AAFP Chronic Pain Toolkit

HOP20012003

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INTRODUCTION

Chronic pain is common in the U.S., with anywhere from 11% to 40% of the adult population reporting daily pain.[1] Approximately one-third of patients experiencing pain receive a pain medication.[2] While the number of prescriptions for pain management have declined in recent years,[3] opioid misuse remains a significant public health crisis. Roughly 21-29% of patients who are prescribed opioids for chronic pain will misuse them.[4]

The solutions to this public health crisis include continued emphasis on improving chronic pain care, increasing research into pain and pain management, improving training for physicians who manage chronic pain, and increased public awareness.

Scope and Purpose

This toolkit serves as one primary care solution to assist in the effective assessment, diagnosis, and management of chronic pain. It provides a brief overview of current evidence, along with useful tools and resources to manage chronic pain and related issues. These sections and tools can be used together or separately, depending on the needs of the practice.

Toolkit Sections*

Section Title	Description	Location
1. Pain Assessment	Overview of appropriate strategies and diagnostic tools to support chronic pain assessment in patients	Jump to section
2. Functional and Other Assessments	Overview of strategies and supporting tools for the diagnostic assessment of functional activity and other coexisting conditions in patients, including mental and emotional health, quality of life, and other psychological factors	Jump to section
3. Pain Management	Overview of strategies and considerations for effective acute and chronic pain management in patients	Jump to section
4. Opioid Prescribing	Overview of opioid prescribing as related to the treatment of chronic pain, including information and resources for safe prescribing; risk mitigation and monitoring; opioid conversion and tapering tools; and opioid resources for patients	Jump to section
5. Opioid Use Disorders: Prevention, Detection, and Recovery	Overview and resources to support opioid use disorder prevention; recognition and assessment; and treatment and recovery	Jump to section

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References

1. Centers for Disease Control and Prevention. Prevalence of chronic pain and high-impact chronic pain among adults — United States, 2016. *MMWR.* 2018;67(36):1001-1006.
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3. Centers for Disease Control and Prevention. U.S. opioid dispensing rate maps. Accessed January 7, 2021. www.cdc.gov/drugoverdose/maps/rxrate-maps.html#:~:text=The%20overall%20national%20opioid%20dispensing%20rate%20declined%20from%202012%20to,than%20153%20million%20opioid%20prescriptions
4. National Institute on Drug Abuse. Opioid overdose crisis. Accessed January 7, 2021. www.drugabuse.gov/drug-topics/opioids/opioid-overdose-crisis

PAIN ASSESSMENT | Section 1

OVERVIEW

Assessment of chronic pain should be multidimensional. Consideration should be given to several domains, including the physiological features of pain and its contributing factors, with physicians and other clinicians assessing patients for function, quality of life, mental health, and emotional health.

In addition to a complete medical and medication history typically obtained at an office visit, documentation should be obtained about pain intensity, location, duration, and factors that aggravate or alleviate pain.

A physical exam should include musculoskeletal and neurological components, as appropriate. Diagnostic testing and imaging may also be considered for some types of chronic pain. Many organizations, including the AAFP, recommend against imaging for low back pain within the first six weeks of treatment unless there are reasons for the imaging. These reasons may include concerns of underlying conditions, such as severe or progressive neurological deficits, or if osteomyelitis is suspected.[1]

Periodic reassessments of chronic pain and treatment should focus on evaluating improvements in physical health; mental and emotional health; progress towards functional treatment goals; and effectiveness and tolerability of medications for chronic pain treatment.

Currently, there are no universally adopted guidelines or recommendations for assessment of chronic pain. The use of appropriate assessment tools can assist in diagnostic assessment, management, reassessment, and monitoring of treatment effects. Multiple tools are available, with many embedded in electronic health record (EHR) systems.

Pain Assessment Tools

The table on the next page includes selected tools for pain assessment included in this toolkit, along with links and reference to additional tools. Assessments about other relevant domains are covered in Functional and Other Assessments (Section 2).

Pain Assessment Tools in Toolkit				
Name	**Use**	**Scoring**	**Description**	**Location**
Brief Pain Inventory (BPI) Short Form	Assess pain severity and impact on daily function	• Worst pain score: 1-4 = mild pain • Worst pain score: 5-6 = moderate pain • Worst pain score: 7-10 = severe pain Pain severity can be calculated by averaging responses of questions 3-6. Pain interference can be calculated by averaging responses of questions 9a-9g.	Fillable PDF completed in approximately five minutes with the patient	Jump to tool in toolkit.
Pain, Enjoyment of Life and General Activity (PEG) Scale	Assess pain interference with enjoyment of life and general activity	• Mild pain = 0-11 or 0 to <4 • Moderate pain = 12-20 or 4 to <7 • Severe pain = 21-30 or 7-10 PEG score is calculated by an average of questions 1-3	Three-question assessment of pain takes 1-2 minutes	Jump to tool in toolkit.
Additional Pain Assessment Tools				
Numeric Pain Rating Scale (NPRS)[2]	Rate pain intensity	Scores range from 0-10 points, with higher scores indicating greater pain intensity.	Evaluates one aspect of pain—intensity Evaluates pain experienced only in the past 24 hours or "an average pain intensity"	www.sralab.org/rehabilitation-measures/numeric-pain-rating-scale
Verbal Rating Scale (VRS)[3]	Describe pain intensity Use when the NPRS cannot be used	• No pain • Mild pain • Moderate pain • Severe pain	Word options describe pain intensity	www.oxfordclinicalpsych.com/view/10.1093/med:psych/9780199772377.001.0001/med-9780199772377-interactive-pdf-003.pdf
Wong-Baker FACES® Pain Rating Scale[4]	Describe pain intensity Used for children and adults	Series of faces range from 0 for a happy face (no hurt) to 10 for a crying face (hurts worst)	Faces depict the pain the patient experiences Evaluates one aspect of pain—intensity	https://wongbakerfaces.org/
McGill Pain Questionnaire (MPQ)[5]	Assess quality and intensity of pain Monitor pain over time and determine effectiveness of interventions	Scores are calculated by summing values associated with each word Scores range from 0 (no pain) to 78 (severe pain)	Numerical intensity scale Set of descriptor words and a pain drawing	www.sralab.org/rehabilitation-measures/mcgill-pain-questionnaire

For additional resources on assessment algorithms, visit the Institute for Clinical Systems Improvement's guideline, Pain; Assessment, Non-Opioid Treatment Approaches and Opioid Management.

References

1. American Academy of Family Physicians. Imagining for low back pain. Choosing Wisely®. Accessed January 7, 2021. www.aafp.org/family-physician/patient-care/clinical-recommendations/all-clinical-recommendations/cw-back-pain.html
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3. Jensen MP. The 0-3 Verbal Rating Scale (VRS). Accessed January 7, 2021. www.oxfordclinicalpsych.com/view/10.1093/med:psych/9780199772377.001.0001/med-9780199772377-interactive-pdf-003.pdf
4. Wong-Baker FACES Foundation (2020). Wong-Baker FACES® Pain Rating Scale. Accessed January 7, 2021. https://wongbakerfaces.org/
5. Shirley Ryan AbilityLab. McGill Pain Questionnaire. Accessed January 7, 2021. www.sralab.org/rehabilitation-measures/mcgill-pain-questionnaire

Brief Pain Inventory

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

Brief Pain Inventory (Short Form)

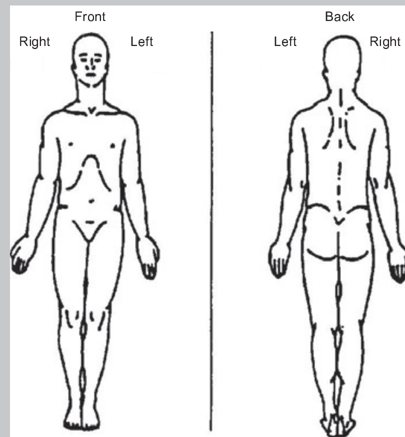
Date: ____/____/____ Time: _______

Name: __________________ __________________ ______________
Last First Middle Initial

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

1. Yes 2. No

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



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

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

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

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

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

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

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

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

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

Date:____/____/____ Time:________

Name: __________________ __________________ ______________
Last First Middle Initial

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

____

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

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

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

A. General Activity

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

B. Mood

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

C. Walking Ability

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

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

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

E. Relations with other people

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

F. Sleep

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

G. Enjoyment of life

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

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PEG SCALE ASSESSING PAIN INTENSITY AND INTERFERENCE

(Pain, Enjoyment, General Activity)

1. What number best describes your **pain on average** 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 **enjoyment of life**?

