WYOMING Rx ABUSE STAKEHOLDERS

CHRONIC PAIN MANAGEMENT TOOLKIT

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INTRODUCTION

The Wyoming Rx Abuse Stakeholders (RAS) is comprised of representatives of the health care community, law enforcement, government and community members in Wyoming to prevent the increasing abuse of prescription medications while ensuring that they remain available for patients in need. We seek to help doctors, physician assistants, nurses, pharmacists, other health care professionals, law enforcement and the general public become more aware of both the use and abuse of prescription medication. In addition, we seek to improve the regulatory framework to ensure that prescription medications are available to the patients who need them while preventing these drugs from becoming a source of harm or abuse.

The RAS understands the management of chronic pain patients is a challenge for both providers and their patients. To assist Wyoming health care providers and patients in the management of chronic pain a Chronic Pain Management Toolkit was developed with the assistance of Riverstone Health of Montana, Heather Christensen with West Park Hospital Prevention & Wellness and the Park County Coalition Against Substance Abuse, funded in part by the Drug-Free Communities Support Program, the Wyoming Center on Aging (WyCOA), as well as contributions from RAS members representing the Board of Dentistry, Board of Medicine, Board of Nursing, Board of Pharmacy, the Department of Health, Prevention Management Organization of Wyoming, and the University of Wyoming School of Pharmacy. The goal for providing a toolkit is to assist Wyoming health care providers in the appropriate evaluation, documentation and monitoring of their chronic pain patients to ensure their safety and maintain the quality of care they deserve.

It is the hope of the RAS that the information provided in this toolkit will assist Wyoming medical providers in the treatment of their chronic pain patients. It is not meant to be regulatory in nature. The presentation of this toolkit is purely to provide a resource to health care professionals on pain management. Your comments on how the toolkit can be improved to meet the needs of Wyoming practitioners and their patients are welcomed. Please direct all comments to the Rx Abuse Stakeholders at: **wyrxabusestakeholders@gmail.com**.

USE OF OPIOIDS FOR CHRONIC PAIN

The American Academy of Pain Medicine [1]

Due to concerns about drug misuse, diversion and addiction, and regulatory requirements, prescribers may want guidance as to what should generally be followed when prescribing opioids for chronic or recurrent pain states. The American Academy of Pain Medicine (AAPM) offers Tools for Practice on the use of opioids for the treatment of pain. Those tools include the following:

I. Safe storage and disposal guidelines for opioids and all medications.

II. Educational resources the American Medical Association (AMA) recommends to reduce opioid misuse.

III. Eight prescribing practices for clinicians.

IV. Patient document templates including an agreement on the use of controlled substances for the treatment of chronic pain and consent for chronic opioid therapy.

The AAPM is the medical society representing physicians practicing in the field of pain medicine. They strive to be the recognized authority for appropriate and effective pain care through the practice of a multidisciplinary approach incorporating modalities from various specialties. AAPM offers resources, tools, and guidelines designed to support clinicians in their pain practice.

The Rx Abuse Stakeholders (RAS), in conjunction with Riverstone Health, developed this toolkit to assist prescribers in treating their chronic pain patients in a safe, responsible and effective manner. It is the hope of the RAS that this toolkit in part or in full will provide useful information to prescribers in treating their non-cancer, chronic pain patients. For more information on the AAPM and their position on pain management, please visit their website at:

https://painmed.org/about-the-american-academy-of-pain-medicine

Risk Evaluation and Mitigation Strategies [2]

In July 2012, the FDA approved the *Extended-Release and Long-Acting (ER/LA) Opioid Analgesic Risk Evaluation and Mitigation Strategy (ER/LA REMS)*. This REMS was created to ensure that the benefits of extended-release and long-acting (ER/LA) opioid analgesics used in an outpatient setting outweigh the risks. That REMS was modified and the new *Opioid Analgesics REMS* was released in September 2018 and

includes all immediate-release (IR) opioids used in the outpatient setting that are not already covered by another REMS program.

As part of the REMS, all ER/LA opioid analgesic companies must provide:

- Education for health care providers (HCPs) who participate in the treatment and monitoring of pain. For the purpose of the Opioid Analgesic REMS, HCPs includes not only prescribers, but also HCPs who participate in the treatment and monitoring of patients who receive opioid analgesics, including pharmacists and nurses.
    - Education will be offered through accredited continuing education (CE) activities. These activities will be supported by unrestricted educational grants from opioid analgesic companies.
- Information for HCPs to use when counseling patients about the risks of ER, LA, and IR opioid analgesic use.

The FDA developed core messages to be communicated to prescribers in the *Blueprint for Prescriber Education* (FDA Blueprint) and that blueprint has been revised. The new FDA Blueprint is the *FDA Education Blueprint for Health Care Providers Involved in the Treatment and Monitoring of Patients with Pain*. The FDA Blueprint contains a high-level outline of the core educational messages that will be included in the educational programs developed under the Opioid Analgesic REMS. The FDA Blueprint focuses on the fundamentals of acute and chronic pain management and provides a contextual framework for the safe prescribing of opioid analgesics. The core messages are directed to prescribers, pharmacists, and nurses, but are also relevant for other HCPs who participate in the management of pain.

The FDA is making the FDA Blueprint, approved as part of the Opioid Analgesic REMS, available on the REMS@FDA Website:

www.fda.gov/REMS

As information becomes available, a list of the REMS-compliant CE activities supported by unrestricted educational grants from the opioid analgesic companies to accredited CE providers will be posted at:

www.opioidanalgesicREMS.com

Accrediting bodies and CE providers will ensure that the CE activities developed comply with the standards for CE of the Accreditation Council for Continuing Medical Education or another CE accrediting body, depending on the target audience's medical specialty or health care profession.

Pain Management Policies

The Wyoming Board of Medicine adopted a pain management policy in February of 2009. Prescribers may reference this policy on the board's website at:

http://wyomedboard.wyo.gov/resources/board-of-medicine-policies-and-procedures

This policy is supported by the Boards of Medicine, Nursing, Dental Examiners, Pharmacy, Podiatry, Optometry, and Veterinary Medicine. In addition, other Wyoming licensing boards have information regarding the prescribing of controlled substances by licensed prescribers. Prescribers may want to refer to their respective boards' websites for these policies.

GUIDELINES FOR MEDICAL VISITS [3][4]

It is important when treating patients with chronic pain to work with the patient early in treatment to set a treatment agenda. Allowing the patient input and setting realistic expectations is critical to the initial visit.

The main mission of the initial chronic pain management visit is to lay the groundwork for a successful therapeutic relationship where healing can take place. This can be done through a careful clinical interview, which also should inquire into any history of physical, emotional or sexual abuse, because those are risk factors for substance misuse. Assessment of the patient's personal and family history of alcohol or drug abuse and relative risk for substance use disorder should also be part of the initial evaluation. Use of a validated screening tool (such as the Screener and Opioid Assessment for Patients with Pain (SOAPP-R) or an Opioid Risk Tool (ORT) or other validated screening tools can save time in collecting and evaluating the information and determining the patient's level of risk. Patients should be given information and be allowed to discuss how their evaluation and treatment for chronic pain will occur.

