

## SUMMARY

## DECISION SUPPORT

## PATIENT EDUCATION/SELF MANAGEMENT

## GOALS

- ✓ Pain will be treated in a systematic, step-wise approach based on comprehensive assessment and planning
- ✓ Improve function; facilitate participation in rehabilitative efforts; reduce sense of suffering
- ✓ Avoid injury/complications by iteratively considering risks and benefits

## ALERTS

- ▶ Attitudes about managing pain require socioeconomic, cultural, and religious sensitivity. Therefore, the method in which care is delivered is equally as important as the care itself.
- ▶ Non-pharmacologic therapies and non-opioid therapies are preferred for managing chronic non-cancer pain.

## DIAGNOSTIC CRITERIA

See CCHCS Care Guide: Pain Management Part 1—Assessment for guidance on identifying types of pain and formulating a differential diagnosis. This care guide does not cover cancer, hospice, or palliative care pain management.

## EVALUATION/TREATMENT

[See CCHCS Care Guide: Pain Management Part 1—Assessment for details on conducting a full assessment.]

Pain is a multidimensional experience. Pain management is most effective when a biopsychosocial model and a multimodal approach are used together. Each patient has different needs and it is essential they play an active role in their own pain management program. A Stepwise Approach to Chronic Pain Management<sup>1</sup> shows the gradual progression necessary to create an individualized program for your patient.

**Step 1: Self-Management**

- Recommended first line treatment for all chronic pain patients.
- There are a host of tools and techniques available to providers that can be used to assist patients with the management of their chronic pain.
- Patients are much more likely to embrace self-management strategies if they are taught how to do things rather than being told “you need to learn to live with it.”
- The pain treatment paradigm is changing and the focus is “now on a biopsychosocial model of pain care”<sup>1</sup> (See page 4).
- After completing your patient assessment (See CCHCS Care Guide: Pain Management Part 1 — Assessment), you should be able to suggest several “self-management activities”<sup>1</sup> to help your patient start their self-management process.
- Be sure to introduce concepts such as, the mind-body connection, the importance of physical activity, sleep hygiene, healthy eating, relaxation techniques, etc. (See page 5 and Patient Education page PE-1). As providers we need to address our patient’s pain, but with a shift toward “using a whole-health approach to improve quality of life and increase functional status.”<sup>1</sup>

**Step 2: Non-Pharmacologic Therapies** (See pages 6-7)**Physical Therapy (PT)**

- Therapeutic exercise (graded and progressive with coaching)
- Range of motion, stretching and strengthening
- Gait and balance retraining
- Soft tissue, joint, and spinal mobilization
- Transcutaneous Electrical Nerve Stimulation (TENS)
- Mobility aids

**Behavioral Therapies**

- Cognitive Behavioral Therapy (CBT)
- Psychotherapy
- Dialectical Behavioral Therapy
- Support groups
- Motivational Enhancement Therapy (MET)

**Step 3: Non-Opioid Pharmacologic Therapy** (See pages 8-9 & 11-12)

- Recommended for patients who continue to have intolerable pain impacting function, despite incorporating Steps 1 and 2.
- Selections of non-opioid therapy (agent trials) should be based on type of pain (i.e., somatic vs. neuropathic pain).
- Other Agents: Corticosteroids, muscle relaxants, topical anesthetics, etc.

**Step 4: Procedures/Interventions** (See page 10)

Interventional techniques ranging from trigger point injections, intra-articular injections, spinal interventions, and surgery may be beneficial in select cases (consider them based on clinical findings and differential diagnosis).

## MONITORING

- Monitor functional status and progress toward patient goals.
- Encourage patient to complete the pain log (see Patient Education, PE-2 & 3 attachments on Lifeline) before each visit to track functional impact.
- Schedule prudent follow-up visits that are timed appropriately for the stage of treatment (i.e., ranging from 1-4 weeks for new agent trials, to 3-6 months for stable patients without changes to management plan).

*Information contained in the Care Guide is not a substitute for a health care professional's clinical judgment. Evaluation and treatment should be tailored to the individual patient and the clinical circumstances. Furthermore, using this information will not guarantee a specific outcome for each patient. Refer to “Disclaimer Regarding Care Guides” for further clarification. <https://cchcs.ca.gov/clinical-resources/>*

**2. Non-Opioid Therapies Algorithm**

**Assessment**

**Complete Initial Pain Assessment** (See page 3)  
(See CCHCS Care Guide: Pain Management Part 1-Assessment for full assessment criteria)

**Self-Management**

**Step 1:** (See page 5)  
**Recommend as First Line of Treatment**

- Patient Education and Self-management pain management strategies that include:
  - Promoting a Healthy Lifestyle (healthy eating, exercise, sleep hygiene)
  - Relaxation Therapies (deep breathing exercises, progressive muscle relaxation, meditation)
  - Peer/Other Support Groups

If continued pain, continue to Step 2

**Non-Pharmacologic Therapy**

**Step 2:** (See pages 6-7)  
**Begin Physical/Behavioral Therapies**

- Exercise
- Physical Therapy (therapeutic exercise, range of motion, mobilization, physical modalities)
- Behavioral Therapies (counseling, CBT, MET, Peer Support groups)

If continued pain, continue to Step 3

**Pharmacologic Therapy (Non-Opioid)**

**Step 3:** (See pages 8-9)  
**Select Type of Non-Opioid Therapy Based on Type of Pain Present**

**If Somatic Pain present:** (See pages 8-9)

- Acetaminophen
- NSAIDs
- Corticosteroids
- Muscle relaxants (limited indication)
- Topical capsaicin

**If Neuropathic Pain present:** (See page 9)

- Tricyclic Antidepressants (amitriptyline, nortriptyline)
- SNRI (venlafaxine, duloxetine)
- Antiepileptics (carbamazepine)
- Topical lidocaine

- Continue current treatment
- Encourage exercise and stress reduction
- Monitor functional status and patient goals

Adequate Pain Relief?

Yes

No

**Consider Procedures/Interventions**

**Step 4:** (See page 10)  
**Consider Procedures/Interventions**

Evidence of significant Substance Use Disorder?

No

Yes

If potential benefits outweigh risks, refer to CCHCS Care Guide: Pain Management Part 3 – Opioid Therapy for Treatment and Monitoring.  
-Use extreme caution in patients with a history of Substance Use Disorder

If risks outweigh potential benefits of opioid treatment consider referral to MAT or other Substance Use Disorder treatment (See MAT Care Guide)

