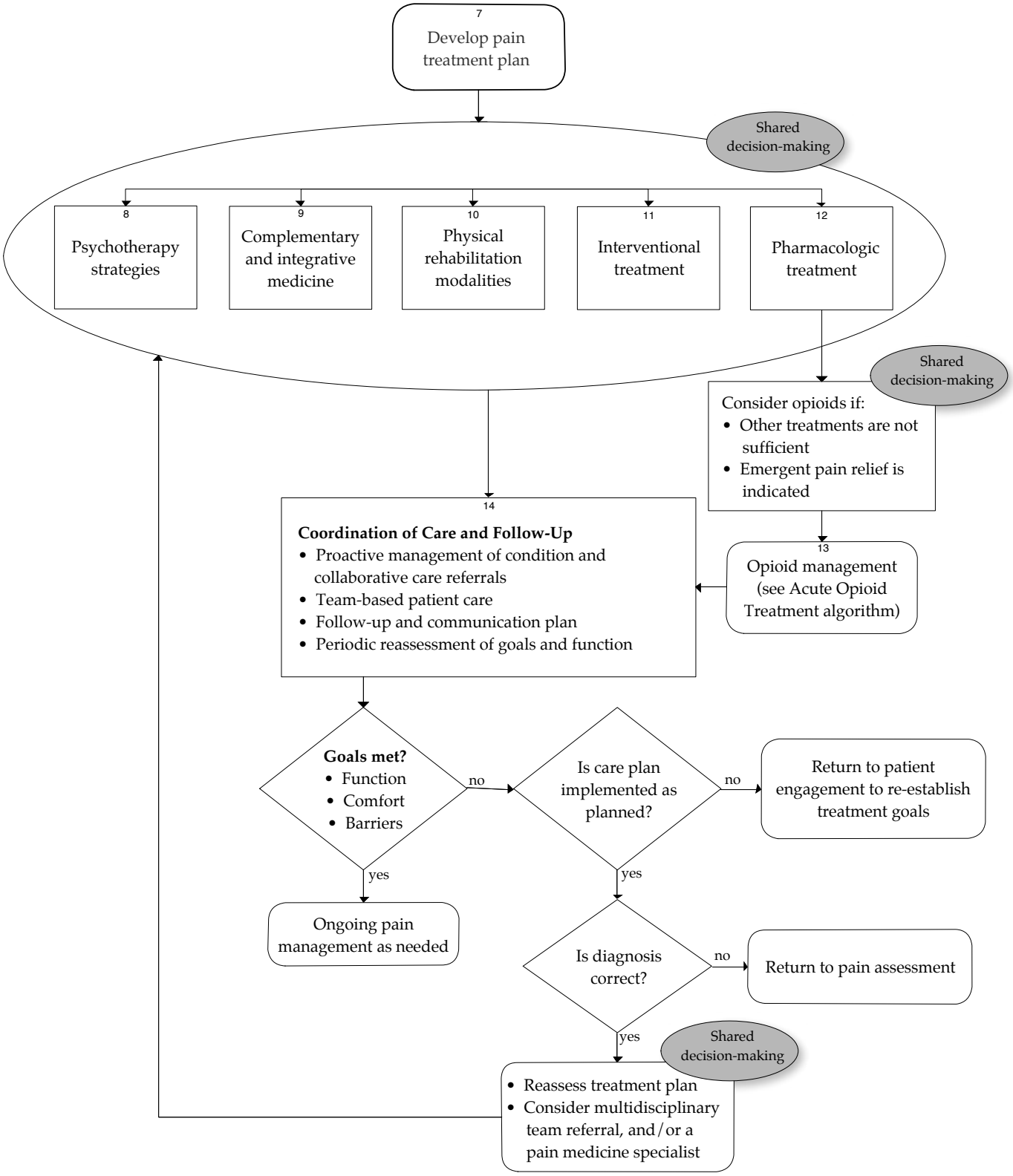
Addendum 4:

Assessment and Management of Pain Algorithm

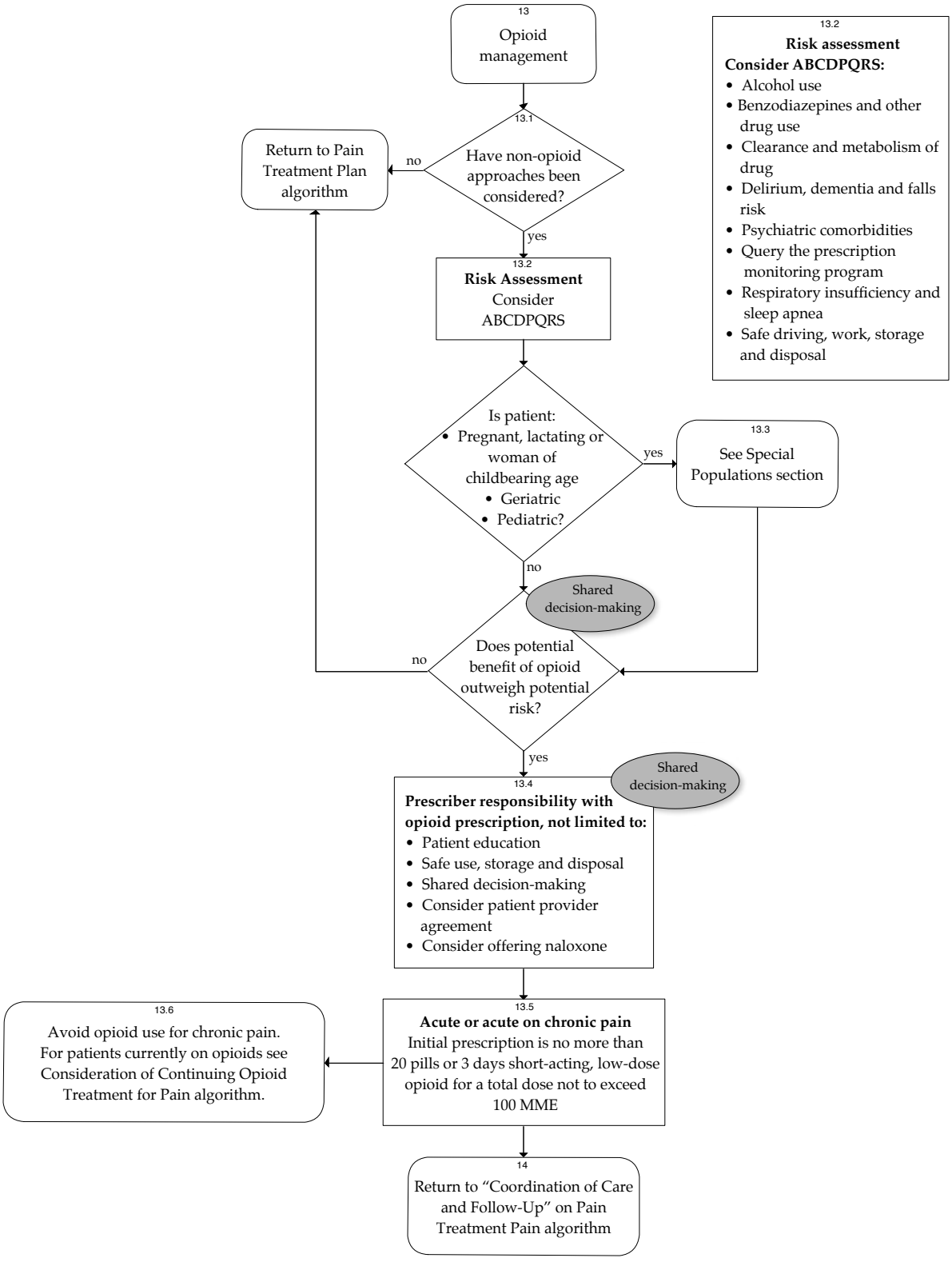
Pain Assessment Algorithm



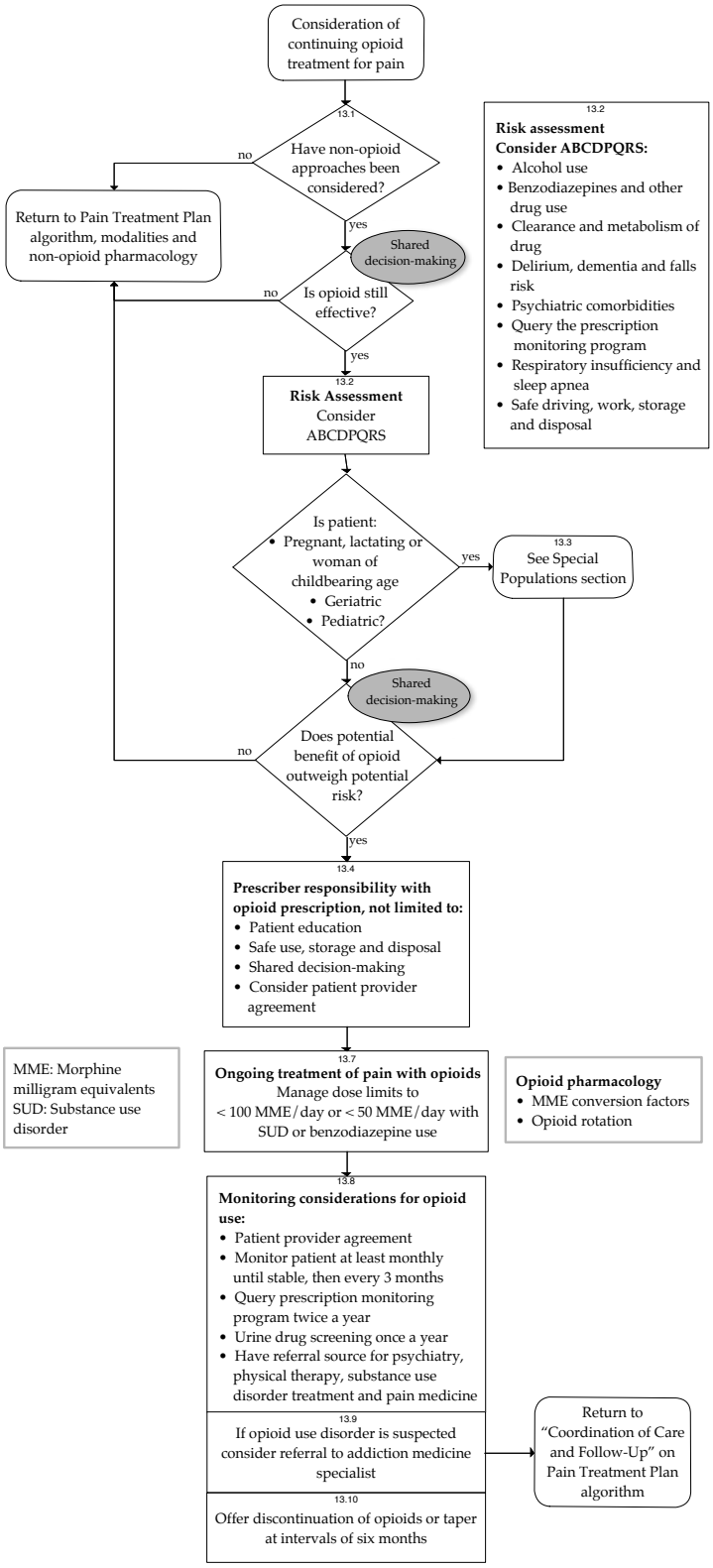
Pain Treatment Plan Algorithm



Acute Opioid Treatment Algorithm



Consideration for Continuing Opioid Treatment Algorithm



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Addendum 5:

Non-Opioid Treatment Options

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Outpatient Pain Management Options