The medical record should document the presence of one or more recognized medical indications for prescribing an opioid analgesic and reflect an appropriately detailed patient evaluation. Such an evaluation should be completed before a decision is made as to whether to prescribe an opioid analgesic. Assessment of the patient's pain should include:

- ☐ The nature and intensity of the pain
- ☐ Past and current treatments for the pain
- ☐ Any underlying or co-occurring disorders and conditions
- ☐ The effect of the pain on the patient's physical and psychological functioning

For every patient, the initial work-up should include the following:

- ☐ A systems review and relevant physical examination
- ☐ Laboratory investigations as indicated
- ☐ Review of secondary manifestations, such as effects on the patient's sleep, mood, work, relationships, and recreational activities
- ☐ Alcohol and drug use
- ☐ Good social supports, housing, and meaningful work in existence
- ☐ Home environment (stressful or nurturing)
- ☐ Assessment of the patient's personal and family history of alcohol or drug abuse and relative risk for medication misuse or abuse and ideally should be completed prior to a decision as to whether to prescribe opioid analgesics

☐ Screened for depression and other mental health disorders

Patients with untreated depression and other mental health problems are at increased risk for misuse or abuse of controlled medications, including addiction, as well as overdose. Patients who have a history of substance use disorder are at an increased risk for failure of opioid analgesic therapy to achieve the goals of improved comfort and function, and also are at high risk for experiencing harm from this therapy, since exposure to addictive substances often is a powerful trigger of relapse. Therefore, treatment of a patient who has a history of substance use disorder should, if possible, involve consultation with an addiction specialist before opioid therapy is initiated (and follow-up as needed). Patients who have an active substance use disorder should not receive opioid therapy until they are established in a treatment/recovery program or alternatives are established such as co-management with an addiction professional.

Reports of previous evaluations and treatments should be confirmed by obtaining records from other providers, if possible. If there is any reason to question the truthfulness of a patient's medical history, it is best to request records directly from the other providers. If possible, the patient evaluation should include information from family members and/or significant others. The state prescription drug monitoring program (WORx in Wyoming) should be consulted to determine whether the patient is receiving prescriptions from any other physicians, and the results obtained should be documented in the patient record.

The appendix that follows the end of this toolkit provides sample checklists and a general overview of each visit type that can be used during the first and subsequent chronic pain management visits to ensure consistency in treating each chronic pain patient and to assist in setting a treatment agenda.

OLDER ADULTS & OPIOIDS

This information is intended for prescribers treating general chronic pain in older adults that is not cancer-related or end-of-life pain.

Opioid pain medication is one of many treatment options for severe pain in older adults, and some caution and exploration of alternatives should be evaluated before starting patients on this kind of analgesic. Prior to any prescribing, providers should evaluate the patient's cause of pain and treatment options for this cause, and document this assessment along with current medications, substance use history, and psychiatric status. Providers should ensure patients are not receiving prescriptions for any opioids from other providers in order to prevent overdose. In cases where opioids are a fitting treatment, they should be started at 25-50% of the usual adult dose and slowly increased if needed. [6] Providing low-dose amounts of opioids to be used as-needed for severe pain can be a useful treatment for pain that may not be regularly occurring. [7]

When to use opioids?

Acute and chronic pain are two types of pain that have different sources and should be assessed differently to decide what might be the best pain choice for effective treatment. Acute pain is a sharp, stabbing pain that lasts less than 3-6 months and is caused by a sudden, specific trauma, such as surgeries, severe injuries like broken bones, dental work, or childbirth. Opioids can be a good choice for treating acute pain for a very short period of time. [7] Chronic pain, on the other hand, is pain that lasts longer than 3-6 months, can occur without a specific injury, and continues despite having time to heal. Chronic pain may come from headaches, arthritis, nerve pain, or back pain, as well as many other sources. Chronic pain treatment should not begin with opioids in older adults; if pain does not respond to other alternative medications and therapies, then opioids can be considered. Non-opioids, such as topical pain medicines like lidocaine patches, gels, or topical NSAIDs, may also be a good pain relief option for some conditions. [5] At the start of treatment for pain relief, providers should talk with patients about reasonable expectations for their chronic pain management. It is not always realistic to expect to completely alleviate pain. A decrease in pain and a strong increase in functioning is the goal for a better quality of life. [5]

Risk of Overdose

An overdose from opioid use can be accidental. A prescribed dose taken as recommended can sometimes still be too much in older adults. This could be due to organs not processing the drug as they should and as the body might have earlier in life. Patients who are "opioid naïve", meaning they do not take opioids on a regular

basis, are more likely to accidentally overdose on their prescribed dose. Unintentional overdose can also happen in patients with cognitive impairment, where the patient takes a second dose too soon after not remembering they already took their medication.

Providers should consider providing a prescription for naloxone when there is a concern about a possible overdose. New opioid prescriptions for "opioid naïve" persons are a good example of a situation where caregivers should be made aware of overdose symptoms and how to give naloxone to an unresponsive patient if needed. Patients should be reminded that even when a dose of naloxone is given in an overdose situation, they still need to seek medical attention due to the short duration of time it will work in preventing the overdose. Also, patients and caregivers should be educated that it is not harmful to give naloxone; in cases when the caregiver may think the patient is overdosing, but is not sure, it is safe to use either way. Providers should be aware that a naloxone prescription is available to patients from many types of providers including physicians, nurse practitioners, and pharmacists.

Combination Therapies for Maximum Relief

There are a number of treatments that can ease pain in addition to prescription and OTC pain medications. Exercise, weight loss, physical therapy, occupational therapy, alternating hot and cold packs, or psychological therapy such as cognitive behavioral therapy often help alleviate or lessen pain and improve quality of life. Massage, acupuncture, yoga, and other similar therapies may also offer relief and increased comfort. [6] These options should be considered prior to or along with pain relief medications. Pain is often best treated with a combination of types of therapies. Studies have not shown that higher doses of opioids result in better physical and mental functioning or decreases in reported pain. [6]

Adverse Effects from Opioids

Opioids commonly cause constipation, and providers should prescribe or recommend treatment for this side effect at the time of prescription, as the constipation will not resolve itself over time. [5][6] Adverse effects from opioids can be especially pronounced in older patients and are increasingly likely with higher doses of opioids.

Some adverse side effects of opioid use can include: [5][6][7]

- Impaired cognitive and physical functioning
- Constipation
- Sedation and impaired balance, which can lead to an increased risk of fractures that can occur in an increased number of falls
- Increased risk of aberrant drug-related behaviors

- Risk of death from overdose
- Somnolence
- Sleep disordered breathing
- Dizziness
- Hypogonadism
- Nausea and vomiting
- Erectile dysfunction
- Urinary retention
- Pruritus
- Respiratory depression (particularly in patients with sleep apneas, respiratory disease, patients taking benzodiazepines, or other sedatives)
- With high doses, risk of opioid-induced hyperalgesia

Dangerous Combinations

Avoiding addiction to opioids should always be top of mind. Some providers may consider using a medication agreement where the patient undergoes urine drug screening, as well as monitoring for symptoms of addiction or diversion throughout treatment. [6][7] Opioids are not recommended for any patient with any active substance abuse disorder.