SUMMARY		DECISION SUPPORT		PATIENT EDUCATION/SELF MANAGEMENT	
<b>ASSESSMENT/FUNCTIONAL ASSESSMENT</b>					
<b>(SEE CCHCS CARE GUIDE: PAIN MANAGEMENT PART 1—ASSESSMENT FOR DETAILS; RECAP BELOW)</b>					
When properly performed, patient-centered care may decrease patient anxiety, increase trust in providers, and improve treatment adherence. As part of the patient-centered care approach, providers should review the patient's history including previous treatments, their results, and overall progress. Providers should ask the patient about his or her interest in a referral to a Substance Use Disorder program or mental health provider, when appropriate.					
<b>History</b>			<b>Risk Assessment/Supplemental Assessments</b>		
Obtain outside records and search CURES 2.0 if patient is new to CDCR ( <a href="https://oag.ca.gov/cures">https://oag.ca.gov/cures</a> )			Screen for Depression using PHQ-9 (See Attachment A)		
Pain onset, descriptors?			Screen for Substance Use Disorder-using NIDA Quick Screen and other tools as indicated (See Attachment B)		
What makes the pain better/worse?					
Associated symptoms?			<b>Physical Exam</b>		
Family and Social history?					
Comorbid Conditions/ Mental Health History?					
Assess functional Status (See Patient Education pages PE-2 & PE-3 and instruct patient on how to complete forms prior to each visit)			Rule out Red Flags for Serious Disease		
Prior diagnostic testing?			<b>Diagnostic Testing</b>		
Previous/Ongoing treatments?			Imaging, Electromyography (EMG)/Nerve Conduction Study (NCS), Electrocardiogram (EKG) as needed		
			Lab tests		
<b>GOALS, EXPECTATIONS, AND EDUCATION</b>					
<ul style="list-style-type: none"> <li>• Complete pain relief is not a realistic goal</li> <li>• Focus on function</li> <li>• Document the patient's expectations and help them reframe, if necessary, toward realistic goals</li> <li>• Document agreed upon functional goals. Use specific examples: Taking walks (define distance/# laps), attendance at programming sessions, returning to job duties, participation in recreational activities, etc.</li> </ul>					
<b>Goal</b>	<b>Pain Reduction</b>	<b>Improved Function</b>	<b>Minimize Side Effects</b>		
<b>Education</b>	<ul style="list-style-type: none"> <li>• Total pain relief is not realistic</li> <li>• Goal is to take the edge off and reduce pain by 20-30%</li> </ul>	<ul style="list-style-type: none"> <li>• Ultimate goal is to improve quality of life (QOL)</li> <li>• Degree of pain that interferes with QOL is highly personal</li> </ul>	<ul style="list-style-type: none"> <li>• Educate on potential side effects and risks associated with the chosen treatment(s)</li> </ul>		
Set Realistic Patient Expectations. Adapted from <i>Transforming the Treatment of Chronic Pain, Moving Beyond Opioids</i> , by U.S. Department of Veterans Affairs, May 15, 2018, retrieved from <a href="https://www.pbm.va.gov/PBM/AcademicDetailingService/Documents/Academic_Detailing_Educational_Material_Catalog/Pain_ChronicPainProviderEducationalGuide_IB101000.pdf">https://www.pbm.va.gov/PBM/AcademicDetailingService/Documents/Academic_Detailing_Educational_Material_Catalog/Pain_ChronicPainProviderEducationalGuide_IB101000.pdf</a> . Published August 2017.					
<b>Specific</b>	A goal should be clear and concise. It is difficult to know when action toward a goal has been started and when it has been completed if it is not specific.				
<b>Measurable</b>	A goal should be measurable. It should have clear criteria for progress and completion – so that patients can track their progress. Keeping tabs on progress can be inspiring.				
<b>Action</b>	A goal should include action. The patient should be in direct control of that action.				
<b>Realistic</b>	A goal should be largely within the reach of the patient. It is best to work on small lifestyle changes that are doable. Avoid the pitfalls of seeing only the big picture and not the small steps.				
<b>Timed</b>	A goal should be tied to a timetable for completing a specific, measurable, and realistic action.				

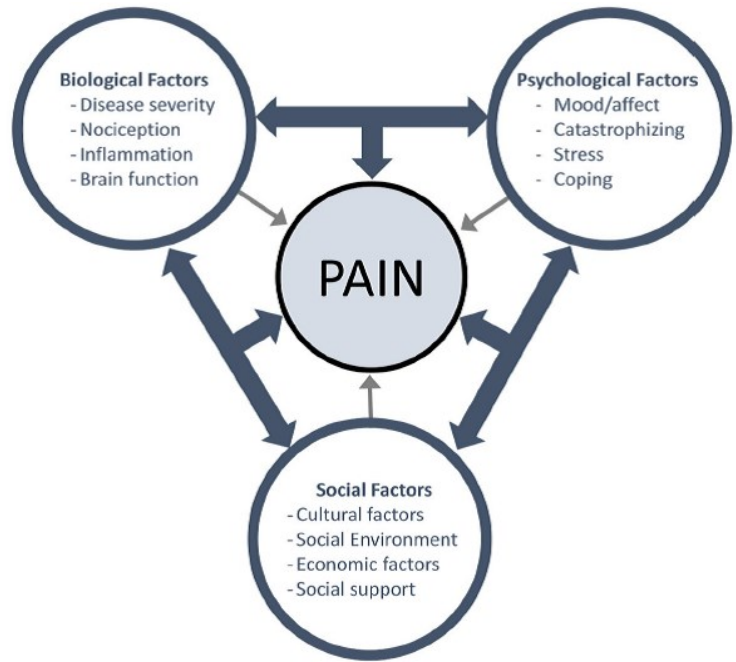
**SUMMARY**

**DECISION SUPPORT**

**PATIENT EDUCATION/SELF MANAGEMENT**

**WHAT IS THE BIOPSYCHOSOCIAL MODEL OF PAIN MANAGEMENT?**

Pain is a multidimensional experience. Pain management is most effective when a biopsychosocial model and a multimodal approach are used together. “The biopsychosocial model provides an ideal framework for conceptualizing individual differences in pain.”<sup>2</sup> This figure illustrates “that the experience of pain is sculpted by the influences of biological, psychological and social factors. Notably, while each of these factors can independently influence pain (as depicted by small bidirectional arrows), the more important and complex influences emerge from interactions among the factors, as depicted by the larger three-way arrows. These interactions among multiple biopsychosocial factors results in a unique mosaic of individual difference factors contributing to pain in each person.”<sup>2</sup>



**Biomedical Model**

- Pain as symptom
- Disease based
- Focus on cure and resolution
- Common in acute care settings
- Patient plays a passive role
- Provider serves as the expert
- Treatments reliant on science & technology

**Biopsychosocial Model**

- Pain as experience
- Holistic based
- Focus on management
- Long-term functional restoration
- Patient shares responsibility as a team member
- Provider serves as coach; provides guidance
- Treatments reliant on adaptive behaviors and choices

**WHY IS THE BIOMEDICAL MODEL NO LONGER WORKING?**

“Biomedical theories of pain concentrate upon its neurophysiological aspects in both diagnosis and treatment . . . **scientific medicine reduces the experience of pain to an elaborate broadcasting system of nerve signals, rather than seeing it as molded and shaped by the person who is experiencing it and his or her particular sociocultural context.**” The paradigm shift towards a biopsychosocial model is occurring because the biomedical concept of pain is unsophisticated and oversimplified.”<sup>3</sup> It essentially ignores “a whole-health approach to improve quality of life and increase functional status.”<sup>1</sup>