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

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

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

Computing the PEG Score

Add the responses to the three questions, then divide by three to get a mean score (out of 10) on overall impact of points.

Using the PEG Score

The score is best used to track an individual's changes over time. The initiation of therapy should result in the individual's score decreasing over time.

Source

Krebs EE, Lorenz KA, Blair MJ, et al. Development and initial validation of the PEG, a three-item scale assessing pain intensity and interference. *J Gen Intern Med*. 2009;24(6):733-738.

FUNCTIONAL AND OTHER ASSESSMENTS | Section 2

OVERVIEW

In addition to pain itself, a comprehensive assessment of chronic pain should cover other domains, including function, impact on daily activities, quality of life, mental health, and comorbidities and conditions that may require additional assessment and management.[1] Examples of conditions that might be impacted or contribute to changes in quality of life include anxiety, depression, trauma, stigma, substance use disorder, and pain-related factors, such as pain catastrophizing or kinesiophobia.[1]

Functional and General Health Tools

Currently, there are no universal guidelines for pain-related functional assessment. Many validated, self-reporting tools are available to assess the impact of chronic pain. The use of appropriate assessment tools can assist in functional and general psychosocial evaluation.

The table below includes selected tools for functional assessment and coexisting conditions included in this toolkit, along with links and references to additional tools assessing function and general health.

Functional Assessment and General Health Tools				
Name	**Use**	**Scoring**	**Description**	**Location**
Patient-Reported Outcomes Measurement Information System (PROMIS®) Global Health	Evaluate and monitor physical, mental, and social health in adults and children	Sum of response score with high scores reflecting better functioning	Ten-item global health assessment tool	Jump to tool in toolkit.
Short Form Health Survey (SF-36)	Routine monitoring and assessment of care outcomes in adult patients	Scoring process described here: www.rand.org/health-care/surveys_tools/mos/36-item-short-form/scoring.html	Generic, coherent, and easily administered quality-of-life measures	Jump to tool in toolkit.
Work Productivity and Activity Impairment Questionnaire	Measure impairment in work and activities	Response review	Six-item, validated questionnaire	Jump to tool in toolkit.
Functional Goals	Assist with setting functional goals for paints with chronic pain	N/A	Goal-setting worksheet	Jump to tool in toolkit.
Tables of Functional Assessment Instruments and Coexisting Conditions Tools				
Table A. Considerations for Common Coexisting Conditions	Additional resources, tools, and considerations for common coexisting conditions to be considered in chronic pain assessments			Jump to table in toolkit.
Table B. Selected Condition Specific Functional Assessment	Overview and links to a select list of functional assessment instruments			Jump to table in toolkit.

References

1. Williams DA. The importance of psychological assessment in chronic pain. *Curr Opin Urol.* 2013;23(6):554-559.

(PROMIS® Scale v1.2–Global Health)

GLOBAL HEALTH

Please respond to each question or statement by marking one box per row.

	Excellent	Very good	Good	Fair	Poor
GLOBAL01 — In general, would you say your health is:	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
GLOBAL02 — In general, would you say your quality of life is:	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
GLOBAL03 — In general, how would you rate your physical health?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
GLOBAL04 — In general, how would you rate your mental health, including your mood and your ability to think?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
GLOBAL05 — In general, how would you rate your satisfaction with your social activities and relationships?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
GLOBAL09R — In general, please rate how well you carry out your usual social activities and roles. (This includes activities at home, at work and in your community, and responsibilities as a parent, child, spouse, employee, friend, etc.)	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1

	Completely	Mostly	Moderately	A Little	Not at All
GLOBAL06 — To what extent are you able to carry out your everyday physical activities such as walking, climbing stairs, carrying groceries, or moving a chair?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1

In the past 7 days...

	Never	Rarely	Sometimes	Often	Always
GLOBAL10R — How often have you been bothered by emotional problems such as feeling anxious, depressed or irritable?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1

	None	Mild	Moderate	Severe	Very Severe
GLOBAL8R — How would you rate your fatigue on average?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1

GLOBAL7R — How would you rate your pain on average?	☐ 0 No Pain	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10 Worst pain Imaginable

13 April 2018
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HEALTH

36-Item Short Form Survey Instrument (SF-36)

RAND 36-Item Health Survey 1.0 Questionnaire Items

Choose one option for each questionnaire item.

1. In general, would you say your health is:

- 1 - Excellent
- 2 - Very good
- 3 - Good
- 4 - Fair
- 5 - Poor

---

2. **Compared to one year ago**, how would you rate your health in general **now**?

- 1 - Much better now than one year ago
- 2 - Somewhat better now than one year ago
- 3 - About the same
- 4 - Somewhat worse now than one year ago
- 5 - Much worse now than one year ago

The following items are about activities you might do during a typical day. Does **your health now limit you** in these activities? If so, how much?

	Yes, limited a lot	Yes, limited a little	No, not limited at all
3. **Vigorous activities**, such as running, lifting heavy objects, participating in strenuous sports	○ 1	○ 2	○ 3
4. **Moderate activities**, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	○ 1	○ 2	○ 3
5. Lifting or carrying groceries	○ 1	○ 2	○ 3
6. Climbing **several** flights of stairs	○ 1	○ 2	○ 3
7. Climbing **one** flight of stairs	○ 1	○ 2	○ 3
8. Bending, kneeling, or stooping	○ 1	○ 2	○ 3
9. Walking **more than a mile**	○ 1	○ 2	○ 3
10. Walking **several blocks**	○ 1	○ 2	○ 3
11. Walking **one block**	○ 1	○ 2	○ 3
12. Bathing or dressing yourself	○ 1	○ 2	○ 3

During the **past 4 weeks**, have you had any of the following problems with your work or other regular daily activities **as a result of your physical health**?

	Yes	No
13. Cut down the **amount of time** you spent on work or other activities	◯ 1	◯ 2
14. **Accomplished less** than you would like	◯ 1	◯ 2
15. Were limited in the **kind** of work or other activities	◯ 1	◯ 2
16. Had **difficulty** performing the work or other activities (for example, it took extra effort)	◯ 1	◯ 2

During the **past 4 weeks**, have you had any of the following problems with your work or other regular daily activities **as a result of any emotional problems** (such as feeling depressed or anxious)?

	Yes	No
17. Cut down the **amount of time** you spent on work or other activities	◯ 1	◯ 2
18. **Accomplished less** than you would like	◯ 1	◯ 2
19. Didn't do work or other activities as **carefully** as usual	◯ 1	◯ 2

20. During the **past 4 weeks**, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups?

◯ 1 - Not at all

◯ 2 - Slightly

◯ 3 - Moderately

◯ 4 - Quite a bit

◯ 5 - Extremely

21. How much **bodily** pain have you had during the **past 4 weeks**?

- 1 - None
- 2 - Very mild
- 3 - Mild
- 4 - Moderate
- 5 - Severe
- 6 - Very severe

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22. During the **past 4 weeks**, how much did **pain** interfere with your normal work (including both work outside the home and housework)?

- 1 - Not at all
- 2 - A little bit
- 3 - Moderately
- 4 - Quite a bit
- 5 - Extremely

These questions are about how you feel and how things have been with you **during the past 4 weeks**. For each question, please give the one answer that comes closest to the way you have been feeling.

How much of the time during the **past 4 weeks**...

	All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
23. Did you feel full of pep?	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ 6
24. Have you been a very nervous person?	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ 6
25. Have you felt so down in the dumps that nothing could cheer you up?	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ 6
26. Have you felt calm and peaceful?	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ 6
27. Did you have a lot of energy?	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ 6
28. Have you felt downhearted and blue?	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ 6
29. Did you feel worn out?	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ 6
30. Have you been a happy person?	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ 6
31. Did you feel tired?	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ 6

32. During the **past 4 weeks**, how much of the time has **your physical health or emotional problems** interfered with your social activities (like visiting with friends, relatives, etc.)?

◯ 1 - All of the time

◯ 2 - Most of the time

◯ 3 - Some of the time

◯ 4 - A little of the time

◯ 5 - None of the time

How TRUE or FALSE is **each** of the following statements for you.