- Patients should be made aware that combining alcohol with opioids is very risky and could be deadly due to the stronger effects of alcohol in an older adult where it is metabolized differently. [6]
- Extreme caution should be used when prescribing benzodiazepines or soporifics with someone using opioids. [6]
- Acetaminophen amounts in various medications, including where it is part of an opioid medication and an over-the-counter pain relief option, should be monitored to avoid hepatic toxicity. The recommended daily dose of acetaminophen across all medications should not exceed 3000 mg a day for older adults and even less for frail patients or those with liver disease. However, Tylenol is the best choice of for an OTC pain medication for older adults. NSAIDs such as ibuprofen, aspirin, and naproxen should be avoided for long-term use. [5]
- For oral morphine sulfate, in older adults it's rare to need a dose of 60 mg a day or greater. If doses begin to reach 100 mg daily, recommending the patient see a pain specialist or taper off is appropriate. [6]

Messages To Tell Caregivers:

- Older adults and their caregivers should always be made aware of the risks and side effects of opioid use, as well as the importance of keeping opioid prescriptions out of medicine cabinets where adolescent family members or other visitors may be able to access them. A locked cabinet or box is the best place to

store these medications. Patients should be aware that others may want their medication to sell or use themselves. [6]

- Providers may provide a prescription for naloxone to caregivers when there is a concern about a possible overdose. New opioid prescriptions for "opioid naïve" persons are a good example of a situation where caregivers should be made aware of overdose symptoms and how to give naloxone if needed.
- Caution about not taking too much acetaminophen, especially if present in prescription pain medications.
- Caution about the importance of not combining alcohol and opioids.
- Regardless of the pain medications chosen, exercise, weight loss, physical therapy, occupational therapy, massage, acupuncture, yoga, alternating hot and cold packs, or psychological therapy can frequently help to alleviate or lessen pain and improve quality of life. [6]

Patients with Dementia:

- When patients have dementia or cognitive disabilities, they are more likely to misuse their pain medication by taking another dose too soon after a prior dose, or not remembering they already took a dose at all. [6]
- Encourage caregivers to take part in the patient's medication schedule to help the patient remember exactly when medications were taken, and encourage them to consider writing down these times where the patient can see them too. Using pill boxes to schedule medications for the upcoming week is a good way to help clearly visualize the medication schedule. Medication organizers help decrease the likelihood of a patient taking too many opioids at a time.

OPIOID OVERDOSE [8]

The CDC developed guidelines to improve communication between prescribers and patients about the risks and benefits of opioid therapy for chronic pain, improve the safety and effectiveness of pain treatment, and reduce the risks associated with long-term opioid therapy, including opioid use disorder (OUD), overdose, and death. The twelve recommendations for prescribing opioids for adults with chronic pain outside of active cancer, palliative, and end-of-life care are targeted toward primary care providers and are organized into three overarching categories.

I. Determining when to initiate or continue opioids for chronic pain.

II. Opioid selection, dosage, duration, follow-up and discontinuation.

III. Assessing risk and addressing harms of opioid use.

When potentially harmful behaviors are identified (e.g. high-volume use of opioids; taking opioids in combination with alcohol, benzodiazepines, or other respiratory depressants; using illicit opioids, etc.), it is important to offer education that can reduce that individual's risk for overdose. Providing basic risk reduction messaging, overdose prevention education, and a naloxone prescription can be lifesaving interventions.

Risk reduction messaging from a prescriber may include:

I. Information about other medications a patient is taking that are respiratory depressants.

II. Letting the patient know that mixing these substances with opioids or taking more than prescribed in combination with opioids may increase his or her risk of overdose.

III. Use of naloxone.

USE OF NALOXONE IN OVERDOSE [8]

If considering prescribing naloxone along with the patient's opioid prescription, there are a few things that should be considered.

- Does the patient have a history of overdose?
- Does the patient have a history of substance use disorder?
- Is the patient taking benzodiazepines with opioids?
- Is the patient at risk for returning to a high dose opioid to which they are no longer tolerant (e.g., former inmates recently released from prison, patients leaving detoxification facilities)?
- Is the patient taking higher dosages of opioids (more than 50 MME/day)?
- Is the patient at high risk for overdose because of a legitimate medical need for analgesia coupled with a suspected or confirmed history of substance abuse, dependence, or non-medical use of prescription or illicit opioids?
- Is the patient completing a mandatory opioid detoxification or abstinence program?
- Does the patient have an overdose plan that can be shared with family, friends, caregivers, etc. that includes information on the signs and symptoms of overdose and how to administer naloxone and provide emergency care?

TREATMENT PLAN & GOALS [3][4]

The goals of pain treatment include:

- Reasonably attainable improvement in pain and function;
- Avoidance of unnecessary or excessive use of medications; and
- Improvement in pain-associated symptoms such as sleep disturbance, depression, and anxiety.

The treatment plan and goals should be established as early as possible in the treatment process and revisited regularly, so as to provide clear-cut, individualized objectives to guide the choice of therapies. The treatment plan should contain:

- ☐ Information supporting the selection of therapies, both pharmacologic (including medications other than opioids) and non-pharmacologic
- ☐ The objectives that will be used to evaluate treatment progress, such as relief of pain and improved physical and psychosocial function
- ☐ Documentation of any further diagnostic evaluations, consultations or referrals, or additional therapies that have been considered.

INFORMED CONSENT & TREATMENT AGREEMENT [3][4]

The decision to initiate opioid therapy should be a shared decision between the prescriber and the patient. The prescriber should discuss the risks and benefits of the treatment plan (including any proposed use of opioid analgesics) with the patient or with persons designated by the patient. Use of a written informed consent and treatment agreement (sometimes referred to as a "treatment contract") is recommended.

Informed consent documents typically address:

- The potential risks and anticipated benefits of chronic opioid therapy;
- Potential side effects (both short- and long-term) of the medication, such as constipation and cognitive impairment;
- The likelihood that tolerance to and physical dependence on the medication will develop;
- The risk of drug interactions and over-sedation;
- The risk of impaired motor skills (affecting driving and other tasks);
- The risk of opioid misuse, dependence, addiction, and overdose;
- The limited evidence as to the benefit of long-term opioid therapy;
- The prescriber's prescribing policies and expectations, including the number and frequency of prescription refills, as well as the prescriber's policy on early refills and replacement of lost or stolen medications.
- Specific reasons for which drug therapy may be changed or discontinued (including violation of the policies and agreements spelled out in the treatment agreement).

Treatment agreements outline the joint responsibilities of prescriber and patient and are indicated for opioid or other abusable medications. They typically discuss:

- The goals of treatment, in terms of pain management, restoration of function, and safety;
- The patient's responsibility for safe medication use (e.g., by not using more medication than prescribed or using the opioid in combination with alcohol or other substances; storing medications in a secure location; and safe disposal of any unused medication);
- The patient's responsibility to obtain his or her prescribed opioids from only one physician or practice;
- The patient's agreement to periodic drug testing (as of blood, urine, hair, or saliva); and
- The prescriber's responsibility to be available or to have a covering physician/provider available to care for unforeseen problems and to prescribe scheduled refills.

SAMPLE PAIN CONTRACT [4]

Controlled Substance Agreement

_____ Clinic is a primary care facility offering the full-spectrum of family medicine. All patients presenting to _____ Clinic may receive preventive health services and treatment of chronic medical conditions. We utilize controlled substances for treatment of our established clinic patients within the typical scope of family medicine.