SUMMARY	DECISION SUPPORT	PATIENT EDUCATION/SELF MANAGEMENT
<b>STEP 1: SELF-MANAGEMENT</b>		
<ul style="list-style-type: none"> <li>• Recommended first line treatment for all chronic pain patients.</li> <li>• Self-management is a critical and effective aspect of managing chronic pain and takes time and effort to hone.</li> <li>• “Don’t tell me, teach me”. Patients are more likely to develop effective self-management techniques and habits if they are instructed and encouraged as they learn their skill building tools.</li> </ul>		
<b>Patient Education</b>		
<ul style="list-style-type: none"> <li>• Patient beliefs and expectations about pain and its treatment are major determinants of treatment outcomes.</li> <li>• It is essential to engage the patient in their treatment process and emphasize their role in the care team.</li> <li>• The Patient Education materials included in this care guide provide interactive tools to assist with patient-provider communication and to actively engage patients to participate in their care.</li> <li>• Patients should be encouraged to prepare for their visits by filling out the PE-2 and PE-3 forms (attachments on Lifeline), <i>Chronic Pain: Preparing for Your Health Care Visit</i> before each visit.</li> </ul>		
<b>Promoting A Healthy Lifestyle</b>		
<ul style="list-style-type: none"> <li>• Promoting a healthy lifestyle is just as important in managing chronic pain as it is for other chronic conditions.</li> <li>• Patients should be encouraged to eat healthy, exercise, and maintain an ideal weight.</li> <li>• Good sleep hygiene is important in pain management. Simple solutions such as using ear plugs or practicing meditation and relaxation exercises, may improve a patient’s sleep.</li> </ul>		
<b>Relaxation Therapies</b>		
<ul style="list-style-type: none"> <li>• Appreciate the mind-body connection and use to your advantage <ul style="list-style-type: none"> <li>▶ Avoid negative self-talk: What patients say to themselves can affect their perception of pain.</li> <li>▶ Find distractions: Have the patient try to identify activities that distract them from their symptoms such as leisure time activities, reading, drawing, watching TV, listening to or playing music, playing cards, etc.</li> </ul> </li> <li>• Relaxation therapies comprise a number of strategies aimed towards promoting a state of relaxation--useful for: reducing levels of anxiety and pain; and subsequently altering pain thresholds.</li> <li>• The following relaxation techniques expand the patient’s repertoire of coping strategies for pain management. However, these techniques require the patient’s involvement and acceptance: <ul style="list-style-type: none"> <li>▶ Deep-breathing exercises: Breathe in slowly and deeply through the nose to a count of five. Hold the air in the lungs for a count of five and then breathe out slowly through the mouth to a count of ten.</li> <li>▶ Progressive muscle relaxation: Tighten and then relax body parts one at a time, starting at either the head or the feet.</li> <li>▶ Meditation: Focusing on a single object or repeating a particular sound can help quiet the mind and relax the muscles.</li> <li>▶ Visualization/Imagery: Imagery is a simple procedure designed to promote general relaxation. This technique involves imagining a pleasant or relaxing scene such as lying in the sun listening to the waves on a beach. With practice, imagery can be used to reduce autonomic arousal and be used as an effective attention diversion strategy.</li> <li>▶ Diaphragmatic breathing: Instruct the patient to slowly and deeply inhale through the nose, usually to a count of 10, followed by a slow and complete exhalation for a similar count. The process may be repeated 5 to 10 times, several times a day and is a way to trigger the body’s normal relaxation response.</li> </ul> </li> </ul>		
<b>Peer/Other Support Groups</b>		
<ul style="list-style-type: none"> <li>• Peer support groups, if available, can be helpful in providing hope, modeling positive behaviors, and promoting a strong foundation of self-management.</li> <li>• Some institutions have been able to design their own peer support groups; others follow existing curriculums.</li> <li>• Groups are typically run by Psychiatric Technicians, nursing and/or mental health providers (as resources allow).</li> <li>• Meetings are usually held weekly, but may vary from institution to institution.</li> </ul>		

**SUMMARY****DECISION SUPPORT****PATIENT EDUCATION/SELF MANAGEMENT****STEP 2: NON-PHARMACOLOGIC THERAPY—PHYSICAL**

Many patients with chronic pain are able to manage adequately without medications and can function at a near-normal level. For patients who need more help managing their pain, non-pharmacologic therapies and non-opioid pharmacologic therapy are preferred for chronic pain.

**Exercise**

- No one type of exercise has been shown to be more effective than another in the management of chronic pain. Exercise choices need to be individually tailored to each patient. Studies have shown flexion exercises, extension exercises, isokinetic muscle strengthening, and low-impact aerobic exercises to be beneficial. There is no significant difference in outcomes when comparing relatively inexpensive group aerobics/stretching to more traditional physiotherapy and muscle conditioning; thus, suggesting low-cost alternatives may be effective.
- While patients with acute pain are often encouraged to rest to promote healing, patients with chronic pain often do worse with decreased activity – leading to subsequent decondition. General activity should be encouraged and progressively increased where possible.
- Work classifications may need to be modified in order to avoid specific activities that can exacerbate pain, such as heavy lifting or strenuous activity. A Chrono should be supplied that details patient-specific limitations; custody will then assign appropriate job duties.
- Similarly, sports, gym, and other athletic activities should be assessed for continued or limited participation on a patient-by-patient basis.
- Activities such as walking, stretching, strength and balance exercises are encouraged as indicated.

**Physical Therapy (PT)**

- A consultation with a physical therapist may be beneficial for those patients that need help setting specific goals to restore function; and/or incorporating specific modalities into a rehabilitative program.
- General components of a PT program include:
  - ▶ A gradually progressive therapeutic exercise program that includes goal setting and interval progress reports.
  - ▶ Focused therapies designed to improve: range of motion, gait, and mobilization of joints (including the spine) and soft tissues.
  - ▶ Supplemental modalities such as TENS and traction.
  - ▶ Tips on how to complete assigned exercises (homework) between PT visits.
  - ▶ Assessments for Mobility Assistive Equipment (MAE).

**STEP 2: NON-PHARMACOLOGIC THERAPY— BEHAVIORAL****Psychological Therapies**

- Not all psychological therapies require a referral to mental health.
- General counseling (i.e., education to promote wellness) can be accomplished by ancillary members of the health care team. A positive patient-provider relationship with members of the health care team, consistent support of realistic goals, and reinforcement of the patient's role in his or her improvement is important.
- Biofeedback – A mind-body technique in which individuals are taught – through monitoring of a normally automatic bodily function (i.e., heart rate, respirations, etc.) – to acquire voluntary control of that function. This mind-body technique in which individuals learn how to modify their physiology is used for the purpose of improving health. Biofeedback requires active participation on the part of patients and often regular practice between trainings.
- Some patients may benefit from more formal psychotherapy sessions.

**Cognitive Behavioral Therapy (CBT)**

- Focuses on building skills to effectively control the tendency toward maladaptive thinking. CBT provides understanding and insight into the connection between one's thoughts and behaviors. Phases of CBT for pain management include:
  - ▶ Reconceptualization of chronic pain as a chronic disease (i.e., pain as manageable and controllable)
  - ▶ Skills Acquisition – Emphasis on self-management, behavioral activation, and coping skills
  - ▶ Maintenance and Relapse Prevention – Problem solving
- CBT teaches self-monitoring for early recognition of triggering situations and assists in developing strategies for coping with these. The skills acquired can be applied to many areas other than pain management.

SUMMARY	DECISION SUPPORT	PATIENT EDUCATION/Self MANAGEMENT
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**STEP 2: NON-PHARMACOLOGIC THERAPY— BEHAVIORAL (CONTINUED)**

**Dialectical Behavioral Therapy**

A form of CBT that combines standard CBT techniques for emotion regulation and reality-testing with concepts of distress tolerance, acceptance, and mindful awareness. Originally designed to help people suffering from borderline personality disorder, the technique has had success in treating a broader selection of conditions including substance use disorders, post-traumatic stress disorder, traumatic brain injuries, binge-eating disorder, and mood disorders.