Oral, Injectable, and Topical Pain Management Options

Oral Medications	Injectable Medications	Topical Medications
Scheduled: Acetaminophen every 4 hours (Max 4000mg per day)	Steroid injections	Topical NSAIDS (diclofenac gel)
Scheduled: Rotation of Acetaminophen and Ibuprofen every 3 hours.	Epidural steroids	Topical capsaicin, salicylates, menthol, camphor, etc. (Tiger Balm, SalonPas, Aspercreme, Biofreeze)
TCA's: Desipramine Nortriptyline, Amitriptyline		Lidocaine Patches, Gel or Cream
SNRI's: duloxetine, venlafaxine, desvenlafaxine, milnacipran		Nitroglycerin patches (for chronic tendinitis)
Anticonvulsants: gabapentin, pregabalin, carbamazepine		Essential oils
Muscle Relaxants/Antispasmodics: baclofen, cyclobenzaprine, tizanidine, carisoprodol, metaxalone, methcarbamol		Diltiazem cream (for rectal fissures/spasms)
Tramadol		

Alternative Pain Treatment Options

Lifestyle modifications that can affect pain management	Therapy Options	Pain counseling and neurological treatment options	Naturopathic Therapy Options
Address and stabilize sleep, psychological (depression) and weight conditions	Physical Therapy Spinal Cord Stimulations TENS	Cognitive Behavioral Therapy	Chiropractic
Smoking Cessation	Occupational Therapy	Environmental Condition Modifications	Acupuncture
Blood Glucose Control	Osteopathic Manipulative Treatment (OMT)	Biofeedback	Reflexology
Body Movement Therapy Exercise/Yoga	Fascial Distortion Model	Breathing Exercises Distraction Techniques Imagery	Massage Therapy
Nutrition: Identify triggers, eliminate inflammatory foods (wheat, dairy, gluten, soy, processed foods)	Nerve Ending Ablation	Music Therapy	Hot/Cold Therapy

Reference: CDC Chronic Pain Management

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Addendum 6:

Opioid Taper Example

TAPERING FLOWCHART

START HERE

Consider opioid taper for patients with opioid MED > 120/methadone > 40, aberrant behaviors, significant behavioral/physical risks, lack of improvement in pain and function.

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

1. Explain to the patient the reason for the taper: "I am concerned…"
2. Determine rate of taper based on degree of risk.
3. If multiple drugs involved, taper one at a time (e.g., start with benzos, follow with opioids).
4. Set a date to begin, provide information to the patient, and set up behavioral supports, prior to instituting the taper. See page 26 of OPG guidelines.

OPIOID TAPER

Opioids (not methadone)

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. Utilize the drug the patient is taking as the tapering medication. If you switch medications, follow MED equivalency chart and then reduce the dose by 25–50% as starting dose. Metabolic variability can be quite significant. Utilize a 90% dose reduction if switching to methadone. See dose calculator link below.
2. Decrease total daily starting dose by 5–15% per week in divided doses.
3. See patient frequently during process and stress behavioral supports. Consider UDS, pill counts, and PDMP to help determine adherence.
4. After ¼ to ½ of the dose has been reached, with cooperative patient, you can slow the process down.
5. Consider adjuvant medications: antidepressants, NSAIDs, clonidine, anti-nausea, anti-diarrhea agents.

Methadone

Basic principle: Very long half life may necessitate a more protracted tapering process. Otherwise follow opioid principles.

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

Link to Morphine Equivalent Dosing (MED) Calculator

agencymeddirectors.wa.gov/mobile.html

OPG
OREGON PAIN GUIDANCE

BENZODIAZEPINE TAPER

Basic principle: Expect anxiety, insomnia, and resistance. Patient education and support very important. Risk of seizures with abrupt withdrawal increases with higher doses. The slower the taper, the better tolerated.

1. **Slow taper:** Calculate total daily dose. Switch from short acting agent (alprazolam, lorazepam) to longer acting agent (diazepam, clonazepam). Upon initiation of taper reduce the calculated dose by 25–50% to adjust for possible metabolic variance.
2. First follow up visit 2–4 days after initiating taper to determine need to adjust initial calculated dose.
3. Reduce the total daily dose by 5–10% per week in divided doses.
4. After ¼ to ½ of the dose has been reached, with cooperative patient, you can slow the taper.
5. Consider adjunctive agents to help with symptoms: trazodone, buspirone, hydroxyzine, clonidine, antidepressants, neuroleptics, and alpha blocking agents.