Goals of Treatment

The main goal of treatment with or without controlled substances is to improve function in daily life and is not likely to relieve all symptoms. Abuse and diversion of controlled substances make monitoring of all patients mandatory for their safety and for good public health practices.

Coordination of Care

- All primary health care will be coordinated through _____ Clinic with a single provider with the support of his/her team.
- All controlled substances related to the treatment of chronic illness(es) are to be managed through _____ Clinic.
- Patients are responsible for notifying ER physicians or other outside providers of the existence of this controlled substance agreement.
- Patients will not seek or accept any medications for pain other than those prescribed through _____ Clinic including prescriptions from other providers, medications borrowed or accepted from family, friends, etc., any illicit/street drugs, or alcohol that may interfere with treatment.
- Patients are expected to keep all appointments with _____ Clinic and other providers to which referral appointments have been made, such as specialty providers and physical therapy.
- All clinical staff must be treated with respect and courtesy.

Care Plan

- Varieties of medication or treatments may be used over time with the goal of improvement in function. Medications may be decreased or discontinued if objective functional improvement is not achieved.
- Use of adjunctive medications and participation in non-pharmacologic recommendations are required components for any care plan.
- Information regarding this agreement may be provided to local emergency departments, walk-in clinics, pharmacies or other providers involved in your care.
- _____ Clinic is required to comply with federal regulations regarding scheduled drugs.
- Patients cannot use medical marijuana while receiving any controlled substances through _____ Clinic.
- Patients choosing medical marijuana as a pain treatment modality will be offered transfer of care to a specialist for the management of the chronic pain condition.
- We will periodically review patient contracts for scope of care for appropriateness of care, and patient compliance to the treatment plan. Treatment plans and medication dosing may be modified based upon committee recommendations

Medication Dispensing

- Medications are only to be taken as prescribed.
- Controlled substance prescriptions are written for monthly intervals with no refills and held between clinic visits.
- Routine patient follow-up visits are to be scheduled at a minimum of every three months.
- Refills or changes to medication regimens of controlled substances will only be made during a face-to-face clinic visit. No changes will be made over the phone or between visits.
- Replacements will not be given for controlled substance prescriptions that are lost or stolen, or for running out of medication early.
- Controlled substance prescriptions will not be refilled during evenings or on weekends.

Public Health Responsibilities

- Patients receiving controlled substances are subject to random urine drug screening. If refused, the medication may be stopped.
- Patients are responsible for all charges associated with urine drug screening.

- Photo identification is required of the patient or a registered representative when picking up controlled substances prescriptions from _____ Clinic.
- Controlled substance medications must be purchased through a pharmacy documented with _____ Clinic.
- At any time, the patient may be asked to bring in their medication bottles for pill counts

Opioid Risks

- Patients must tell their provider if they are pregnant, become pregnant, or would like to become pregnant while on these medications.
- Avoid alcoholic beverages while taking opiates.
- Use caution while operating machinery or any vehicle, regardless of the mode of transportation. Many controlled substances will make you drowsy or otherwise impair your ability to safely operate machinery or any vehicle.
- Illegal use of controlled medications or falsifying prescriptions is a felony offense and may lead to prosecution.
- Patients are responsible for protection and security of medications. This includes keeping the medication out of reach of children.

Failure to comply with any part of this agreement will prompt a review and possible loss of privileges to receive controlled substance medications through _____ Clinic.

Patient Signature: _____ Date: _____

Provider Signature: _____ Date: _____

Important Information About Your Medications [4]

1. Patients with chronic pain often take a combination of medications. These may include over-the-counter pain medications like acetaminophen (Tylenol®) or ibuprofen (Motrin®). It may also include prescription medications like codeine.

2. If opioid medications like codeine are prescribed they will require special monitoring and regular doctor visits. These pain medications are not refilled over the phone. You should see your doctor 1-2 weeks before you are out of medication. It is best to call at least 2-3 weeks ahead for an appointment.

3. If you are on opioid medication, you may have an upset stomach when you start the medication. This usually goes away over a few weeks. Constipation is a common side effect that may not go away. Drinking lots of fluids and eating fruits and vegetables is important. Some patients have to take a medication to help with constipation. Make sure to discuss this with your doctor.

4. The medication may make you sleepy or drowsy when you start taking it. Do not drive until you know how it makes you feel. This effect usually wears off after a few weeks. Even with medications you are familiar with, however, you need to always take precautions when operating machinery or any vehicle, regardless of the mode of transportation, to ensure that you are able to do so safely.

5. Do not drink alcohol while taking this medication as taking the two together can increase the side effects of this medication such as slowed or irregular breathing, drowsiness, and very low blood pressure.

6. Don't suddenly stop taking this medication if you have been on it for more than a couple of weeks. Talk to your doctor before you change what you are taking. Your body can get used to the medicine and you may have withdrawal effects if you stop taking it. If you do not make follow up appointments and suddenly need medication, you will be scheduled into a clinic appointment as available. No refills are made over the phone.

7. Do not take more of the medication than what your doctor has prescribed. Do not give it to anyone else. Do not use illegal drugs while taking this medicine.

8. Receiving medications for chronic pain requires that patients agree to participate in exercise that is appropriate for their condition and be involved with making lifestyle changes that will help control pain. The best results are seen with a

combined approach of medication, exercise, and behavioral changes to promote a healthy lifestyle.

9. Taking this medication with other sedating medications such as those to treat allergies, anxiety, cough, seizures, etc. may increase the side effects of both medications such as slowed or irregular breathing, drowsiness, and very low blood pressure. Be sure to check with your pharmacist or prescriber before taking other medications along with your mediation(s) for pain.

ABERRANT BEHAVIORS [4]

Minor Aberrancy

- Aggressive complaining about the need for higher doses
- Drug hoarding during times of reduced pain
- Requesting specific drugs
- Unapproved use of the drug to treat other symptoms
- Obtaining similar drugs from other medical sources
- One or two unsanctioned dose escalations
- Requesting early refills

Major Aberrancy

- Selling prescription drugs
- Prescription forgery
- Stealing or borrowing another person's drugs
- Buying prescription drugs from non-medical sources
- Administering oral formulations by means of non-oral routes (e.g. injections)
- Concurrent abuse/use of related illicit drugs including marijuana
- Multiple unsanctioned dose escalations
- Recurrent prescription losses or early refill requests

Other Aberrancy of Concern

- Patient not willing/able to provide urine sample when requested for a urine drug screen
- Unwillingness to participate in adjuvant therapies
- Seeking primary care elsewhere
- Failure to schedule timely follow-up appointments

PRINCIPLES OF PAIN MANAGEMENT [4]