**Motivational Enhancement Therapy (MET)**

A technique that focuses on the treatment of substance addictions where the goal of the therapy is not to guide the patient through the recovery process, but to invoke inwardly motivated change, develop a plan for change, and improve coping strategies. MET consists of 5 key components:

1. Express Empathy – Acknowledge (validate) the patient’s pain, establish trust and a sense of working together
2. Develop Discrepancy – Establish goals and note the distance needed to travel to achieve those goals
3. Avoid Argument – Skilled positive responses rather than negative ones
4. Rolling with Resistance – Encourages the patient to recognize that there will be resistance at times and to "roll with" it
5. Support Self-Efficacy – Encourages the patient to realize they are capable of achieving the goals they set

**Support Group Resources**

- Refer to CCHCS Care Guide: Pain Management Part 2—Therapy—Non-Opioid, page 5

**The Evidence for NOT Using Opioids to Treat Chronic Pain**

- The Biomedical Model is insufficient and not preferred in treating chronic pain
- The U.S. is in the middle of an opioid crisis that has been progressively worsening
- As providers, we need to REFOCUS our efforts:
  - ▶ Change the way we assess and treat chronic pain.
  - ▶ Accept the Biopsychosocial Model as more relevant than the Biomedical model for treating chronic pain.
  - ▶ Immerse yourself in the newest chronic pain management guidelines from the U.S. Department of Veterans Affairs (VA), Centers for Disease Control (CDC), and American College of Physicians (ACP).
  - ▶ Show what you know—share the knowledge with your patients and colleagues.
- The guidelines are EVIDENCED-BASED; use NON-OPIOID THERAPIES to treat chronic pain.

**MORE EVIDENCE: Meta-analyses comparing different treatments for chronic pain from arthritis, low back pain, neuropathic pain and fibromyalgia.<sup>1</sup> The study results below show a similar reduction in pain intensity between non-pharmacologic therapy and non-opioid, low opioid and high potency opioid therapy.**

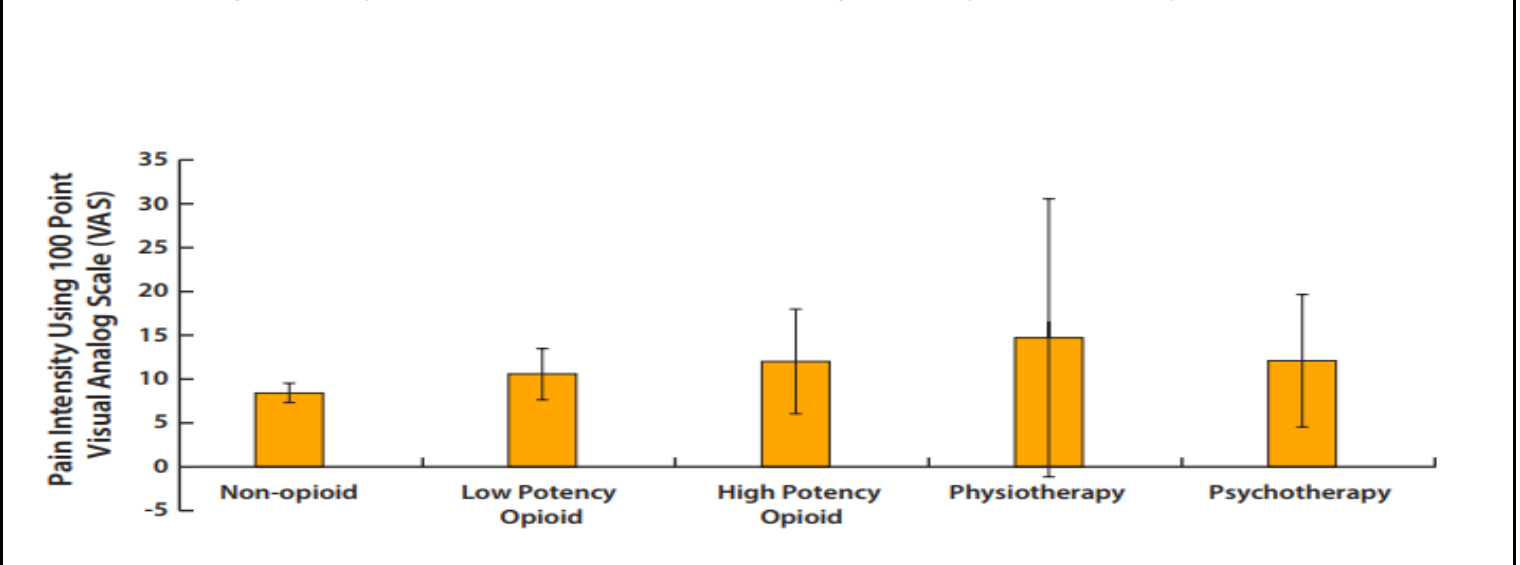


Figure 8. Similar Reduction in Pain Intensity Between Non-Pharmacologic Therapy and Non-Opioid, Low Potency Opioid and High Potency Opioid Therapy. Reprinted from *Transforming the Treatment of Chronic Pain, Moving Beyond Opioids*, by U.S. Department of Veterans Affairs, May 9, 2018, retrieved from [https://www.pbm.va.gov/PBM/AcademicDetailingService/Documents/Academic\\_Detailing\\_Educational\\_Material\\_Catalog/Pain\\_ChronicPainProviderEducationalGuide\\_IB101000.pdf](https://www.pbm.va.gov/PBM/AcademicDetailingService/Documents/Academic_Detailing_Educational_Material_Catalog/Pain_ChronicPainProviderEducationalGuide_IB101000.pdf) Published August 2017.

## SUMMARY

## DECISION SUPPORT

## PATIENT EDUCATION/SELF MANAGEMENT

**STEP 3: NON-OPIOID PHARMACOLOGIC THERAPY**

For patients who continue to have intolerable pain, despite using non-pharmacologic approaches, select non-opioid therapy based on the type of pain and patient specific comorbidities.

The expectation is that the patient will maintain engagement in non-pharmacologic and self-care strategies initiated as Steps 1 and 2. Selection of pharmacotherapy should be based on assessment of the underlying pain mechanism, i.e., neuropathic versus somatic.

Non-Opioid Analgesics	Pain Type	
	Somatic	Neuropathic
	Acetaminophen NSAIDs Corticosteroids Muscle Relaxants Topicals	TCAs SNRIs AEDs Local Anesthetics Topicals

Distinct from agents typically used to treat somatic pain, neuropathic analgesics generally exert their pain relieving properties by gradually changing the patient's chemistry thereby reducing neural responsiveness. As such, trials for neuropathic treatments tend to require several weeks to several months to adequately assess overall responsiveness. No response or intolerable side effects warrant taper/discontinuation and consideration for an alternative agent. Partial response—even with titration to maximal dosing—may warrant consideration (adding another agent with a different mechanism of action).