	Definitely true	Mostly true	Don't know	Mostly false	Definitely false
33. I seem to get sick a little easier than other people	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5
34. I am as healthy as anybody I know	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5
35. I expect my health to get worse	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5
36. My health is excellent	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5

ABOUT

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Work Productivity and Activity Impairment Questionnaire

The following questions ask about the effect of your health problems on your ability to work and perform regular activities. "Health problems" are defined as any physical or emotional problem or symptom. *Please fill in the blanks or check the appropriate box, as indicated.*

1. Are you currently employed (working for pay)?
   If NO, check "NO" and skip to question 6. ☐ Yes ☐ No
2. During the past seven days, not including today, how many hours did you miss from work because of **your health problems?**
   Include hours you missed on sick days, times you went in late, left early, etc., because of your health problems. Do not include time you missed to participate in this study. _____ HOURS
3. During the past seven days, not including today, how many hours did you miss from work because of any other reason, such as vacation, holidays, time off to participate in this study? _____ HOURS
4. During the past seven days, not including today, how many hours did you actually work?
   (If "0", skip to question 6.) _____ HOURS
5. During the past seven days, not including today, how much did your health problems affect your productivity while you were working?
   Think about days you were limited in the amount or kind of work you could do, days you accomplished less than you would like, or days you could not do your work as carefully as usual. If health problems affected your work only a little, choose a low number. Choose a high number if health problems affected your work a great deal.

   Consider only how much **health problems** affected productivity **while you were working.**

   Health problems had no effect on my daily activities — Health problems completely prevented me from doing my daily activities

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

6. During the past seven days, not including today, how much did your health problems affect your ability to do your regular, daily, non-work activities?
   "Regular activities" are defined as the usual activities you do, such as work around the house, shopping, childcare, exercising, studying, etc. Think about times you were limited in the amount or kind of activities you could do and times you accomplished less than you would like. If health problems affected your activities only a little, choose a low number. Choose a high number if health problems affected your activities a great deal.

   Consider only how much **health problems** affected your ability to do your regular, daily, non-work activities.

   Health problems had no effect on my daily activities — Health problems completely prevented me from doing my daily activities

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

Reilly MC, Zbrozek AS, Dukes EM. The validity and reproducibility of a work productivity and activity impairment instrument. PharamcoEconomics 1993; 4(5):353-65

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Functional Goals

Which, if any, activities are limited due to pain? (Check all that apply)

- ☐ walking
- ☐ exercise
- ☐ sleep
- ☐ sexual activity
- ☐ work
- ☐ housework
- ☐ relationships (family, friends)
- ☐ self-care (bathing, dressing, eating)
- ☐ Other:______________________________

Which activites are most important to you?

Provider: Work with patient to determine realistic goals and on an action plan to achieve these goals.

Activity	Goal	Action

Reassess improvement/decline in function at regular intervals.

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Table A. Considerations for Common Coexisting Conditions			
Assessment Domains	**Common Conditions**	**Selected Assessment Tools**	**Selected Additional Resources**
Mental Health	Anxiety	General Anxiety Disorder-7 (GAD-7)	www.aafp.org/afp/2015/0501/p617.html https://adaa.org/sites/default/files/GAD-7_Anxiety-updated_0.pdf
	Depression	Patient Health Questionnaire-9 (PHQ-9)	www.aafp.org/afp/2018/1015/p508.html www.aafp.org/dam/AAFP/documents/patient_care/pain_management/mental-health-assessment.pdf
	Substance Use/ Substance Used Disorders (SUD)	Alcohol, Smoking and Substance Involvement Screening Test (ASSIST)	ASSIST: www.who.int/substance_abuse/activities/assist_test/en/ NIDA Drug Screening Tool: www.drugabuse.gov/sites/default/files/pdf/screening_qr.pdf SBIRT (screening, brief intervention, and referral to treatment for substance use): www.sbirt.care/tools.aspx
	Trauma and/or PTSD	Post-traumatic Stress Disorder (PTSD) Checklist for DSM-5 (PCL-5)	www.aafp.org/afp/2013/1215/p827.html
Functional Limitations	Reduced QoL	See tools included in this Toolkit	https://journals.lww.com/anesthesia-analgesia/fulltext/2007/03000/a_primer_on_health_related_quality_of_life_in.49.aspx
	Functional limitations	See tools included in this Toolkit	
	Disability	WPAQ	https://aneskey.com/disability-evaluation-of-patients-with-chronic-pain/
Emotional Health	Stigma	N/A	www.hhs.gov/sites/default/files/pmtf-fact-sheet-stigma_508-2019-08-13.pdf
Pain Related Psychological Factors	Pain Catastrophizing	Pain Catastrophizing Scale (PCS)	www.practicalpainmanagement.com/pain/other/co-morbidities/pain-catastrophizing-what-clinicians-need-know https://sullivan-painresearch.mcgill.ca/pdf/pcs/PCSManual_English.pdf
	Kinesiophobia	Tampa Scale for Kinesiophobia	https://bjsm.bmj.com/content/53/9/554 www.tac.vic.gov.au/__data/assets/pdf_file/0004/27454/tampa_scale_kinesiophobia.pdf
	Chemical coping/ self-medication	N/A	https://pubs.niaaa.nih.gov/publications/PainFactsheet/Pain_Alcohol.pdf

Table B. Selected Condition Specific Functional Assessment Tools	
Knee Injury and Osteoarthritis Outcome Score (KOOS)	Tool: www.koos.nu/koos-english.pdf Scoring: www.koos.nu/KOOSscoring2012.pdf
West Haven Yale Multidimensional Pain Inventory (WHYMPI/MPI)	Tool: www.va.gov/PAINMANAGEMENT/WHYMPI_MPI.asp
Quick Disabilities of Arm, Shoulder and Hand (QuickDASH)	Tool: dash.iwh.on.ca/about-quickdash
Hip Disability and Osteoarthritis Outcome Score (HOOS)	Tool: www.koos.nu/

PAIN MANAGEMENT | Section 3

OVERVIEW

Pain management is determined primarily by whether pain is acute or chronic. Management of chronic pain should be individualized, patient-centered, and based on shared decision making and goals of treatment. Considerations for determining acute versus chronic pain can be found in the table on the next page.

Pharmacological treatment of pain should use the lowest effective dosage for pain relief and functional improvement. Both pharmacological and non-pharmacologic treatments have shown to be effective in managing pain. Evidence for the effectiveness of various treatments for chronic pain can be found in the table on the next page.

Management of chronic pain is covered by several different guidelines and systematic reviews with varying recommendations based on location and type of chronic pain.

In response to the opioid public health crisis, new guidance recommends non-pharmacologic and non-opioids as first-line therapies, when clinically appropriate.[1] If an opioid is considered for treatment, the lowest effective dosage for pain relief and functional improvement should be used.

Guidelines and Evidence Reviews

The following are recent evidence reviews and evidence-based guidelines for primary care physicians and other clinicians in addressing acute and chronic pain:

- The American College of Physicians (ACP) and the AFFP jointly developed the clinical practice guideline, Management of Acute Musculoskeletal Pain, which includes evidence-based recommendations for pharmacologic and non-pharmacologic management of acute pain resulting from musculoskeletal injuries.[2]
- The ACP developed, and the AAFP endorsed, the clinical practice guideline, Low Back Pain, which includes evidence-based recommendations for management of acute and chronic low back pain with an emphasis on non-pharmacologic and non-opioid therapies as first-line treatment.[3]
- The U.S. Department of Health and Human Services' Pain Management Best Practices Inter-Agency Task Force developed the report, Pain Management Best Practices, which is a comprehensive document outlining different approaches for the treatment of pain.[4]

Two evidence reviews developed by the Agency for Healthcare Research and Quality (AHRQ) summarize and provide assessment of the quality of current evidence on pharmacologic and non-pharmacologic treatment of chronic pain:

- Nonopioid Pharmacologic Treatments for Chronic Pain[5]
- Noninvasive Treatments for Low Back Pain[6]

Chronic Pain Management Tools

The table below includes selected tools for chronic pain management in this toolkit, along with links and reference to additional tools.