- Aberrant behaviors may present for a variety of reasons across a spectrum and prescribers should be sensitive to the differences between tolerance, physical dependence, aberrancy, abuse, addiction and pseudo-addiction and manage each patient accordingly.
- Use of adjunctive medications and participation in non-pharmacologic recommendations should be considered as required components of any care plan.
- A controlled substance/pain management contract should be completed for all patients receiving controlled substances.
- Prescribers should consider using a step-up approach in the pharmacologic management of chronic pain while targeting opiate dosing based on the source and type of pain and maintain accurate documentation of a patient's risk stratification.
- Prescribers should periodically review their patient's chronic pain diagnosis, treatment goals, co-morbidities and aberrant behaviors.
- Urine drug screens should be done upon initial evaluation for a care plan and then randomly based on a patient's risk stratification. Patient's receiving controlled substances should have ***at least*** one randomized urine drug test annually.
- Patients that show any new aberrant behavior should be required to have a urine drug screen.
- A patient exhibiting 'major' aberrant behavior may be considered for the termination of their controlled substance/pain management contract with a taper and discontinuation of their opiate therapy.
- Consultation with a pain specialist should be considered when opiate dosing regimens reach greater than 120mg daily morphine equivalent and/or the care plan is not achieving functional or pain reduction goals.
- Referral to a pain specialist should be considered when:
    - Opiate dosing regimens reach greater than 180mg daily;
    - Patients are stratified as 'High Risk';
    - Patients are too high of a risk for medications dispensed more frequently than monthly (e.g. suicide risk);
    - Patients fail to follow treatment agreements or are consistently non-compliant;
    - Patients exhibit three or more minor aberrant behaviors or one major aberrant behavior during the course of opiate treatment;
    - Patients choose 'medical marijuana' as a primary treatment modality;
    - The required monitoring is unachievable or unsuccessful;
    - There is a major aberrant behavior that results in the suspicion for abuse or addiction.

OPIOID DOSE CONVERSION [4]

For assistance with how to safely and accurately calculate appropriate opioid doses for either opioid-naïve patients or when switching from one agent to another, there are various resources practitioners may consult. The Rx Abuse Stakeholders does not recommend or promote any particular site. However, to assist prescribers in locating potential resources for opiate dose conversion/calculation, a couple of website resources are provided as an informational tool only.

The *Practical Pain Management* website has developed an opioid conversion calculator. This calculator was designed to be easily used at the point of care. The Opioid Conversion Calculator is available at no charge on the *Practical Pain Management* website. The calculator can be found at:

http://opioidcalculator.practicalpainmanagement.com

The CDC also provides a downloadable flyer that addresses calculating the total daily dose of opioids at:

https://www.cdc.gov/drugoverdose/pdf/calculating_total_daily_dose-a.pdf

******Please be aware that extra caution is required for fentanyl patch and methadone use and conversion.***

PATIENT COUNSELING POINTS

1. Inform patients of the risk of substance abuse with any medication that has the potential for abuse (opioid narcotics, stimulants, muscle relaxants, benzodiazepines, etc.)

2. Provide information on utilizing medication(s) with the lowest relative abuse potential or the use of non-medicinal therapies.

3. Make patients/care-givers aware of the symptoms of substance abuse and when and how to seek assistance if substance abuse is suspected. (See "Resources for Recovery" under the 'Resources' section of this toolkit.)

4. Stress the importance of keeping medications in a safe and secure place so they are not accessed by others living in or visiting the home and to properly dispose of them when no longer taking them. (See "Resources for Health Care Professionals, Communities & Schools/Prescription Drug Disposal in Wyoming" under the 'Resources' section of this toolkit.)

5. Stress the importance of not sharing medications with others and promptly disposing of unwanted/unused medications. Provide information about local drop boxes for medication disposal. Prescription drop box locations in Wyoming can be found at:

   https://health.wyo.gov/healthcarefin/medicationdonation/donate-meds

6. Inform patients/care-givers that your pharmacy uses the Board of Pharmacy WORx prescription drug monitoring programming for all scheduled/narcotic prescriptions. Let them know that any concerns/issues will be followed up on with all of the patient's providers, as needed.

7. Stress the importance of using extra care in operating machinery or any vehicle, regardless of the mode of transportation, while taking any controlled substance, including, but not limited to, opioids. Even when a patient is familiar with the effects of a medication, he needs to exercise caution for his own safety and that of other persons.

8. Inform patients they should not drink alcohol while taking an opioid due to the increased risk of an adverse reaction between the two substances such as slowed or irregular breathing, drowsiness, and very low blood pressure.

OPIOID WITHDRAWAL SYMPTOM MANAGEMENT [4]

Opioid withdrawal is typically not dangerous, but may be very uncomfortable and painful. Below are the typical signs/symptoms of withdrawal and some over-the-counter products that may ease a patient's withdrawal symptoms.

Signs and Symptoms of Opiate Withdrawal

- Abdominal cramps
- Anxiety
- Agitation
- Diaphoresis
- Diarrhea
- Dilated pupils
- Goose bumps
- Hypertension
- Insomnia
- Lacrimation
- Muscle twitching &/or aches
- Rhinorrhea
- Tachycardia
- Tachypnea
- Nausea/vomiting

Non-Pharmacologic Treatment of General Withdrawal

- Exercise
- Hot showers
- Eating small meals more frequently throughout the day
- Rest in cool, low light rooms
- Wear light/loose fitting clothing
- Drink plenty of water
- Use ice packs/heating pads as needed

UNIVERSITY OF WASHINGTON TELEPAIN CASE CONFERENCES [9]

The University of Washington Division of Pain Medicine offers weekly TelePain services, an audio and videoconference-based consultative knowledge network of interprofessional specialists with expertise in the management of challenging chronic pain problems. The goal is to increase the knowledge and skills of community practice providers who treat patients with chronic pain.

UW Medicine TelePain conducts these collegial interactive videoconferences, which include:

- Didactic presentations from the UW Pain Medicine curriculum for primary care providers
- Case presentations from community clinicians
- Interactive consultations for providers with an interprofessional panel of specialists
- The use of measurement based clinical instruments to assess treatment effectiveness and outcomes for individuals and larger populations

Practitioners are invited to present your difficult chronic pain cases to the TelePain panel of specialists whose expertise spans pain medicine, internal medicine, anesthesiology, rehabilitation medicine, psychiatry, addiction medicine, and nursing care coordination. Practitioners are welcome to attend and ask questions, even if you don't present a case.

Sessions take place each Wednesday from 12:00pm to 1:30pm PST. Community providers are invited to participate in an NIH-sponsored study of UW TelePain to help us measure the impact of the program.

ACCREDITATION

The University of Washington School of Medicine is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

The University of Washington School of Medicine designates this live activity for a maximum of *72 AMA PRA Category 1 Credit(s)*™. Physicians should claim only the credit commensurate with the extent of their participation in the activity. (Each session is 1.5 credits)

For more information, or to participate in UW TelePain, please go to:

https://depts.washington.edu/anesth/care/pain/telepain/mini-site/index.shtml

or contact UW TelePain at:

Telephone: **206-543-2673**
telepain@uw.edu

WYOMING MEDICAID PHARMACY LOCK-IN PROGRAM [10]

The Wyoming Medicaid Pharmacy Lock-In Program was initiated to address serious issues related to Medicaid recipients with a documented history of obtaining excessive quantities of prescribed drugs, specifically controlled substances, through multiple visits to physicians, pharmacies and emergency rooms. This program helps protect the health and safety of clients, reduces duplication of services by providers, and avoids inappropriate and unnecessary utilization of prescription medications. Recipients who meet evaluation criteria will be required to utilize one pharmacy for filling all of their Medicaid prescriptions.

Medical histories are reviewed to ensure that clients with certain diagnoses, including cancer, are excluded from lock-in. For the first offense the client is locked in for one (1) year, second offense is for two (2) years, and the third offense is for six (6) years. If the client does not meet lock-in criteria, the case is referred to the appropriate program as needed. For questions or concerns please call the Pharmacy Case Manager at 307-777-8773.