**Non-Opioid Analgesics for Somatic Pain****Acetaminophen (APAP)**

- Excellent safety profile when administered at therapeutic doses
- Central anti-inflammatory effect
- No antiplatelet effects and does not cause gastrointestinal (GI) toxicity
- Less effective for chronic inflammatory pain conditions in the periphery (e.g., rheumatoid arthritis)
- Hepatotoxicity may occur with concomitant alcohol use or exceeding the maximum recommended dose of 4 gm/day
- In patients with liver disease or at risk of hepatotoxicity, the recommended maximum daily dose is 2 gm/day

**Nonsteroidal Anti-Inflammatories (NSAIDs) (e.g., aspirin, ibuprofen, ketorolac, naproxen, salsalate, sulindac)**

- Frequently used for soft tissue injury, strains, sprains, headaches, and arthritis
- Unresponsiveness or intolerance to one NSAID may warrant a trial of a different NSAID from a different class
- Combining NSAIDs is not recommended (does not increase analgesia, but does increase toxicity)
- Caution against prolonged regular use, as this increases the risk of adverse effects including: gastritis, GI bleeding, edema, hypertension, cardiotoxicity, renal toxicity, CNS effects, and coagulopathy
- Consider using NSAIDs in combination with a proton pump inhibitor (PPI) or Histamine H2 blocker
- Avoid in patients with:
  - ▶ Renal insufficiency (CrCl < 30 mL/min); CrCl 30-60 mL/min - use with caution
  - ▶ Cirrhosis (Serum albumin < 3 gm, INR > 1.2, Platelets < 100K, LFT's > 3X normal)
  - ▶ Reduced cardiac output; CHF
  - ▶ Uncontrolled hypertension
  - ▶ Hypovolemia
  - ▶ Hyponatremia
  - ▶ Platelet dysfunction, coagulopathy or on anticoagulants
  - ▶ Aspirin-sensitive asthma
  - ▶ Active or history of GI bleeding
  - ▶ Last 6-8 weeks of pregnancy

**Corticosteroids (e.g., dexamethasone, prednisone)**

- Potent anti-inflammatory properties
- Used for pain caused by nerve compression, visceral distension, or increased intracranial pressure
- Dexamethasone has more potent anti-inflammatory, less mineralocorticoid effects and a long duration (36-54 hrs)
- Prednisone has more rapid effects, and a shorter duration of action (12-36 hrs)
- The combination of NSAIDs and corticosteroids should be avoided due to ~15 fold increased risk of GI bleeding
- Risk of adverse effects increases with the duration of use; beyond 2-3 months, steroid-induced risks outweigh benefits



SUMMARY	DECISION SUPPORT	PATIENT EDUCATION/SELF MANAGEMENT
<b>STEP 3: NON-OPIOID PHARMACOLOGIC THERAPY (CONTINUED)</b>		
<b>Non-Opioid Analgesics for Somatic Pain (Continued)</b>		
<b>Muscle Relaxants (e.g., baclofen, methocarbamol) – ALL NON-FORMULARY</b>		
<ul style="list-style-type: none"> <li>• No current studies supporting their use. No more effective than NSAIDs for chronic low back pain</li> <li>• Generally not intended for long term use, except in managing spasticity associated with spinal cord injury</li> <li>• Abrupt withdrawal may precipitate anxiety, seizures, tachyarrhythmia, other CNS effects (e.g., hallucinations)</li> <li>• DOT administration only</li> <li>• Non-formulary use for: documented muscle spasms due to: Cerebral Palsy, Multiple Sclerosis, Spinal Cord Injury, or Stroke</li> <li>• Methocarbamol is restricted for use following acute injury; and limited in duration to 10 days or less with no refills for 90 days</li> </ul>		
<b>Topical Agents (e.g., capsaicin, salicylic acid)</b>		
<ul style="list-style-type: none"> <li>• Capsaicin can be used to treat minor aches and pains of the muscles/joints (e.g., arthritis, backache, sprains)</li> <li>• Capsaicin works by decreasing substance P that facilitates pain signals to the brain</li> <li>• Transient increased pain at application site may occur (dissipates with continued use)</li> <li>• Warmth, stinging, erythema, or burning on the application site may occur</li> <li>• Avoid breathing in the dried residue as this may trigger coughing, sneezing, watery eyes, or throat irritation</li> </ul>		
<b>Non-Opioid Analgesics for Neuropathic Pain</b>		
<b>Tricyclic Antidepressants (TCAs) (e.g., amitriptyline, nortriptyline)</b>		
<ul style="list-style-type: none"> <li>• First-line agents for neuropathic pain syndromes such as diabetic neuropathy and post-herpetic neuralgia</li> <li>• Doses used for neuropathic pain are typically lower than doses used for depression and analgesic effects of TCAs are independent of their antidepressant effect</li> <li>• All TCAs have comparable efficacy, but variable tolerability due to anticholinergic effects</li> <li>• Adverse effects include sedation, dry mouth, blurred vision, constipation, urinary retention, cognitive impairment, anxiety, increased body temperature, sweating, emotional blunting (apathy/anhedonia), restlessness, dizziness, changes in appetite and weight, muscle twitches</li> <li>• Tolerance to adverse effects often develops with continuation—rationale for initiating low doses and gradually increasing</li> <li>• Maximum analgesic effect may take several weeks to several months</li> <li>• Failure of one TCA does not preclude success with a different agent; consider trying 2-3 different TCAs sequentially before switching to a different class</li> <li>• Caution in patients with heart disease, prostatic hypertrophy, neurogenic bladder, dementia and narrow-angle glaucoma</li> <li>• Recommended monitoring: Baseline ECG in patient &gt;40 and if at risk for cardiac events; heart rate and blood pressure with dose adjustments, weight—especially in patients with diabetes</li> </ul>		
<b>Serotonin Norepinephrine Reuptake Inhibitors (SNRIs) (e.g., duloxetine, venlafaxine)</b>		
<ul style="list-style-type: none"> <li>• Useful for patients unable to tolerate TCA</li> <li>• Pre-existing hypertension should be controlled prior to initiating therapy</li> <li>• Avoid abrupt discontinuation of SNRIs. A gradual dose reduction is recommended</li> <li>• Adverse effects: nausea, dizziness, sweating, tiredness, constipation, insomnia, anxiety, headache, and loss of appetite</li> <li>• Recommended monitoring: blood pressure with dose adjustment</li> </ul>		
<b>Antiepileptic Drugs (AEDs) (e.g., gabapentin, pregabalin, carbamazepine)</b>		
<ul style="list-style-type: none"> <li>• Gabapentin or pregabalin may be abused and diverted in the correctional health setting and are not on formulary; recommend using other therapeutic agents that are preferred for neuropathic pain. See page 14 for limited indications</li> <li>• Carbamazepine is first line agent for trigeminal neuralgia <ul style="list-style-type: none"> <li>▶ <b>Note: Oxcarbazepine may be used as an alternative to carbamazepine for trigeminal neuralgia; however, it has no utility in any other neuropathic pain condition and should not be used for pain management in general.</b></li> </ul> </li> <li>• Slow titration of AEDs is recommended to find the lowest effective dosage while avoiding adverse effects</li> <li>• A slow taper is recommended when discontinuing antiepileptic therapy</li> <li>• Recommended monitoring for Carbamazepine—see page 13</li> <li>• Monitor for worsening of depression, suicidal thoughts/behavior, and/or any other unusual changes in mood or behavior</li> <li>• Rare adverse effects include hepatitis and hematologic abnormalities</li> </ul>		
<b>Topical Local Anesthetics (e.g., lidocaine)</b>		
<ul style="list-style-type: none"> <li>• May be useful for treatment of post-herpetic neuralgia or other localized neuropathic conditions</li> <li>• Tends to be more effective than topical capsaicin in post-herpetic neuralgia</li> </ul>		