Chronic Pain Management Tools in Toolkit		
Name	**Description**	**Location**
Table C. Management Considerations Based on Pain Type: Acute Versus Chronic Pain	Overview of background and management considerations for acute versus chronic pain	Jump to table in toolkit.
Table D. Chronic Pain Treatments Overview	Overview of pharmacologic and non-pharmacologic treatment options for chronic pain with evidence-based indications	Jump to table in toolkit.
Chronic Pain Patient Handout	Two-page patient handout lists chronic pain treatment options and provides information on treatment goals	Jump to tool in toolkit.
Additional Chronic Pain Management Tools		
Pain Self-Management Strategies	Self-management resource guide for patients with chronic pain	https://health.ucdavis.edu/nursing/Research/INQRI_Grant/Long-Term%20Non-Surgery%20Pain%20Management%20Strategies%20Booklet%20WebFINAL082311.pdf
Complementary Health Approaches for Chronic Pain: What the Science Says	Current evidence on complementary health products and practices for managing chronic pain	www.nccih.nih.gov/health/providers/digest/complementary-health-approaches-for-chronic-pain-science

References

1. Dowell D, Haegerich TM, Chou R. CDC guideline for prescribing opioids for chronic pain – United States, 2016. *MMWR Recomm Rep.* 2016;65(1):1-49.
2. American Academy of Family Physicians. Management of acute musculoskeletal pain. Clinical Practice Guideline. Accessed January 8, 2021. www.aafp.org/family-physician/patient-care/clinical-recommendations/all-clinical-recommendations/musculoskeletal-pain.html
3. American Academy of Family Physicians. Low back pain. Clinical Practice Guideline. Accessed January 8, 2021. www.aafp.org/family-physician/patient-care/clinical-recommendations/all-clinical-recommendations/back-pain.html
4. Pain Management Best Practices Inter-Agency Task Force. Pain management best practices. U.S. Department of Health and Human Services. Accessed January 8, 2021. www.hhs.gov/sites/default/files/pain-mgmt-best-practices-draft-final-report-05062019.pdf
5. Agency for Healthcare Research and Quality. Nonopioid pharmacologic treatments for chronic pain. Accessed January 8, 2021. https://effectivehealthcare.ahrq.gov/sites/default/files/pdf/nonopioid-chronic-pain.pdf
6. Agency for Healthcare Research and Quality. Noninvasive treatments for low back pain. Accessed January 8, 2021. https://effectivehealthcare.ahrq.gov/sites/default/files/pdf/back-pain-treatment_research.pdf

Table C. Management Considerations Based on Pain Type: Acute vs. Chronic Pain		
Characteristics	**Acute Pain**	**Chronic Pain**
Duration	Normal healing duration; <3-6 months	Prolonged duration >6 months
Function	Physiologic (protective)	Pathologic (non-protective)
Cause	Acute illness, injury, trauma, surgery or other medical procedure	Injury, chronic illness, cancer, may have no indefinable pathology
Characteristics	Usually nociceptive; sharp, localized, sudden/gradual onset	Usually a combination of nociceptive and neuropathic, dull, aching, generalized, persistent
Treatment options (non-inclusive list no in any particular order)	Nonsteroidal anti-inflammatory drugs (NSAIDS), acetaminophen, opioids, nerve bocks, ketamine, muscle relaxants, pain-reducing modalities (e.g., immobilization, heat/cold, and elevation), graded exercise of the affected body area, physical therapy. Opioids are not recommended for acute low back pain.	Non-opioid analgesics, physical therapy, cognitive behavioral therapy, rehabilitation, exercise, integrative medical therapies (e.g., yoga, relaxation, tai chi, massage, and acupuncture), opioids on a case-by-case basis
Goals of treatment	Pain Resolution + Resolve underlying cause: - Facilitate recovery - Reduce pain - Minimize side effects - Prevent chronic pain	Pain Control + Restore function: - Restore function (physical, emotional, social) - Decrease pain (e.g., treat underlying cause, minimize medication use) - Correct secondary consequences (e.g., maladaptive behavior)

Treatment Options for Chronic Pain

This table outlines different classes of medications and non-pharmacological treatments with indications for use in chronic pain. While pain management is a major issue in the United States, the evidence is still limited, especially for non-pharmacologic treatments. Long-term studies for almost all treatments are lacking. Please note that this table is provided as an overview and should not be considered as a guideline for specific management.

Table D. Pharmacologic Treatments			
Class of Medication	**Indications[a]**	**Magnitude of Benefit[b]**	
		PAIN	**FUNCTION**
NSAIDs (topical or oral)	Low back pain, asteoarthritis, inflammatory arthritis, acute musculoskeletal (MSK) pain	Small to noderate	None to small
Acetaminophen	Acute MSK pain	Small	None
Antidepessants	Diabetic peripheral neuropathy, fibromyalgia	Small	None
Anticonvulsants	Diabetic peripheral neuropathy, fibromyalgia	Small to moderate	None (neuropathic pain) Small (fibromyalgia)
Opioids	Acute MSK pain, chronic pain, neuropathy	Small to no benefit[c]	Small to no benefit[c]
Non-Pharmacologic Treatments			
Therapy	**Indications[a]**	**Magnitude of Benefit[b]**	
		PAIN	**FUNCTION**
Exercise	Low back pain, neck pain, knee and hip osteoarthritis, fibromyalgia	Small to moderate	Small to moderate
Cognitive Behavioral Therapy	Low back pain, fibromyalgia	Small to moderate	Small to moderate
Massage/Acupuncture/ Spinal Manipulation	Low back pain, fibromyalgia, chronic headache, neck pain	Small to moderate	Small to moderate
Yoga/Tai Chi	Low back pain, fibromyalgia	Small	Small (fibromyalgia) Moderate (low back pain)

a. Summary of treatments and indications pulled from recent guidelines and evidence reviews as outlined above (references 3, 4, 6, 7)

b. Magnitude of benefit compared to harms of treatment; will vary based on type/location of pain

c. Not considered first line treatment for most indications

PROMOTING SAFER AND MORE EFFECTIVE PAIN MANAGEMENT

UNDERSTANDING PRESCRIPTION OPIOIDS

Opioids are natural or synthetic chemicals that relieve pain by binding to receptors in your brain or body to reduce the intensity of pain signals reaching the brain. Opioid pain medications are sometimes prescribed by doctors to treat pain. Common types include:

- Hydrocodone (e.g., Vicodin)
- Oxycodone (e.g., OxyContin)
- Oxymorphone (e.g., Opana), and
- Morphine

Opioids can have serious risks including addiction and death from overdose.

1 in 4

As many as 1 in 4 people receiving prescription opioids long term in a primary care setting struggles with addiction.

4.3 million

Americans engaged in non-medical use of opioid pain medication in the last month.[1]

[1] National Survey on Drug Use and Health (NSDUH), 2014

OPIOIDS AND CHRONIC PAIN

Many Americans suffer from chronic pain, a major public health concern in the United States. Patients with chronic pain deserve safe and effective pain management. At the same time, our country is in the midst of a prescription opioid overdose epidemic.

- The amount of opioids prescribed and sold in the US quadrupled since 1999, but the overall amount of pain reported hasn't changed.
- There is insufficient evidence that prescription opioids control chronic pain effectively over the long term, and there is evidence that other treatments can be effective with less harm.

PRESCRIPTION OPIOID OVERDOSE IS AN EPIDEMIC IN THE US

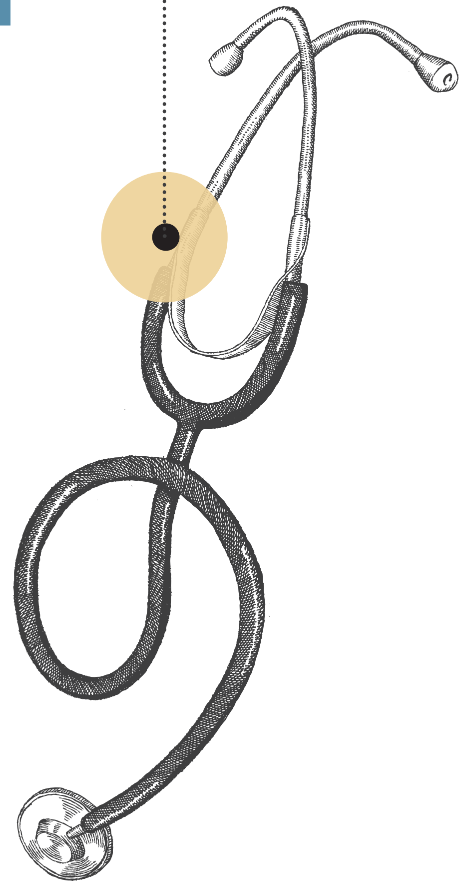
U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

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

IMPROVE DOCTOR AND PATIENT COMMUNICATION

The Centers for Disease Control and Prevention's (CDC) *Guideline for Prescribing Opioids for Chronic Pain* provides recommendations to primary care doctors about the appropriate prescribing of opioid pain medications to improve pain management and patient safety:

- It helps primary care doctors determine when to start or continue opioids for chronic pain
- It gives guidance about medication dose and duration, and on following up with patients and discontinuing medication if needed
- It helps doctors assess the risks and benefits of using opioids



Doctors and patients should talk about:

- How opioids can reduce pain during short-term use, yet there is not enough evidence that opioids control chronic pain effectively long term
- Nonopioid treatments (such as exercise, nonopioid medications, and cognitive behavioral therapy) that can be effective with less harm
- Importance of regular follow-up
- Precautions that can be taken to decrease risks including checking drug monitoring databases, conducting urine drug testing, and prescribing naloxone if needed to prevent fatal overdose
- Protecting your family and friends by storing opioids in a secure, locked location and safely disposing unused opioids

GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN

CDC developed the *Guideline for Prescribing Opioids for Chronic Pain* to:

- Help reduce misuse, abuse, and overdose from opioids
- Improve communication between primary care doctors and patients about the risks and benefits of opioid therapy for chronic pain

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

OPIOID PRESCRIBING | Section 4

OVERVIEW

While opioids are not recommended for first-line treatment of chronic pain, there are instances when opioids should be considered based on patient preferences. These include effects of pain on function and quality of life, tolerance of other pharmacologic treatments, and availability of alternative therapy with a favorable balance of benefits to harms.

Before initiating opioid therapy, physicians and other clinicians should document the patient's medical history and conduct a physical examination and appropriate testing, including an assessment of risk of substance abuse, misuse, or addiction. Clinicians and patients should regard initial treatment with opioids as a therapeutic trial to determine whether the treatment is appropriate. The prescribing of opioids should be considered in the context of shared decision making with clear goals of improving function.

Some general recommendations for initiating opioid treatment for chronic, noncancer pain includes:

- Avoiding prescribing opioids on the first visit
- Conducting a thorough risk assessment
- Creating a care plan that includes functional goals
- Discussing the risks versus benefit of opioids
- Obtaining a signed informed consent and treatment agreement
- Discussing and planning for dose escalation and reduction
- Considering prescribing a naloxone rescue kit to a family member, loved one, or caregiver
- Anticipating, identifying, and treating common opioid-associated adverse effects
- Recommending co-interventions, such as psychological therapy, functional restoration, interdisciplinary therapy, and other adjunctive non-opioid therapies
- Counseling patients on the effects of opioids on other aspects of life, such as driving and work safety

Guidelines for Opioid Prescribing

In response to the opioid epidemic, the Centers for Disease Control and Prevention (CDC) published guidance for primary care clinicians for opioid prescribing.[1] These guidelines were based on limited evidence with many recommendations relying solely on expert opinion. As such, these recommendations are considered more good practice, and the AAFP cautions in their use without further evidence.[2]

The guideline recommendations summarized by the AAFP are as follows:[2]

- "Nonpharmacologic and nonopioid pharmacologic therapies are preferred for chronic pain. Opioid therapy should be considered only when benefits for both pain and function are anticipated to outweigh the risks."
- "When starting opioid therapy for chronic pain, the lowest effective dose of immediate-release opioids should be prescribed instead of extended-release/long acting (ER/LA) opioids."
- Benefits and risks should be routinely assessed, particularly before increasing dosages of opioids, with plans for discontinuing or tapering developed.
- "Risk factors for opioid-related harms should be evaluated prior to initiation and periodically during treatment. Strategies to mitigate risk should be developed, including offering naloxone to those at increased risk for overdose."
- "A patient's history of controlled substance prescriptions using a prescription drug monitoring program (PDMP). PDMP data should be reviewed when starting opioid therapy and periodically during treatment."

Risk Mitigation

The guideline recommendations found limited evidence of the benefits and harms of risk mitigation strategies for opioid use. However, all patients taking opioids for a prolonged period of time should be monitored to ensure these medications are still helpful and being taken appropriately. Physicians and other clinicians should be careful to avoid stigmatizing language and keep all processes centered on the patient. To ensure this monitoring is consistent, at every visit, patients should be:[1]

- Evaluated for progress toward functional goals. Strong consideration should be given to tapering and discontinuing the use of opioids in the absence of functional improvement when using the medications.
- Assessed for appropriate medication use and problematic medication behavior.

It is also recommended that clinicians periodically conduct a risk mitigation assessment of patients' opioid therapy at least every three months. This assessment includes:[2]

- Developing an opioid management plan
- Providing patient education
- Screening urine for drugs
- Reviewing PDMP data
- Counting pills
- Scheduling more frequent monitoring visits

Opioid Prescribing Tools

The table below includes opioid prescribing tools and resources included in this toolkit, along with additional resources for patients, physicians, and other clinicians.

Opioid Prescribing Tools and Resources in Toolkit		
Resources	**Description**	**Location**
Risk Assessment and Monitoring Checklist	A checklist for physicians and other clinicians to document risk assessment and monitor red flags for opioid use (i.e., opioid risk, alcohol use, substance use), as well as review PDMP data, and screen urine for drugs	Jump to tool in toolkit.
Opioid Risk Tool (ORT)	Brief, self-reporting screening tool designed for adult patients in primary care settings to assess risk for opioid abuse Patients categorized as high risk are at an increased likelihood of future abusive drug-related behavior. Takes about one minute to complete	Jump to tool in toolkit.
Opioid Conversion Table	Table and conversion chart for calculating total daily doses of opioids in morphine milligram equivalents to facilitate appropriate prescribing and/or tapering	Jump to tool in toolkit.
Patient Agreement	Sample patient agreement form used for patients beginning long-term treatment with opioid analgesics or other controlled substances Statements in the agreement help patients understand their role and responsibilities regarding their treatment (e.g., how to obtain refills, conditions of medication use), as well as the conditions in which treatment may be terminated, and the responsibilities of the health care provider. Helps facilitate communication between patients and the health care team to resolve questions or concerns before initiation of long-term treatment	Jump to tool in toolkit.
Tapering Resource and Tapering Worksheet	Resources and recommendations for tapering of opioid medications, including a worksheet to record and manage tapering doses	Jump to tool in toolkit.
Urine Drug Testing Resource	Brief overview for urine drug testing, including a table outlining the tests used and potential false positives	Jump to tool in toolkit.
Patient Education Resource	Referral resource for patients detailing important aspects of opioids for patients to know, including risks and side effects	Jump to tool in toolkit.

Additional Opioids Prescribing Tools and Resources		
Resources	**Description**	**Location**
Patient Communication Resource	Communication resource for patients prescribed opioids to help communicate with physicians about medications Six questions/conversation starters are included	www.oregonpainguidance.org/wp-content/uploads/2020/06/18.-CDC-Handout-Conversation-Starter-If-You-Are-Prescribed-Opioids-compressed.pdf
Words That Work for Opioid Conversations	Resource for physicians offering suggested principles and language to use when communicating with patients about safe management of opioid use	https://knowledgeplus.nejm.org/wp-content/uploads/2020/03/words_that_work.jpg
Current Opioid Misuse Measure (COMM)™	Patient self-assessment to monitor patients experiencing chronic pain who are in opioid therapy	http://mytopcare.org/wp-content/uploads/2013/05/COMM.pdf
Training and Technical Assistance	Opioid Response Network provides technical assistance for prevention, treatment, and recovery for opioid use disorders (OUDs)	www.aafp.org/family-physician/patient-care/care-resources/pain-management/opioid-response-network.html
Opioid Use Disorder Training	Free medication-assisted treatment (MAT)-waiver training courses and peer-support resources	https://pcssnow.org/
Opioid Overdose Guideline Resources	Training videos and courses to aid with tapering and other questions	www.cdc.gov/drugoverdose/prescribing/resources.html
Tapering Resource	Evidence-based best practices for primary care physicians and other clinicians for initiating and managing of tapering off opioids for patients	https://nam.edu/best-practices-research-gaps-and-future-priorities-to-support-tapering-patients-on-long-term-opioid-therapy-for-chronic-non-cancer-pain-in-outpatient-settings/
Opioid Use Disorder Practice Manual	Guide for implementing MAT in family medicine practices	www.aafp.org/dam/AAFP/documents/patient_care/pain_management/OUD-Chronic-Condition.pdf

References

1. Dowell D, Haegerich TM, Chou R. CDC guideline for prescribing opioids for chronic pain - United States, 2016. *MMWR Recomm Rep.* 2016;65(1):1-49.
2. American Academy of Family Physicians. Opioid prescribing for chronic pain. Accessed January 11, 2021. www.aafp.org/family-physician/patient-care/clinical-recommendations/all-clinical-recommendations/opioid-prescribing.html

Risk Assessment and Monitoring Checklist

Prior to initiation of opioid therapy, it is imperative to assess the patient's risk for misuse/abuse. This toolkit provides resources to identify possible red flags for opioid misuse, links to find your state's prescription drug monitoring program (PDMP), opioid risk assessment, and mental health assessment tools. Use the table below to track completion and results for each potential risk item.