If a client should be considered for the Pharmacy Lock-In Program, please contact the Medicaid Pharmacy Services Lock-In Program at:

307-777-8773

Fax: 307-777-6964

RESOURCES FOR SCREENING, BRIEF INTERVENTION & REFERAL TO TREATMENT (SBIRT)

SBIRT is an evidence based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol, illicit drugs and other substances of abuse. [11] In Wyoming the Wyoming Department of Health Substance Abuse Prevention Program provides community-level prevention activities based on data through Community Prevention Specialists (CPS). Prevention in Wyoming includes:

- Alcohol
- Prescription and illicit opioids
- Tobacco

More information can be found at: [12]

https://health.wyo.gov/publichealth/prevention/substanceabuseandsuicide/

Resources are also available online at the Substance Abuse and Mental Health Services Administration's (SAMHSA) website: [11]

https://www.integration.samhsa.gov/clinical-practice/sbirt

HIPAA

Health care providers should be aware that there are times when law enforcement is allowed to request health information on an individual. Various sections of 45 CFR 164.512, allows individuals to disclose health information as part of:

- reports of child abuse or neglect
- reports of abuse or neglect of a vulnerable adult
- injuries required to be reported by law
- compliance with a warrant, subpoena or summons
- the location of a suspect, fugitive, material witness or missing person
- obtaining information about the victim of a crime
- obtaining information about the death of an individual
- obtaining information about a crime that has occurred on the premises
- obtaining information when health care was provided in an emergency

Law enforcement officials should be able to site why health care information is needed and the specific information that is required. It is preferred that law enforcement obtain consent from an individual when requesting medical information, but when that is not possible, law enforcement should be able to site the Wyoming statute and/or CFR that allows them to obtain health care information on an individual.

A WORD ABOUT HEROIN [13] [14]

Due to an increased focus on prescription drug abuse, patients with substance abuse problems are increasingly moving to other illicit drugs such as heroin. Heroin use has increased sharply across the United States among men and women, most age groups, and all income levels. Nearly all people who use heroin also use at least one other drug. As heroin use has increased, so have heroin-related overdose deaths. Between 2010 and 2017, the rate of heroin-related overdose deaths in the United States increased by almost 400%. In Wyoming, overdose deaths from prescription and/or illegal drugs accounted for 154 deaths in the year 2016-2017 according to the latest figures available to the Wyoming Department of Health. Twenty seven of those deaths were from illegal drugs, which may include heroin and other drugs. Fourteen of the 154 deaths were a combination of illegal and prescription drugs.

One way to help prevent patients from starting heroin is by reducing prescription opioid abuse. Among people presenting for treatment for addiction to opioids, and who initiated use of an opioid in 2015, about two out of three started with prescription opioids. People who are addicted to prescription opioids are 40 times more likely to also be addicted to heroin. Assist patients with a heroin use disorder access prevention services, as well as Medication-Assisted Treatment (MAT). Also, encourage the use of naloxone which will reverse a heroin overdose, as well as other opioid overdoses.

ADDITIONAL RESOURCES

RESOURCES FOR HEALTH CARE PROFESSIONALS, COMMUNITIES & SCHOOLS

Resources that may be useful to local communities, schools, organizations and health care professionals are found at the following websites:

- **American Academy of Pediatrics**
  - **http://www.aap.org/en-us/Pages/Default.aspx**
- **American Association for the Treatment of Opioid Dependence (AATOD)**
  - Prevalence of Prescription Opioid Abuse: **http://www.aatod.org**
- **American Chronic Pain Association**
  - **http://theacpa.org**
- **American Society for Pain Management Nursing**
  - **http://aspmn.org/Pages/default.aspx**
- **Association of State and Territorial Health Officials (ASTHO)**
  - Prescription Drug Overdose: State Health Agencies Respond (2008): **http://www.astho.org**
- **Centers for Disease Control and Prevention (CDC)**
  - **http://www.cdc.gov/Features/VitalSigns/PainkillerOverdoses**
  - **http://www.cdc.gov/HomeandRecreationSafety/Poisoning**
- **Generation Rx**
  - Provides medication safety and prescription drug abuse prevention resources for schools, colleges, and communities: **https://pharmacy.osu.edu/outreach/generation-rx-initiative**

- **Medication Abuse Project**
    - Provides comprehensive resources for parents and caregivers, law enforcement officials, health care providers, educators and others: **http://medicineabuseproject.org**
- **National Association of State Alcohol and Drug Abuse Directors (NASADAD)**
    - State Issue Brief on Methadone Overdose Deaths: **http://www.nasadad.org/nasadad-reports**
- **National Association of State EMS Officials (NASEMSO)**
    - National Emergency Medical Services Education Standards: **http://www.nasemso.org**
- **Partnership for Drug-Free Kids**
    - Information, tools and opportunities to help prevent and get help for drug and alcohol abuse by teens and young adults: **http://www.drugfree.org**
- **Prescription Drug Disposal in Wyoming**
    - Information on prescription drug drop box locations and the proper methods for the disposal of medications: **https://health.wyo.gov/healthcarefin/medicationdonation/donate-meds**
    - Information on medication donation: **http://www.wyomedicationdonation.org**
- **Substance Abuse and Mental Health Services Administration (SAMHSA)**
    - National Treatment Referral Helpline **1-800-662-HELP (4357)** or **1-800-487-4889** (TDD — for hearing impaired)
    - National Substance Abuse Treatment Facility Locator: to search by state, city, county, and zip code: **https://findtreatment.samhsa.gov**
    - Buprenorphine Physician & Treatment Program Locator: **http://www.buprenorphine.samhsa.gov/bwns_locator**

- State Substance Abuse Agencies: **http://findtreatment.samhsa.gov/TreatmentLocator/faces/abuseAgencies.jspx**
- Center for Behavioral Health Statistics and Quality (CBHSQ): **http://www.samhsa.gov/data**
- SAMHSA Publications: http://www.store.samhsa.gov or call **1-877-SAMHSA (1-877-726-4727)**

- **Whitehouse Office of National Drug Control Policy (ONDCP)**
  - State and Local Information: **http://www.whitehouse.gov/ondcp/state-map**

RESOURCES FOR MEDICAL PROVIDERS CONTINUING MEDICAL EDUCATION

American Academy of Pain Medicine – Continuing Medical Education courses are available to providers at:

https://live.blueskybroadcast.com/bsb/client/CL_DEFAULT.asp?Client=204187&PCAT=8344&CAT=8344

American Association of Nurse Practitioners – Continuing Medical Education courses are available at:

http://www.aanp.org/education/continuing-education-ce

American College of Physicians – Continuing Medical Education courses are available to providers at:

http://www.acponline.org/education_recertification/cme/safe_opioid_prescribing.htm?pr40

http://www.pri-med.com/PMO/Featured/Pain%20Management/Default.aspx

Boston University – Continuing Medical Education courses are available to providers at:

http://www.opioidprescribing.com/overview

Federally funded Continuing Medical Education courses are available to providers at no charge at:

http://www.OpioidPrescribing.com

Links to accredited CME/CE REMS-compliant activities supported by the REMS Program Companies available at:

http://www.er-la-opioidrems.com

http://www.fsmb.org/safeprescribing

RESOURCES FOR RECOVERY

Resources that may be useful to those in recovery are found at the following websites:

http://www.recoverwyoming.org

Recovery links at a federal level include:

- **Substance Abuse and Mental Health Services Administration SAMHSA:**

  http://www.samhsa.gov

- **Faces and Voices of Recovery:**

  http://www.facesandvoicesofrecovery.org

- **Partners in Recovery:**

  http://Pfr.samhsa.gov

These treatment providers are certified by the Department of Health to provide substance abuse treatment in the state of Wyoming:

http://www.health.wyo.gov/mhsa/treatment/index.html

OTHER USEFUL RESOURCES FOR PROVIDERS & COMMUNITIES

- **National Association of Drug Diversion Investigators (NADDI):**

  http://www.naddi.org

- **Wyoming Council for Advanced Practice Nursing:**

  http://www.wcapn.org

- **Wyoming Department of Health:**

  http://www.health.wyo.gov/default.aspx

  - Office of Pharmacy Services:
    http://www.health.wyo.gov/healthcarefin/pharmacy/index.html

  - Mental Health and Substance Abuse Division:
    http://www.health.wyo.gov/mhsa/index.html

  - Medication Donation:
    http://www.wyomedicationdonation.org

APPENDIX

Visit #1 [4]

Patients may present requesting evaluation for a chronic pain complaint or may ask for help with this in the context of multiple other medical needs. It is important for the provider and the patient to work together early in the visit to set the agenda. Allowing the patient input and setting realistic expectations is critical to this visit. Often the chronic pain evaluation is more important to the patient than their other medical needs. If so, and none of the other needs are critical, it is recommended to start there and reschedule time to address the other health care needs.

The chief mission of this visit is to lay the groundwork for a successful therapeutic relationship where healing can take place. Patients are given information and a discussion takes place regarding how evaluation and treatment for chronic pain occurs. It is possible that not all of the patient's history is obtained in the first visit. Acknowledging this is important as it allows space for patients to share their expectations, ask questions, and understand the process for evaluation and treatment.

Patients often request medication management at this visit. Medical licensing boards are clear and have given specific information on this topic. Evaluation should be completed first. Providers can counsel the patient about interim strategies for pain control. Attention to the scheduling of the next visit is important and allows the patient to see the care system at work.

Visit #1 Checklist [4]

Patient Name: _____ Date of Birth: _____

Pain Complaint: _____ Date of Visit: _____

- ❑ Obtain urine sample for urine drug screen.
- ❑ Complete basic assessment and document all current medications.
- ❑ Graded Chronic Pain Scale completed prior to being seen by provider.
- ❑ Complete Opioid Risk Tool
- ❑ Complete Release of Information forms with the patient prior to end of visit.
- ❑ Schedule patient for visit #2 in one to two weeks.
- ❑ Schedule patient for visit #3 within one month.
- ❑ Give patient appointment cards.

- ❑ Explain Three-visit Process for evaluation of chronic illness with pain.
  - Assessment of chronic illness and need for treatment of pain.
  - Likely use of adjuvant therapy without certainty of any opiates being dispensed.
  - Requirement of Controlled Substance Agreement and Opioid Risk Tool.
  - No use of medical marijuana if receiving opiates.

- ❑ **Search Wyoming State WORx (Prescription Drug Monitoring Program)**
  http://www.worxpdmp.com/

Visit #2 [4]

The main emphasis during the second visit should be completing the patient's medical history. This includes the history of the chronic pain illness including reviewing old records and pertinent imaging studies. These records are to be requested during the first visit. If they are not received, they need to be requested again during the second visit. If they have been received, they are reviewed with the patient and summarized in the medical record. The rest of a standard visit history is obtained – medical history, surgical history, social history, and family history.

The second component of the second visit is a physical exam. In patients with simple histories, this is completed in the second visit. In patients with complex histories, the physical exam may be deferred until the next visit. The extent of the physical exam is up to the provider but should certainly, at a minimum, include all body parts affected by chronic pain. Co-morbidities are intrinsic to medication management so it is efficient and prudent to examine certain other body parts as well (i.e. lung exam in patient with lung disorder).

Identification and management of mental health disorders is essential to chronic pain treatment. Simply, it can be depressing to be in pain. In addition, the existence of other, more complex mental health disorders (schizophrenia, active substance use) can make medication management difficult. Providers that sense complicated mental health problems are encouraged to explore this further during the second visit. This may involve the help of behavioral health colleagues as available.

Visit #2 Checklist [4]

Patient Name: _____ Date of Birth: _____

Pain Complaint: _____ Date of Visit: _____

- ❑ Graded Chronic Pain Scale completed prior to being seen by provider.
- ❑ Verify urine toxicology results received.
- ❑ Obtain any interim medical records (i.e., ER) since last appointment.
- ❑ Document all current medications.
- ❑ Preview old records with the patient.
- ❑ Perform physical examination with focus on area of chronic pain.
- ❑ Complete documentation of sentinel injury, definitive imaging, etc. in medical history. Add specific ICD-9 or ICD-10 code to support chronic illness with pain diagnosis.
- ❑ Complete Release of Information forms with the patient prior to end of visit.
- ❑ Write prescriptions as applicable.
- ❑ Schedule patient for Visit #3 if not already done so and within two weeks.
- ❑ Give patient appointment cards.

- ❑ **Search Wyoming State WORx (Prescription Drug Monitoring Program)**
  http://www.worxpdmp.com/

Visit #3 [4]

The major focus during this visit is the treatment plan. Expectations from the patient are high during this visit and should be acknowledged. Accumulated information is reviewed. A diagnosis of the type of pain is made. Recall that multiple types of pain may exist in the same patient. Specific medication management is recommended based on the diagnosis, patient's past experiences, and co-morbidities. Initial treatment rarely includes opioids. Patients are involved in the discussion/selection of the medication. Risks and benefits of medication selection are discussed.

Excellence in pain management always involves a comprehensive strategy. The care plan should include attention to stress, sleep, exercise, and patient selected functional goals. This is in addition to the medication management component. It becomes obvious with this method that medication is an important piece but only part of the treatment plan. This can be somewhat disappointing to patients and should be acknowledged. Treatment is aimed at improving function and most chronic pain cannot go away entirely. Therefore, teaching patients to live with some pain in order to have tolerable side effects of medication and reasonable function is the aim of good chronic pain medication management.

The final task of this visit is to document the summary of the evaluation and plan in the medical record. Screening tools for risk of opioid use, functional assessment, depression screen, and pain assessment should be filed in the medical record. Summarizing the findings for reference at follow up visits by the same or another provider is necessary to facilitate good patient care.

Visit #3 Checklist [4]

Patient Name: _____ Date of Birth: _____

Pain Complaint: _____ Date of Visit: _____

- ❑ Verify receipt of all requested medical records.
- ❑ Graded Chronic Pain Scale completed prior to being seen by provider.
- ❑ Verify urine toxicology results received.
- ❑ Obtain any interim medical records (i.e., ER) since last appointment.
- ❑ Complete basic assessment and document all current medications.
- ❑ Preview old records with the patient.
- ❑ Discuss Care Plan and Controlled Substance Agreement with the patient.
- ❑ Complete documentation of sentinel injury, definitive imaging, etc. in Medical History. Add specific ICD-9 or ICD-10 code to support chronic illness with pain diagnosis.
- ❑ Write prescriptions as applicable.
- ❑ Schedule one month follow-up appointment.
- ❑ Give patient appointment cards.