SUMMARY	DECISION SUPPORT	PATIENT EDUCATION/SELF MANAGEMENT
<b>STEP 4: PROCEDURES/INTERVENTIONS</b>		
<b>Trigger Point Injections</b>		
<ul style="list-style-type: none"> <li>• Pain from active myofascial trigger points—taut, tender muscle bands—is often treated by needling the affected muscle and injecting small doses of local anesthetic, providing prompt relief of symptoms from myofascial pain syndrome.</li> <li>• The finding of tenderness alone is not an indication for trigger point injection; the classical findings are of a taut band with local twitch response (“jump sign”) and referred pain pattern.</li> <li>• Conditions involving widespread pain complaints, such as fibromyalgia or endocrine disorders, are not suitable for trigger point injections.</li> <li>• Caution in patients with bleeding disorders or on anticoagulation, since the risk of bleeding may be increased. However, the risk of harmful bleeding remains very low.</li> <li>• Use precautions in patients who are at high risk for infection, including debilitated patients, patients with diabetes mellitus, or patients on steroids.</li> <li>• Contraindications: Presence of systemic or local infection, pregnancy, patients who feel or appear to be ill, allergy to anesthetic agents, acute muscle trauma, and extreme fear of needles.</li> </ul>		
<b>Spinal Interventions</b>		
<b>Epidural Steroid Injections</b>		
<p>Indications:</p> <ul style="list-style-type: none"> <li>• Radicular pain attributed to disc injury/pathology</li> <li>• May be useful for surgical planning (to isolate level of pathology)</li> <li>• &gt; 3 months significant pain and disability</li> <li>• No response to conservative Rx such as NSAIDS, APAP, PT</li> <li>• To facilitate established rehabilitation efforts</li> <li>• Optimal engagement in conservative therapies</li> <li>• Physical examination correlates with indication</li> <li>• May be repeated after 3-4 months</li> </ul>	<p>Contraindications:</p> <ul style="list-style-type: none"> <li>• Patient refusal to proceed</li> <li>• Pregnancy</li> <li>• Hypersensitivity to agents</li> <li>• Local or systemic infection</li> <li>• Local malignancy</li> <li>• Bleeding diathesis</li> <li>• Congestive heart failure</li> <li>• Uncontrolled diabetes mellitus</li> <li>• Anatomic deformity limiting access</li> </ul>	
<b>Facet Joint Injections</b>		
<p>Indications:</p> <ul style="list-style-type: none"> <li>• Axial pain attributed to facet degeneration</li> <li>• &gt; 3 months significant pain and disability</li> <li>• Limited utility in providing long-standing relief for most</li> <li>• Based on response to prior procedure: <ul style="list-style-type: none"> <li>▶ &gt; 80% pain relief from a Medial Branch Block (MBB) to proceed with a radiofrequency ablation (RFA)</li> <li>▶ &gt; 50% x 3 mo for repeat facet/MBB</li> <li>▶ &gt; 50% x 6 mo for repeat RFA</li> <li>▶ AND documented significant improvement in ADLs</li> </ul> </li> </ul>	<p>Contraindications: Similar to above</p>	
<b>Intra-articular Joint Injections</b>		
<p>Joint steroid injections may reduce pain-related inflammation, and can thereby help relieve symptoms. Steroid injections are not a perfect solution in every case, and the risks of steroid use need to be considered. May be useful in perioperative planning or in obviating the need for surgery.</p>		
<b>Surgery</b>		
<p>In the absence of neurological complications, it's typical to try at least several months of non-surgical treatments, such as physical therapy and medications, before proceeding to surgery. Unless there is a discrete identifiable cause of pain, it is generally not recommended to treat chronic pain with surgery. There are significant risks associated with surgery including no improvement and/or worsened pain.</p>		

SUMMARY	DECISION SUPPORT		PATIENT EDUCATION/SELF MANAGEMENT
<b>NONOPIOID ANALGESICS</b>			
MEDICATION	DOSING	ADVERSE EFFECTS* / INTERACTIONS	COMMENTS
<b>PARAAMINOPHENOL ANALGESIC</b>			
<b>Acetaminophen</b> (Tylenol®)  <b>Tabs: 325 mg, 500 mg</b> <b>Susp: 160 mg/mL</b> \$	325–1000 mg every 4 to 6 hours (not more than 4 grams daily)  Renal impairment eGFR 10-50 ml/min: Administer every 6 hours eGFR <10 ml/min: Administer every 8 hours	<ul style="list-style-type: none"> <li>• Drug interactions: isoniazid, warfarin (↑ INR)</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Boxed warning:</b> May be hepatotoxic in acute or chronic over dosage—Do not exceed 4 g/day of acetaminophen</li> <li>• Watch for acetaminophen as a component of combination medication products</li> <li>• Maximum recommended dose for patients with liver injury from hepatitis C is 2 gm/day. Avoid in patients with significant liver disease or risk of hepatotoxicity</li> <li>• No significant antiinflammatory effect or GI toxicity</li> <li>• Useful adjunct agent to NSAIDs or opioids</li> </ul>
<b>NONSTEROIDAL ANTI-INFLAMMATORY DRUGS (NSAIDs)—NONSELECTIVE</b>			
<b>Boxed warning:</b> Associated with an increased risk of adverse cardiovascular thrombotic events, including MI and stroke; increased risk of GI irritation, inflammation, ulceration, bleeding, and perforation			
<b>Ibuprofen</b> (Motrin®)  <b>Tabs: 400 mg, 600 mg, 800 mg</b>  <b>Susp: 100 mg/mL</b> \$  <b>200 mg</b> (OTC Canteen)	400-800 mg every 6-8 hours with food (no additional analgesic benefit demonstrated with single doses > 400 mg except in inflammatory conditions) MAX: 3200 mg/day for acute pain, 2400 mg/day for chronic pain  Renal impairment: eGFR 30 to < 60 ml/min: Avoid use in patients with intercurrent disease that increases risk of acute kidney injury eGFR < 30 ml/min: Avoid use	<ul style="list-style-type: none"> <li>• Adverse effects: gastropathy (e.g., GI ulcers, GI bleeding, perforation), nausea, diarrhea, constipation, dizziness, headache, confusion, edema, rash, pruritus, acute renal failure</li> <li>• Drug interactions: ACE-inhibitors, ARBs, aspirin, beta blockers, diuretics, lithium, methotrexate, warfarin</li> </ul>	<ul style="list-style-type: none"> <li>• Reversibly inhibits platelet function, may increase bleeding time</li> <li>• May alter cardioprotective effect of low dose aspirin</li> <li>• Minimal risk of severe gastropathy with daily dose ≤ 2400 mg</li> </ul>
<b>Naproxen</b> (Naprosyn®)  <b>Tabs: 250 mg, 500 mg</b> \$  <b>220 mg</b> (OTC Canteen)	250 mg - 500 mg BID with food MAX: 1250 mg/day for acute pain; 1000 mg/day for chronic pain  Renal impairment CrCl < 30 mL/min: Not recommended	<ul style="list-style-type: none"> <li>• Adverse effects: gastropathy, dizziness</li> <li>• Drug interactions: ACE-inhibitors, antacids (e.g., aluminum hydroxide, magnesium oxide), ARBs, beta blockers, diuretics, lithium, methotrexate, sucralfate, warfarin</li> </ul>	<ul style="list-style-type: none"> <li>• Reversibly inhibits platelet function, may increase bleeding time</li> <li>• May alter cardio protective effect of low dose aspirin</li> <li>• Best relative cardiovascular safety profile among nonselective COX-2 inhibitors</li> </ul>
<b>Salsalate</b> (Disalcid®)  <b>Tabs: 500 mg</b> \$\$-\$\$\$	500 mg - 1500 mg BID up to 1000 mg TID MAX: 3000 mg/day  Renal impairment: Use with caution	<ul style="list-style-type: none"> <li>• Adverse effects: tinnitus, nausea, hearing impairment</li> <li>• Drug interactions: ACE-inhibitors, ARBs, aspirin, beta blockers, diuretics, lithium, methotrexate, warfarin</li> </ul>	<ul style="list-style-type: none"> <li>• Relatively lower risk of gastropathy compared to aspirin and possibly other NSAID</li> <li>• Does not inhibit platelet function</li> </ul>
<b>Sulindac</b> (Clinoril®)  <b>Tabs: 150 mg, 200 mg</b> \$	150 mg - 200 mg BID with food MAX: 400 mg/day  Advanced Renal Disease: Not recommended due to lack of data from controlled clinical studies	<ul style="list-style-type: none"> <li>• Adverse effects: gastropathy, dizziness</li> <li>• Drug interactions: ACE-inhibitors, ARBs, aspirin, beta blockers, diuretics, lithium, methotrexate, warfarin</li> </ul>	<ul style="list-style-type: none"> <li>• Reversibly inhibits platelet function, may increase bleeding time</li> <li>• Increases effects of highly protein bound agents such as phenytoin and warfarin</li> <li>• May be more lithium-sparing than other NSAIDs</li> </ul>