Document completion, results, and any action needed		
Tool/Test	**Completed (Results)**	**Additional action or comments**
Opioid Risk Tool (ORT) or Another Tool		
Alcohol Use		
Other Substance/Drug Use		
Mental Health Screening		
State PDMP		
Urine Drug Test		

Additional resources: Use the link below to find your state's PDMP and other r esources.

Links to State PDMPs

Opioid Risk Tool

		Item Score if Female	Item Score if Male
1. Family History of Substance Abuse	Alcohol	☐ 1	☐ 3
	Illegal Drugs	☐ 2	☐ 3
	Prescription Drugs	☐ 4	☐ 4
2. Personal History of Substance Abuse	Alcohol	☐ 3	☐ 3
	Illegal Drugs	☐ 4	☐ 4
	Prescription Drugs	☐ 5	☐ 5
3. Age *(Mark box if 16-45)*		☐ 1	☐ 1
4. History of Preadolescent Sexual Abuse		☐ 3	☐ 0
5. Psychological Disease	Attention Deficit Disorder, Obessive Compulsive Disorder, Bipolar, Schizophrenia	☐ 2	☐ 2
	Depression	☐ 1	☐ 1
	TOTAL	______	______

Total Score Risk Category
Low Risk 0-3
Moderate Risk 4-7
High Risk ≥8

AAFP

Used with permission.
Webster LR. Predicting abberrant behaviors in opioid-treated patients: Preliminary validation of the opioid risk tool. Pain Management. 2005;6(6):432-442.
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Opioid Conversion Table

Chronic Pain Management Toolkit

Calculating total daily doses of opioids is important to appropriately and effectively prescribe, manage, and taper opioid medications. There are a number of conversion charts available, so caution is needed when performing calculations. As with all medications, consulting the package insert for dose titration instructions and safety information is recommended. Treatment should be individualized and begin with lower doses and gradual increases to manage pain.

Once the dose is calculated, the new opioid should not be prescribed at the equivalent dose. The starting dose should be reduced by 25-50% to avoid unintentional overdose due to incomplete cross-tolerance and individual variations in opioid pharmacokinetics. This dose can then be gradually increased as needed.

To calculate the total daily dose:

1. Determine the total daily doses of current opioid medications (consult patient history, electronic health record, and PDMP as necessary).
2. Convert each dose into morphine milligram equivalents (MMEs) by multiplying the dose by the conversion factor.
3. If more than one opioid medication, add together.
4. Determine equivalent daily dose of new opioid by dividing the calculated MMEs of current opioid by new opioid's conversion factor. Reduce this amount by 25-50% and then divide into appropriate intervals.

Calculating Morphine Milligram Equivalents (MME)*

Opioid	Conversion Factor (convert to MMEs)	Duration (hours)	Dose Equivalent Morphine Sulfate (30 mg)
Codeine	0.15	4-6	200 mg
Fentanyl (mcg/hr)	2.4		12.5 mcg/hr**
Hydrocodone	1	3-6	30 mg
Hydromorphone	4	4-5	7.5 mg
Morphine	1	3-6	30 mg
Oxycodone	1.5	4-6	20 mg
Oxymorphone	3	3-6	10 mg
Methadone†			
1-20 mg/d	4		7.5 mg
21-40 mg/d	8		3.75 mg
41-60 mg/d	10		3 mg
$\geq$61 mg/d	12		2.5 mg

**The dose conversions listed above are an estimate and cannot account for an individual patient's genetics and pharmacokinetics.*
***Fentanyl is dosed in microgram per hour (mcg/hr) instead of milligram per day (mg/day), and absorption is affected by heat and other factors.*
†Methadone conversion factors increase with increasing dose.

Sample Case

Your patient is a 45-year-old man who is taking oxymorphone 10 mg four times a day for chronic pain. You have determined he is an appropriate candidate for a long-acting regimen and decide to convert him to extended release oxycodone.

1. Total daily dose of oxymorphone → 10 mg X 4 times/day = 40 mg/day
2. Convert to MMEs (oxymorphone conversion factor = 3) → 40 X 3 = 120 MME
3. Determine MMEs of oxycodone (oxycodone conversion factor = 1.5) → 120/1.5 = 80 mg/day
4. Decrease dose by 25% → 25% of 80 = 20 → 80 – 20 = 60
5. Divide by interval (q 12 hours) → 60/2 = 30

The starting dose of extended release oxycodone is 30 mg every 12 hours (q 12h).

Additional Resource

CDC Opioid Conversion Guide
https://www.cdc.gov/drugoverdose/pdf/calculating_total_daily_dose-a.pdf

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Opioid Medication for Chronic Pain Agreement

This is an agreement between ____________________________ (patient) and Dr. _____________________________.

I am being treated with opioid medication for my chronic pain, which I understand may not completely rid me of my pain, but will decrease it enough that I can be more active. I understand that, because this medication has risks and side effects, my doctor needs to monitor my treatment closely in order to keep me safe. I acknowledge my treatment plan may change over time to meet my functional goals, and that my doctor will discuss the risks of my medicine, the dose, and frequency of the medication, as well as any changes that occur during my treatment. In addition, I agree to the following statements:

Patient Initials	Please read the statements below and initial in the box at the left.
	I understand that the medication may be stopped or changed to an alternative therapy if it does not help me meet my functional goals.
	To reduce risk, I will take medication as prescribed. I will not take more pills or take them more frequently than prescribed.
	I will inform my doctor of all side effects I experience.
	To reduce risk, I will not take sedatives, alcohol, or illegal drugs while taking this medication.
	I will submit to urine and/or blood tests to assist in monitoring my treatment.
	I understand that my doctor or his/her staff may check the state prescription drug database to prevent against overlapping prescriptions.
	I will receive my prescription for this medication only from Dr. ___________________________.
	I will fill this prescription at only one pharmacy. (Fill in pharmacy information below.)
	I will keep my medication in a safe place. I understand if my medicine is lost, damaged, or stolen, it will not be replaced.
	I will do my best to keep all scheduled follow-up appointments. I understand that I may not receive a prescrption refill if I miss my appointment.

Medication name, dose, frequency ____

Pharmacy name ____

Pharmacy phone number ____

By signing below, we agree that we are comfortable with this agreement and our responsibilities.

____ ____________________

Patient signature *Date*

____ ____________________

Physician signature *Date*

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Tapering Resource

Chronic Pain Management Toolkit

The objective of a taper is to prevent significant withdrawal symptoms while reducing or discontinuing opiates.

Potential Reasons to Taper Opioids

- Patient request
- Lack of improvement in pain and/or function
- Nonadherence to treatment plan
- Signs of misuse and/or abuse
- Serious adverse events

Recommendations for Tapering

There is no evidence to support one tapering strategy over another. Any tapering protocol should be individualized as some patients may tolerate a more rapid taper, while others will require a more gradual decrease in medication. In general, the longer the patient has been on opiates, the more conservative (slow) the taper will need to be to minimize or avoid withdrawal symptoms. It is important to remember that tapering is unidirectional, and should not be reversed. However, tapering can be slowed or paused if needed. A starting point for tapering is to decrease the dose 10-20% every 1-2 weeks and adjust the rate according to patient response. Once the patient has reached about 1/3 of the original dose, smaller decreases of 5% every 2-3 weeks may be necessary.

For individuals on high dose or multiple opioids, switching to a single long-acting opioid or methadone can be considered (see conversion table). Once stable on the long-acting regimen, proceed with a slow taper, 10-20% every 1-2 weeks, followed by an even slower taper once 1/3 of the original dose is reached. A worksheet to record and track doses for tapering is provided in this toolkit.

Caution patients that they may quickly lose their tolerance to opioids, so they are at risk for overdose if they abruptly resume their original dose.

It is important to note that pregnant patients on chronic opiate therapy should not be weaned due to risks to both the mother and the fetus. Patients with signs of misuse and/or abuse who are pregnant should be considered for MAT.