1. **Rapid taper:** See the tapering guidelines on page 28 of the OPG guidance documents.

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

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Addendum 7:

Chronic Pain Management Contract

Sample Opiate/Pain Management Agreement*

The purpose of this Agreement is to prevent misunderstandings about certain medications you will be taking for pain management. This Agreement is to help you and your provider to comply with the law regarding controlled pharmaceuticals.

_____ I understand that there is a risk of psychological and/or physical dependence and addiction associated with chronic use of controlled substances.

_____ I understand that this Agreement is essential to the trust and confidence necessary in a provider/patient relationship and that my provider undertakes to treat me based on this Agreement.

_____ I understand that if I break this Agreement, my provider will stop prescribing these pain control medicines.

_____ In this case, my provider will taper off the medicine over a period of several days, as necessary, to avoid withdrawal symptoms. Also, a drug-dependence treatment program may be recommended.

_____ I would also be amenable to seek psychiatric treatment, psychotherapy, and/or psychological treatment if my provider deems necessary.

_____ I will communicate fully with my provider about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medicine is helping to relieve the pain.

_____ I will not use any illegal controlled substances, including marijuana, cocaine, etc., nor will I misuse or self-prescribe/medicate with legal controlled substances. Use of alcohol will be limited to times when I am not driving or operating machinery and will be infrequent.

_____ I will not share my medication with anyone.

_____ I will not attempt to obtain any controlled medications, including opioid pain medications, controlled stimulants, or anti-anxiety medications from any other provider.

_____ I will safeguard my pain medication from loss, theft, or unintentional use by others, including youth. Lost or stolen medications will not be replaced.

_____ I agree that refills of my prescriptions for pain medications will be made only at the time of an office visit or during regular office hours. No refills will be available during evenings or on weekends.

_____ I agree to use this pharmacy _____ located at this address _____ with the telephone number of _____ for filling my prescriptions for all of my pain medicine.

_____ I authorize the provider and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including this state's Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medication. I authorize my provider to provide a copy of this Agreement to my pharmacy, primary care provider and local emergency room. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

_____ I agree that I will submit to a blood or urine test if requested by my provider to determine my compliance with my program of pain control medications.

_____ I understand that my provider will be verifying that I am receiving controlled substances from only one prescriber and only one pharmacy by checking the Prescription Monitoring Program web site periodically throughout my treatment period.

_____ I agree that I will use my medicine at a rate no greater that the prescribed rate and that use of my medicine at a greater rate will result in my being without medication for a period of time.

_____ I will bring unused pain medicine to every office visit.

_____ I agree to follow these guidelines that have been fully explained to me.

All of my questions and concerns regarding treatment have been adequately answered. A copy of this document has been given to me.

This Agreement is entered into on this _____ day of _____, 201_.

Patient Signature: _____
Patient Name (printed):_____

Provider signature: _____
Provider Name (printed):_____

Witnessed by:
Signature: _____
Name (printed):_____

Based on the Sample Opiate/Pain Management Agreement used by the Maine Office of Substance Abuse. Used with permission.

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Addendum 8:

Pain Etiology-Based Treatment Options Reference Chart

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Pain Etiology-Based Reference Chart

ACUTE Pain Mechanism-Based Treatment Options		
Neuropathic Pain	**Alternative Treatment Options**	**Medication Options**
Post herpetic neuralgia	Soft diet Cold Packs alternating with moist heat	Topical agents NSAIDs Antidepressants Anticonvulsants
Musculoskeletal Pain	**Alternative Treatment Options**	**Medication Options**
Acute musculoskeletal pain	Exercise/movement Physical Therapy	NSAIDs Acetaminophen Topical Agents Muscle Relaxants
Inflammatory Pain	**Alternative Treatment Options**	**Medication Options**
Tendonitis	Physical therapy Iontophoresis Intra-articular injection	NSAIDs Glucocorticosteroids Topical Agents
Dental/Orofacial	Alternate moist heat and cold therapies Dental consultation	NSAIDs and Acetaminophen Topical anesthetic rinse Chlorhexidine rinse Bupivacaine injection
Temporomandibular Disorder	Soft diet Cold packs alternating with moist heat Physical therapy Phonoophoresis Dental appliances Manual therapy Cognitive behavioral therapy Biofeedback Hypnosis	NSAIDs Anticonvulsants