**BOLD= formulary**

\*See prescribing information for complete description of dosing, adverse effects, and drug interactions.

SUMMARY		DECISION SUPPORT	PATIENT EDUCATION/SELF MANAGEMENT
<b>NONOPIOID ANALGESICS CONTINUED</b>			
MEDICATION	DOSING	ADVERSE EFFECTS* / INTERACTIONS	COMMENTS
<b>NONSTEROIDAL ANTI-INFLAMMATORY DRUGS (NSAIDs)—NONSELECTIVE</b> <b>Boxed warning:</b> Associated with an increased risk of adverse cardiovascular thrombotic events, including MI and stroke; increased risk of GI irritation, inflammation, ulceration, bleeding, and perforation			
<b>Ketorolac (Toradol®)</b>  Tabs: 10 mg \$\$\$  <b>Inj: 30 mg/mL</b> <b>Restricted to Infirmery, CTC, TTA, and OHU settings</b> \$\$	IM/IV: > 50 kg 60 mg, then 30 mg q6 hours, not to exceed 5 days < 50 kg 30 mg, then 15 mg q6 hours, not to exceed 5 days  PO: > 50 kg: 20 mg PO initial dose after IV/IM treatment, then 10 mg q4-6 hours to max 40 mg/day, max 5 days < 50 kg and geriatric patients: 10 mg PO initial dose after IV/IM treatment, then 10 mg q4-6 hours to max 40 mg/day, max 5 days  Total systemic treatment should not exceed 5 days	<ul style="list-style-type: none"> <li>Adverse effects: GI ulceration, bleeding and perforation, postoperative bleeding, acute renal failure, anaphylactic and anaphylactoid reactions, and liver failure</li> <li>Drug interactions: aspirin, NSAIDs, warfarin, pentoxifylline, and probenecid</li> </ul>	<ul style="list-style-type: none"> <li>Contraindications: Concomitant use of aspirin, NSAIDs, pentoxifylline and probenecid; patients with active peptic ulcer disease, patients with recent gastrointestinal bleeding or perforation, and in patients with a history of peptic ulcer disease or gastrointestinal bleeding</li> <li>Note: Oral form of Ketorolac is indicated ONLY for continuation of injectable treatment and should NOT be administered as an initial dose; it is non-formulary</li> <li>Renal impairment: Contraindicated in patients at risk for renal failure or at volume depletion</li> </ul>
<b>Aspirin</b>  <b>Enteric Coated Tabs: 81 mg, 325 mg</b> \$	325-650 mg q4-6 hours MAX: 3.9 gm/day 3000 mg/day for chronic pain Renal Impairment: CrCl < 60mL/min: avoid analgesic doses	<ul style="list-style-type: none"> <li>Adverse effects: upset stomach, vomiting, heartburn, easy bruising/bleeding, difficulty hearing, ringing in the ears, kidney problems</li> <li>Drug interactions: NSAIDs, warfarin, direct oral anticoagulants, plavix</li> </ul>	<ul style="list-style-type: none"> <li>Contraindications: recent history of stomach or intestinal bleeding</li> </ul>

<b>ADJUVANT MEDICATIONS FOR CHRONIC PAIN</b>			
MEDICATION	DOSING	ADVERSE EFFECTS* / INTERACTIONS	COMMENTS
<b>ANTIDEPRESSANTS—TRICYCLICS (TCAs)</b> <b>Boxed Warning:</b> Increased suicidality—patients of all ages who are started on antidepressant therapy should be monitored appropriately and observed closely for clinical worsening, suicidality, or unusual changes in behavior.			
<b>Amitriptyline (Elavil®)</b>  <b>Tabs: 10 mg, 25 mg, 50 mg, 75 mg, 100 mg</b> \$-\$\$  <b>DOT/NA only</b> <b>Mandatory crush &amp; float</b> <b>HEAT DRUG</b>	Initial: 10-25 mg at bedtime Titration: May increase by 10-25 mg weekly as tolerated to 100 mg/day MAX: 150 mg/day  <b>Duration of adequate trial: 6-8 weeks with at least 2 weeks at maximum tolerated dosage</b>	<ul style="list-style-type: none"> <li>Adverse effects: dry mouth, sedation, hypotension, urinary retention, constipation, blurred vision</li> <li>Drug interactions: MAOIs, SSRIs, SNRIs, antiarrhythmic drugs (e.g., amiodarone, flecainide quinidine), CNS depressants (e.g., benzodiazepines, antihistamines, antipsychotics), clonidine, lithium, ritonavir, tramadol, thioridazine, ziprasidone</li> </ul>	<ul style="list-style-type: none"> <li>Contraindicated with MAOIs, recovery period after MI</li> <li>Caution in patients with impaired liver function, QT prolongation, seizures, cardiovascular disorders, BPH, GERD, urinary retention, hyperthyroidism, elderly and bipolar disorder</li> <li>A daily dose of 50-100 mg is usually effective for chronic pain</li> </ul>
<b>Nortriptyline (Pamelor®)</b>  <b>Caps: 10 mg, 25 mg, 50 mg, 75 mg</b> \$  Solution Non-formulary  <b>DOT/NA only</b> <b>Mandatory open &amp; float</b> <b>HEAT DRUG</b>	Initial: 10-25 mg at bedtime Titration: May increase by 10-25 mg weekly up as tolerated to 75 mg/day MAX: 150 mg/day  <b>Duration of adequate trial: 6-8 weeks with at least 2 weeks at maximum tolerated dosage</b>	<ul style="list-style-type: none"> <li>Adverse effects: dry mouth, sedation, hypotension, urinary retention, constipation, blurred vision</li> <li>Drug interactions: MAOIs, SSRIs, SNRIs, antiarrhythmic drugs (e.g., amiodarone, flecainide quinidine), CNS depressants (e.g., benzodiazepines, antihistamines, antipsychotics), clonidine, lithium, ritonavir, tramadol, thioridazine, ziprasidone</li> </ul>	<ul style="list-style-type: none"> <li>Contraindicated with MAOIs, recovery period after MI</li> <li>Caution in patients with impaired liver function, QT prolongation, seizures, cardiovascular disorders, BPH, GERD, urinary retention, hyperthyroidism, elderly and bipolar disorder</li> <li>Less sedation, dry mouth, and urinary retention than amitriptyline</li> <li>A daily dose of 50-100 mg is usually effective for chronic pain</li> </ul>

**BOLD= formulary**

\*See prescribing information for complete description of dosing, adverse effects, and drug interactions.