Management of Withdrawal

Physical withdrawal symptoms generally resolve 5-10 days after dose reduction/cessation, while psychological symptoms may take longer. Not all patients will experience the same withdrawal symptoms. The goal is to minimize these symptoms with a gradual taper. There are additional treatments that may help with specific symptoms (see chart below).

Additional Resources

CDC Tapering Pocket Guide
http://www.cdc.gov/drugoverdose/pdf/clinical_pocket_guide_tapering-a.pdf

VA Tapering Fact Sheet
http://www.healthquality.va.gov/guidelines/Pain/cot/OpioidTaperingFactSheet-23May2013v1.pdf

Washington State Guideline
http://www.agencymeddirectors.wa.gov/Files/2015AMDGOpioidGuideline.pdf

Stage	Grade*	Physical Signs and Symptoms	Treatment Options
Early Withdrawal (8-24 hours after last use)	1	Lacrimation, Rhinorrhea, Diaphoresis, Yawning, Restlessness, Insomnia	- Antihistamines or trazodone for insomnia/restlessness
	2	Piloerection, Myalgias, Arthralgias, Abdominal pain	- NSAIDs/Acetaminophen for muscle and joint pain - Loperamide/bismuth subsalicylate for abdominal cramping
Fully Developed Withdrawal (1-3 days after last use)	3	Tachycardia, Hypertension, Tachypnea, Fever, Anorexia, Nausea	- Clonidine for autonomic symptoms - Ondasetron/H2 blockers for nausea
	4	Diarrhea, Vomiting, Dehydration, Hypotension	- Loperamide for diarrhea - Oral rehydrating solutions
Post Acute Withdrawal Syndrome (PAWS)		Mood swings, Anxiety, Irritability, Anhedonia, Fatigue, Poor concentration, Insomnia	- Recovery services - Relapse prevention strategies

**The severity of opioid withdrawal is defined by symptoms and described by four categories or grades.*

AAFP

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Opioid Tapering Worksheet

Current Dose: ____

Target Dose: ____

Timeline: ____

Medication: ____

Date	Dose	Frequency	# of weeks	Total dose/day
	mg			mg
	mg			mg
	mg			mg
	mg			mg
	mg			mg
	mg			mg
	mg			mg
	mg			mg
	mg			mg
	mg			mg
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AAFP

HOP 20012003

Urine Drug Testing

Chronic Pain Management Toolkit

(see chart on next page)

Most guidelines recommend screening patients to determine risks of drug misuse and abuse and to mitigate those risks as much as possible. Unfortunately, there are no risk assessment tools that have been validated in multiple settings and populations. Screening is typically based on risk factors that can be identified through a thorough patient history, the use of prescription drug monitoring programs (PDMPs), the Opioid Risk Tool (provided in this toolkit), and, on occasion, drug screening. However, it is important to standardize testing as cited risk factors (e.g., sociodemographic factors, psychological comorbidity, substance use disorders, etc.) might unfairly impact certain vulnerable populations. Involvement of the whole health care team and full disclosure and discussion of the screening protocol with patients is central to providing patient-centered and comprehensive pain management. Prior to drug testing, physicians should inform the patient of the reason(s) for testing, how often they will be tested, and what the results might mean. This gives patients an opportunity to disclose any additional drug or substance use which may help with identification of false positives and appropriate interpretation of test results.

Physicians must understand the limitations of the urine and confirmatory tests available, including what substances are detected by a particular test, and the reasons for false-positive and false-negative tests. Changes in prescribing for a particular patient should not be based on the result of one abnormal screening test, but should only occur after looking at all available monitoring tools, as well as repeating the drug screen with the most specific test available.

Interpretation of Results

Following initial testing, physicians should request confirmatory testing for the following results:

- Negative for the opioid(s) prescribed
- Positive for drugs not prescribed
- Positive for other substances such as alcohol, amphetamines, or cocaine (or metabolites)

Additional Resources

Washington State Medical Directors Guideline
http://www.agencymeddirectors.wa.gov/Files/2015AMDGOpioidGuideline.pdf

SAMHSA Guideline for Drug Testing
https://store.samhsa.gov/shin/content/SMA12-4668/SMA12-4668.pdf

Urine Drug Testing, page 2

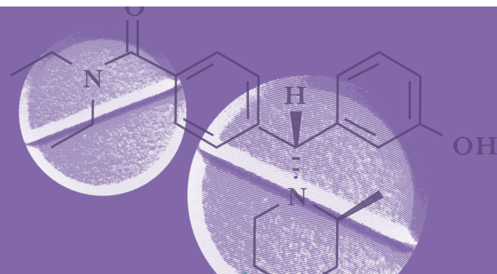
Urine Drug Testing for Commonly Used and Misused Drugs			
OPIATES			
Drug	**Detection Time**	**Test Order**	**False Positive**
Codeine	1-3 days	Opiates Immunoassay* Confirmatory test: GC/MS or LC/MS/MS**	Dextromethorpan, diphenhydramine, heroin, poppy seeds, quinine, quinolones, rifampin, verapamil, other opiates
Morphine	1-3 days	Opiates Immunoassay* Confirmatory test: GC/MS or LC/MS/MS	Dextromethorpan, diphenhydramine, heroin, poppy seeds, quinine, quinolones, rifampin, verapamil, other opiates
Fentanyl	1-3 days	GC/MS or LC/MS/MS Fentanyl	n/a
Meripidine	1-3 days	GC/MS or LC/MS/MS Meperidine	n/a
Methadone	3-7 days	Methadone Immunoassay Confirmatory test: GC/MS or LC/MS/MS Methadone	Diphenhydramine, clomipramine
Hydrocodone	1-3 days	Opiates immunoassay Confirmatory test: GC/MS or LC/MS/MS	Dextromethorpan, diphenhydramine, heroin, poppy seeds, quinine, quinolones, rifampin, verapamil, other opiates
Hydromorphone	1-3 days	Opiates immunoassay Confirmatory test: GC/MS or LC/MS/MS	Dextromethorpan, diphenhydramine, heroin, poppy seeds, quinine, quinolones, rifampin, verapamil, other opiates
Oxycodone	1-3 days	Opiates immunoassay Confirmatory test: GC/MS or LC/MS/MS	Dextromethorpan, diphenhydramine, heroin, poppy seeds, quinine, quinolones, rifampin, verapamil, other opiates
Oxymorphone	1-3 days	Opiates immunoassay Confirmatory test: GC/MS or LC/MS/MS	Dextromethorpan, diphenhydramine, heroin, poppy seeds, quinine, quinolones, rifampin, verapamil, other opiates
ADDITIONAL SUBSTANCES			
Drug	**Detection Time**	**Test Order**	**False Positive**
Alcohol	Up to 8 hours	Alcohol	n/a
Amphetamines	2-3 days	Amphetamines, methamphetamines, or MDMA immunoassay	Ephedrine, pseudoephedrine, selegiline
Barbiturates	1-3 days short acting Up to 30 days long-acting	Barbiturates Immunoassay	NSAIDs
Benzodiazeph-ines	1-3 days short acting Up to 30 days long-acting	Benzodiazepines Immunoassay*** Confirmatory test: GC/MS or LC/MS/MS Alprazolam, Diazepam, Clonazepam, Lorazepam, etc.	Sertraline, oxaprozin
Cocaine	2-4 days	Cocaine metabolites immunoassay	Coca leaf tea
Marijuana	2-4 days Up to 30 days with chronic use	Cannabinoids (THC) Immunoassay	NSAIDs, proton pump inhibitors, food containing hemp, efavirenz

**Opiates Immunoassay – Confirmatory test required to determine which opiate is present*

*** GC/MS/LC – Gas Chromatography/Mass Spectrometry/Liquid Chromatography*

****Benzodiazepine Immunoassay – High false-negative rate; consider confirmatory testing if high suspicion of use*

PRESCRIPTION OPIOIDS: WHAT YOU NEED TO KNOW



Prescription opioids can be used to help relieve moderate-to-severe pain and are often prescribed following a surgery or injury, or for certain health conditions. These medications can be an important part of treatment but also come with serious risks. It is important to work with your health care provider to make sure you are getting the safest, most effective care.

WHAT ARE THE RISKS AND SIDE EFFECTS OF OPIOID USE?