Shelly Rutledge, PharmD, INHC | Reviewed 07/2018
Reference: Bonica's Manangement of Pain 4th Edition. Fishman, Ballantyne, Rathmell

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Pain Etiology-Based Reference Chart

Visceral Pain	Alternative Treatment Options	Medication Options
Headache/ Migraine	Hot/Cold Therapies Essential Oils Nutraceuticals	**Preventative Medications** Propranolol Tricyclics Anticonvulsants **Treatment Medications**: Triptans NSAIDs Acetaminophen Aspirin Caffeine Ergot derivatives
Non-Cardiac Chest Pain	GERD: Dietary Modifications Non-Cardiac Chest Pain: Cognitive Therapy Hypnotherapy	GERD: H2 receptor antagonists PPI Non-Cardiac Chest Pain: Tricyclics SSRIs Trazodone
Abdominal Pain	Lifestyle Modifications Dietary Modifications	Treat underlying comorbidity, if present: stress, regulate bowel movements, psychological-depression, anxiety
Pelvic Pain	Acupuncture TENS Chiropractic Osteopathic manipulations	Treat underlying psychiatric condition, if present
Regional Pain	**Alternative Treatment Options**	**Medication Options**
Dental Pain	Mouthwashes Desensitizing toothpaste	NSAIDs Non-opiate analgesics
Facial Pain	TMJ: NSAID Nonopiate analgesic Physical Therapy	Sinus Pain: Decongestants NSAIDs Topic agents Periocular Pain: NSAIDs Nonopiate analgesics Topical corticosteroids Botox Periauricular Pain: NSAIDs Nonopiate analgesics Topical corticosteroids

Shelly Rutledge, PharmD, INHC | Reviewed 07/2018
Reference: Bonica's Manangement of Pain 4th Edition. Fishman, Ballantyne, Rathmell

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Pain Etiology-Based Reference Chart

Neck and Arm Pain	Physical Therapy Chiropractic	
Lower Extremity Pain	Foot: Arch support Plantar inserts Orthotic shoe inserts Supportive shoes Physical Therapy TENS	NSAIDs Acetaminophen Nonopioid analgesics
Lower Back Pain- Acute	Lifestyle Modifications TENS Physical Therapy	NSAIDs Acetaminophen
Special Populations	**Alternative Treatment Options**	**Medication Options**
Elderly		NSAID + PPI Nortriptyline Duloxetine Gabapentin or pregabalin

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Pain Etiology-Based Reference Chart

Chronic Pain Mechanism-Based Treatment Options		
Neuropathic Pain	**Alternative Treatment Options**	**Medication Options**
Diabetic Neuropathy		Anticonvulsants Antidepressants Topical Agents
Trigeminal Neuralgia	Soft diet Cold packs alternating with moist heat	Anticonvulsants Antidepressants NSAIDs Botox
Nerve compression/radicular pain	Physical rehabilitation Cognitive behavioral therapy Corsets and braces Therapeutic injections Interventional procures	Anticonvulsants Antidepressants Topical Agents
Chronic Neuropathy	TENS	Antidepressants Anticonvulsants Topical agents
Post Spinal Cord Injury	TENS Physical rehabilitation	NSAIDs Baclofen Opioids Anticonvulsants Antidepressants NMDA antagonist
Musculoskeletal Pain	**Alternative Treatment Options**	**Medication Options**
Diffuse non-specific myalgias/ Complex regional pain syndrome	Biopsychosocial interdisciplinary team approach Cognitive behavioral therapy Graded exercise Massage Therapy	Topical agents Acetaminophen Antidepressants Anticonvulsants
Chronic musculoskeletal pain	Mindfulness-based stress reduction CBT Hypnosis Yoga/Tai-chi Acupuncture Healing touch Aquatic therapy Exercise Manual therapies (neck & back pain) TENS Ultrasound	Acetaminophen NSAIDs Topical Agents