- ❑ **Search Wyoming State WORx (Prescription Drug Monitoring Program)**
  http://www.worxpdmp.com/

Chronic Pain Follow-up Visits [4]

After initial management, patients should be seen on a one to three month interim. The first visit after constructing a care plan should always be at one month. Patients are often apprehensive that the treatment plan will work. In fact, it may need modifications, which is not uncommon.

Escalation of dosage of some of the neuropathic pain medications refining how other medications are taken, realistic expectations, and control of co-morbid mental health issues are often the focus of the visit. Partnering with the patient in the treatment plan to adequately improve function is important. It can be tough to hear that the pain will not go away entirely. Consideration of referral for therapeutic options (neurosurgery, orthopedics) often comes up during the initial follow-up visit and should be addressed. Patients should be seen monthly at a minimum until adequate functional improvement is achieved. Some patients may require referral at this time for a disability evaluation, Medicaid eligibility, housing assistance, or vocational rehabilitation.

At some point in follow up, the question of opioid prescribing may come up. Patients well controlled without it are better off in general. Patients not well controlled on non-opioid medications should be risk assessed during their initial visits. Deciding on opioid therapy is based on the diagnosis and risk assessment. It is a big decision and best done with a good explanation to the patient of the risks involved and the goals to be achieved, such as functional improvement. Some patients are simply too high risk to treat in primary care and should be referred to a pain specialist. It is challenging, but not impossible, for primary care providers to find resources in their community to refer to. Networking on a state and national level is often useful in this regard.

Chronic Illness with Pain Follow-Up Visits Checklist [4]

Patient Name: _____ Date of Birth: _____

Pain Complaint: _____ Date of Visit: _____

- ❑ Graded Chronic Pain Scale completed prior to being seen by provider.
- ❑ Verify chief complaint and document.
- ❑ Complete basic assessment and document all current medications.
- ❑ Document average pain, function, medication affects, adverse events and telephone encounters.
- ❑ Write up to three months of prescriptions, if appropriate.
- ❑ Schedule other visits as needed for preventative health care and other chronic illnesses, as well as follow-up pain appointment(s).
- ❑ Give patient appointment cards.

- ❑ **Search Wyoming State WORx (Prescription Drug Monitoring Program)**
  http://www.worxpdmp.com/

OPIOID RISK TOOL [4]

Patient Name: _____

DOB: _____

MARK EACH BOX THAT APPLIES:	FEMALE	MALE
1. Family history of substance abuse		
• Alcohol	☐ 1	☐ 3
• Illegal Drugs	☐ 2	☐ 3
• Prescription Drugs	☐ 4	☐ 4
2. Personal history of substance abuse		
• Alcohol	☐ 3	☐ 3
• Illegal Drugs	☐ 4	☐ 4
• Prescription Drugs	☐ 5	☐ 5
3. Age (mark box if between 16 and 45)	☐ 1	☐ 1
4. History of pre-adolescent sexual abuse	☐ 3	☐ 0
5. Psychological disease		
• ADD, OCD, bipolar, schizophrenia	☐ 2	☐ 2
• Depression	☐ 1	☐ 1
Scoring Totals:	_____	_____

Risk Category is (circle one): **LOW** (Score 0-3: 6% chance of aberrant behavior)

MODERATE (Score 4-7: 28% chance of aberrant behavior)

HIGH (Score >=8: 90% chance of aberrant behavior)

Monitoring Guidelines Based on the Patient's Risk of Abuse [4]

Low Risk (Routine)	Moderate Risk	High Risk
Opioid treatment agreement	**All low risk guidelines plus:**	**All low and moderate risk guidelines plus:**
Get old records	Monthly or bi-weekly visits and scripts	Strongly consider having a pain specialist assume care
Initial prescription database check	Have family in to discuss treatment plan	Weekly visits / scripts
Initial urine drug screen	Semi-annual prescription database checks	Have family in to discuss treatment plan
Brief Pain Inventory	Initial and random urine drug screens	Quarterly prescription database checks
Use flow sheet for every visit	Consider co-morbid mental disease	Scheduled and random drug screens
Document the "Four A's"	Consider a pain or psychiatric consult for co-management	Third party administration (spouse)
Monthly visits to start, then may back off if doing well	Consider medication counts	Psychiatric and / or addiction evaluations
Step up risk if significant aberrancy	Consider limiting rapid onset opioids	Medication Counts
	Step up risk if significant aberrancy seen	Limit rapid onset opioids
		Consider limiting short acting opioids

Graded Chronic Pain Scale [4]

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 activities

0	1	2	3	4	5	6	7	8	9	10

Interpretation of the Two Item Graded Chronic Pain Scale

This two-item version of the Graded Chronic Pain Scale is intended for brief and simple assessment of pain severity in primary care settings. Based on prior research, the interpretation of scores on these items is as follows:

Pain Rating Item	Mild	Moderate	Severe
Average/Usual Pain Intensity	1 - 4	5 - 6	7 - 10
Pain Related Interference with Activities	1 - 3	4 - 6	7 - 10

Although pain intensity and pain-related interference with activities are highly correlated and tend to change together, it is recommended that change over time be tracked for pain intensity and pain-related interference with activities separately when using these two items.

For an individual patient, a reduction in pain intensity and improvement in pain-related interference with activities of two points is considered moderate but clinically significant improvement.

Similar pain ratings have been widely used in the Brief Pain Inventory, the Multidimensional Pain Inventory, and the Pain Severity Scale of the SF-12.

There is extensive research on the reliability, validity, and responsiveness to change of these pain severity ratings, which is summarized in the following reference:

Von Korff M. Chronic Pain Assessment in Epidemiologic and Health Services Research: Empirical Bases and New Directions. Handbook of Pain Assessment: Third Edition. Dennis C. Turk and Ronald Melzack, Editors. Guilford Press, New York., In press

Personal Care Plan for Chronic Pain [4]

Patient Name: _____ Date of Birth: _____

1. Set Personal Goals
   - ☐ Improve Function Ability Score by _____ points by _____.
   - ☐ Return to specific activities, tasks, hobbies, sports by _____.

   List activities, tasks, hobbies &/or sports:

   _____

   _____

2. Improved sleep by _____ hours/night. Current sleep is _____ hours/night.
   - ☐ Follow basic sleep plan
   - ☐ Eliminate caffeine and naps, relaxation before bed, go to bed at target bedtime

3. Increase Physical Activity
   - ☐ Attend physical therapy. _____ days/week.
   - ☐ Complete daily stretching. _____ times/day for _____ minutes.
   - ☐ Complete aerobic exercise/endurance exercise. _____ times/week.

4. Manage Stress

   List main stressors:

   _____

   - ☐ Interventions (Counseling, support groups, therapy groups, classes)
   - ☐ Daily practice of relaxation techniques, yoga, meditation, creative activity, service activity.

Personal Care Plan for Chronic Pain

5. Decrease Pain
   - ☐ Best pain level in past week _____.
   - ☐ Worst pain level in past week _____.

   ALL Medications: _____

   _____

   ALL Non-Medication Treatments: _____

   _____

Patient Signature: _____

Physician Signature: _____

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