Prescription opioids carry serious risks of addiction and overdose, especially with prolonged use. An opioid overdose, often marked by slowed breathing, can cause sudden death. The use of prescription opioids can have a number of side effects as well, even when taken as directed:

- Tolerance—meaning you might need to take more of a medication for the same pain relief
- Physical dependence—meaning you have symptoms of withdrawal when a medication is stopped
- Increased sensitivity to pain
- Constipation
- Nausea, vomiting, and dry mouth
- Sleepiness and dizziness
- Confusion
- Depression
- Low levels of testosterone that can result in lower sex drive, energy, and strength
- Itching and sweating

As many as **1 in 4** PEOPLE* receiving prescription opioids long term in a primary care setting struggles with addiction.

* Findings from one study

RISKS ARE GREATER WITH:

- History of drug misuse, substance use disorder, or overdose
- Mental health conditions (such as depression or anxiety)
- Sleep apnea
- Older age (65 years or older)
- Pregnancy

Avoid alcohol while taking prescription opioids. Also, unless specifically advised by your health care provider, medications to avoid include:

- Benzodiazepines (such as Xanax or Valium)
- Muscle relaxants (such as Soma or Flexeril)
- Hypnotics (such as Ambien or Lunesta)
- Other prescription opioids

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Centers for Disease Control and Prevention

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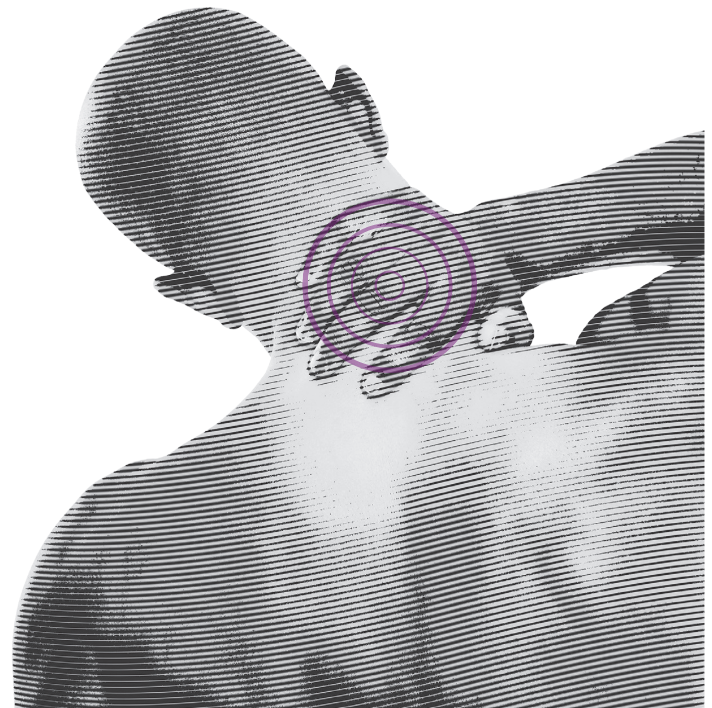
KNOW YOUR OPTIONS

Talk to your health care provider about ways to manage your pain that don't involve prescription opioids. Some of these options **may actually work better** and have fewer risks and side effects. Options may include:

- Pain relievers such as acetaminophen, ibuprofen, and naproxen
- Some medications that are also used for depression or seizures
- Physical therapy and exercise
- Cognitive behavioral therapy, a psychological, goal-directed approach, in which patients learn how to modify physical, behavioral, and emotional triggers of pain and stress.



Be Informed!

Make sure you know the name of your medication, how much and how often to take it, and its potential risks & side effects.

IF YOU ARE PRESCRIBED OPIOIDS FOR PAIN:

- Never take opioids in greater amounts or more often than prescribed.
- Follow up with your primary health care provider within ____ days.
  - Work together to create a plan on how to manage your pain.
  - Talk about ways to help manage your pain that don't involve prescription opioids.
  - Talk about any and all concerns and side effects.
- Help prevent misuse and abuse.
  - Never sell or share prescription opioids.
  - Never use another person's prescription opioids.
- Store prescription opioids in a secure place and out of reach of others (this may include visitors, children, friends, and family).
- Safely dispose of unused prescription opioids: Find your community drug take-back program or your pharmacy mail-back program, or flush them down the toilet, following guidance from the Food and Drug Administration (www.fda.gov/Drugs/ResourcesForYou).
- Visit www.cdc.gov/drugoverdose to learn about the risks of opioid abuse and overdose.
- If you believe you may be struggling with addiction, tell your health care provider and ask for guidance or call SAMHSA's National Helpline at 1-800-662-HELP.

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

OPIOID USE DISORDERS: PREVENTION, DETECTION, AND RECOVERY | Section 5

OVERVIEW

Nearly 70% of drug overdose deaths in 2018 involved opioids, with two-thirds of overdose deaths involving a synthetic opioid (excluding methadone).[1] In addition to the risk of overdose, patients prescribed opioids for chronic pain are at an increased risk for developing an opioid use disorder (OUD).[2] Safer opioid prescribing by physicians and other clinicians is effective at reducing the risk of OUD.[3]

In order to reduce the risk of a patient having an OUD, overdose, and/or death, safer opioid prescribing practices begin with:

- Becoming familiar with opioid prescribing evidence-based guidelines, as well as national, regional, and organizational policies
- Reviewing recommendations (see Sections 1-4 of this toolkit) when selecting treatment options and considering opioid treatment for chronic, noncancer pain
- Evaluating all patients using chronic opioids for problematic medication behavior or signs of an OUD
- Re-evaluating opioid prescriptions after non-fatal overdoses
- Identifying a patient's existing or former substance use disorder via clinical interview, collateral interview, medical records, and screenings prior to prescribing opioids for pain management
- Using effective patient-centered, non-stigmatizing, and non-judgmental communications; patients that exhibit drug-seeking behaviors for poorly controlled severe pain can present very similar to an active OUD

Signs of OUD

Observing patients who are taking opioids as part of their pain management plan is different from screening all patients for signs of OUD. The AAFP's clinical preventive service recommendation, Opioid Use Disorder: Screening, has information and considerations for screening asymptomatic individuals.

Whether monitoring patients currently taking opioids or selectively screening asymptomatic patients, the AAFP recommends that "clinicians must consider potential harms such as stigmatization and medicolegal consequences of labeling. Clinicians must be careful not to participate in punitive screening programs, be aware of applicable state and federal laws, and implement strategies to reduce stigmatization of their patients."[4]

A simplified, but practical way to assess for signs of an OUD is the 4Cs framework:[5]

- Impaired **C**ontrol over drug use
- **C**ompulsive use
- Continued use despite harms (**C**onsequences)
- **C**raving

Diagnostic Criteria of OUD

The Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5) "describes opioid use disorder as a problematic pattern of opioid use leading to problems or distress, with at least two of the following occurring within a 12-month period: taking larger amounts or taking drugs over a longer period than intended."[6] However, other criteria exist for helping to diagnose an OUD. The list on the next page is the DSM-5 scoring system for diagnosing an OUD.[6]

Check all that apply	DSM-5 Diagnostic Criteria for Opioid Use Disorders[6]
☐	Opioids are often taken in larger amounts or over a longer period than was intended.
☐	There is a persistent desire or unsuccessful efforts to cut down or control opioid use.
☐	A great deal of time is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects.
☐	Craving, or a strong desire or urge to use opioids.
☐	Recurrent opioid use resulting in a failure to fulfill major role obligations at work, school or home.
☐	Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids.
☐	Important social, occupational or recreational activities are given up or reduced because of opioid use.
☐	Recurrent opioid use in situations in which it is physically hazardous.
☐	Continued opioid use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the opioid.
☐	Tolerance, as defined by either of the following: (a) a need for markedly increased amounts of opioids to achieve intoxication or desired effect (b) markedly diminished effect with continued use of the same amount of an opioid
☐	Withdrawal, as manifested by either of the following: (a) the characteristic opioid withdrawal syndrome (b) the same (or closely related) substance is taken to relieve or avoid withdrawal symptoms

Total number of boxes checked: __________

Severity: Mild = 2-3 symptoms; Moderate = 4-5 symptoms; Severe = 6 or more symptoms

Other Screening Tools

Many other evidence-based screening tools and assessment resources for OUD and other substances can be found in the National Institute on Drug Abuse's Screening and Assessment Tools Chart.

Treating Patients with an OUD or in Recovery

It is not unusual to encounter patients with chronic pain who have an active OUD or are in recovery for an OUD. Managing patients who experience chronic pain and with substance use disorders is challenging. The Substance Abuse and Mental Health Services Administration's Managing Chronic Pain in Adults With or in Recovery From Substance Use Disorders is a helpful resource to help improve the prevention and treatment of substance use and mental disorders.

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