Shelly Rutledge, PharmD, INHC | Reviewed 07/2018
Reference: Bonica's Manangement of Pain 4th Edition. Fishman, Ballantyne, Rathmell

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Pain Etiology-Based Reference Chart

Fibromyalgia	Graded aerobic exercise Heated aquatic therapy Relaxation Interdisciplinary management CBT Hypnosis Healing touch/Qi-gong massage	Anticonvulsants Antidepressants
Inflammatory Pain	**Alternative Treatment Options**	**Medication Options**
Arthritis, all types	Exercise Aquatic therapy Hypnosis Intra-articular injection	Acetaminophen NSAIDs Glucocorticosteroids Topical agents DMARDs
Gout	Dietary modifications	NSAIDs Antihyperuricemic agents
Joint Pain	**Alternative Treatment Options**	**Medication Options**
Osteoporosis	Exercise Aquatic therapy Intra-articular injection	Calcium + Vitamin D Bisphosphonates Acetaminophen NSAIDs
Visceral Pain	**Alternative Treatment Options**	**Medication Options**
Headache/ Migraine	Hot/Cold Therapies Essential Oils Assess for TMJ	**Preventative Medications** propranolol **Treatment Medications**: Triptans NSAIDs Acetaminophen
Abdominal Pain	Psychotherapy Cognitive Behavioral Therapy Hypnotherapy	IBS: Tricyclic Antidepressants SSRIs Antispasmodics
Pelvic Pain	Acupuncture TENS Chiropractic Osteopathic manipulations	Treat underlying psychiatric condition, if present

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Reference: Bonica's Manangement of Pain 4th Edition. Fishman, Ballantyne, Rathmell

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Pain Etiology-Based Reference Chart

Regional Pain	Alternative Treatment Options	Medication Options
Dental Pain	Mouthwashes Desensitizing toothpaste	NSAIDs Non-opiate analgesics
Facial Pain	<u>TMJ:</u> NSAID Nonopiate analgesic Physical Therapy	<u>Sinus Pain:</u> Decongestants NSAIDs Topic agents <u>Periocular Pain:</u> NSAIDs Nonopiate analgesics Topical corticosteroids Botox <u>Periauricular Pain:</u> NSAIDs Nonopiate analgesics Topical corticosteroids
Neck and Arm Pain	Physical Therapy Chiropractic	
Lower Extremity Pain	<u>Foot:</u> Arch support Plantar inserts Orthotic shoe inserts Supportive shoes Physical Therapy TENS	NSAIDs Acetaminophen Nonopioid analgesics
Lower Back Pain- Chronic	Massage Therapy TENS Exercise Physical Therapy Weight Loss Chiropractic Acupuncture Lifestyle Modifications Interventional Therapies	NSAIDs Acetaminophen Non-opioids Muscle Relaxants SSRI Topical Analgesics
Lower Back Pain- Failed Back Surgery Syndrome	Cognitive Behavioral Therapy Physical Therapy	Treat underlying psychiatric condition, if present Corticosteroid Injection
Special Populations	**Alternative Treatment Options**	**Medication Options**
Elderly		NSAID + PPI Nortriptyline Duloxetine Gabapentin or pregabalin

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Reference: Bonica's Manangement of Pain 4th Edition. Fishman, Ballantyne, Rathmell

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Pain Etiology-Based Reference Chart

Opioid-Induced Pain	Alternative Treatment Options	Medication Options
Withdrawal	Develop opioid taper schedule	Opioid Buprenorphine analgesic or methadone with appropriate license
Hyperalgesia	Opioid reduction Opioid rotation Adjuvant medication Hypnosis	Anticonvulsants Antidepressants
Tolerance	Assess appropriateness of opioid medication Adjuvant medication Opioid rotation	Anticonvulsants Antidepressants Muscle relaxant for flare-up

Shelly Rutledge, PharmD, INHC | Reviewed 07/2018
Reference: Bonica's Manangement of Pain 4th Edition. Fishman, Ballantyne, Rathmell