SUMMARY	DECISION SUPPORT	PATIENT EDUCATION/SELF MANAGEMENT	
<b>ADJUVANT MEDICATIONS FOR CHRONIC PAIN</b>			
MEDICATION	DOSING	ADVERSE EFFECTS* / INTERACTIONS	COMMENTS
<b>ANTIDEPRESSANTS—SEROTONIN NOREPINEPHRINE REUPTAKE INHIBITORS (SNRIs)</b>			
<b>Boxed Warning:</b> Increased suicidality—patients of all ages who are started on antidepressant therapy should be monitored appropriately and observed closely for clinical worsening, suicidality, or unusual changes in behavior.			
<b>Duloxetine</b> (Cymbalta®)  <b>Caps: 20 mg, 30 mg, 60 mg</b>  \$  <b>DOT/NA only</b>	Initial: 30 mg daily Titration: Increase to 60 mg daily after 1 week  MAX: 60 mg/day (Higher doses have not shown benefit and are less tolerated)  <b>Duration of adequate trial: 4 weeks</b> Renal impairment eGFR < 30 mL/min: Avoid use Hepatic impairment, chronic liver disease or cirrhosis: Avoid use	<ul style="list-style-type: none"> <li>• Adverse effects: drowsiness, dry mouth, constipation, insomnia, nausea</li> <li>• Drug interactions: MAOIs, SSRIs, TCAs, ciprofloxacin, paroxetine, fluoxetine, NSAIDs, aspirin, thioridazine</li> </ul>	<ul style="list-style-type: none"> <li>• Contraindicated with MAOIs, closed angle glaucoma, hepatic impairment, severe renal impairment</li> <li>• Use caution in patients with diabetes, hypertension, urinary retention, renal impairment, elderly, and bipolar disorder</li> <li>• Check mental status for depression, suicidal ideation (especially at the beginning of therapy or when doses are increased or decreased), anxiety, social functioning, mania, panic attacks</li> <li>• Monitor glucose levels and Hb A1C levels in patients with diabetes, creatinine, BUN, transaminases</li> <li>• Avoid abrupt discontinuation</li> </ul>
<b>Venlafaxine</b> (Effexor®)  <b>Caps (Extended-release): 37.5 mg, 75 mg, 150 mg</b>  <b>IR formulation unavailable for use within CCHCS</b>  \$  <b>DOT/NA only</b>	Initial: 37.5 mg daily Titration: Increase by 37.5 mg weekly MAX: 225 mg/day  <b>Duration of adequate trial: 4-6 weeks</b> Renal impairment CrCl 30-89 mL/min: decrease usual dose by 25-50%  Mild-Mod Hepatic impairment Childs Pugh A-B: decrease usual dose by 50% or more  Severe Hepatic Impairment Childs Pugh C ↓ usual dose by at least 50%, a reduction of more than 50% may be needed on an individual basis	<ul style="list-style-type: none"> <li>• Adverse effects: nausea, constipation, dizziness, drowsiness, hypertension at high doses</li> <li>• Drug interactions: MAOIs, SSRIs, TCAs, lithium, tramadol, NSAIDs, aspirin, azole antifungals (e.g., fluconazole, itraconazole, ketoconazole, posaconazole, voriconazole), thioridazine, ziprasidone</li> </ul>	<ul style="list-style-type: none"> <li>• Control preexisting hypertension prior to initiation of venlafaxine</li> <li>• Contraindicated with MAOIs</li> <li>• Relative contraindication in bipolar disorder and patients on SSRI's</li> <li>• Caution in patients with recent history of MI, unstable heart disease, hyperthyroidism, hepatic or renal impairment</li> <li>• May cause increase in heart rate of 4-9 beats/minute</li> <li>• Avoid abrupt discontinuation</li> </ul>
<b>ANTIPILEPTIC DRUGS</b>			
<b>Carbamazepine</b> (Tegretol®)  <b>Tab (Immediate-release): 200 mg</b>  <b>Tab (Chewable): 100 mg</b>  \$  <b>DOT/NAT only</b>  <b>First line therapy for Trigeminal Neuralgia</b>	Initial dose: 100 mg BID Titration: Increase by 100 mg – 200 mg weekly as tolerated MAX: 1200 mg/day (200 mg – 400 mg TID)  <b>Duration of adequate trial: 4 weeks</b>  Hepatic Impairment: consider dose reductions	<ul style="list-style-type: none"> <li>• Adverse effects: drowsiness, ataxia, blurry vision, anemia, N/V, hyponatremia, thrombocytopenia, increased LFTs</li> <li>• Many drug interactions: macrolide antibiotics, azole antifungals, calcium channel blockers, TCAs, corticosteroids, warfarin, etc.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Boxed warning:</b> agranulocytosis, anemia, serious dermatologic reactions (e.g., Stevens-Johnson syndrome) &amp; HLA-B * 1502 allele</li> <li>• Contraindicated in patients with agranulocytosis, AV block, bone marrow suppression, decompensated liver disease or in combination with: MAOIs, nefazodone, delavirdine, NNRTIs (e.g., etravirine, rilpivirine)</li> <li>• Caution in patients with cardiac disease, hepatic disease, renal impairment, suicidal behavior and ideation</li> <li>• Monitor CBC, LFTs, height, weight, electrolytes, and drug level at baseline, and Q2 mo for the first 6 mo, then q 6 mos thereafter</li> <li>• HLA-B 1502 allele test prior to initiation for Asian ancestry</li> <li>• Avoid abrupt discontinuation</li> </ul>

**BOLD= formulary**

\*See prescribing information for complete description of dosing, adverse effects, and drug interactions.

SUMMARY	DECISION SUPPORT	PATIENT EDUCATION/SELF MANAGEMENT	
<b>ADJUVANT MEDICATIONS FOR CHRONIC PAIN</b>			
MEDICATION	DOSING	ADVERSE EFFECTS* / INTERACTIONS	COMMENTS
<b>ANTIEPILEPTIC DRUGS</b>			
<p>Gabapentin (Neurontin®)</p> <p>Caps: 100 mg, 300 mg, 400 mg Tabs: 600 mg, 800 mg</p> <p><b>Solution unavailable for use within CCHCS</b></p> <p>\$\$</p> <p><b>DOT/NA</b> <b>Mandatory crush &amp; float</b></p>	<p>Initial dose: 300 mg QD Titration: 300 mg QD x 3 days, 300 mg BID x 3 days, 300 mg AM &amp; 600 mg PM x 3 days, 600 mg BID x 3 days, Increase by 300 mg weekly MAX: 3600 mg/day</p> <p><b>Duration of adequate trial: 3-8 weeks for titration plus 2 weeks at maximum dose</b></p> <p>Renal impairment CrCl 30-59 ml/min: 200-700 mg BID CrCl 16-29 ml/min: 200-700 mg QD CrCl 15 ml/min: 100-300 mg QD CrCl &lt;15 ml/min: reduce dose in proportion to CrCl (e.g., CrCl 7.5 ml/min = 1/2 dose of CrCl 15 ml/min)</p>	<ul style="list-style-type: none"> <li>Adverse effects: dry mouth, edema, dizziness, cognitive impairment, fatigue, nausea and vomiting, headache</li> <li>Drug interactions: antacids (aluminum hydroxide, magnesium oxide), morphine</li> </ul>	<ul style="list-style-type: none"> <li><b>NOT on formulary</b></li> <li><b>Only FDA indications for gabapentin are:</b> <ul style="list-style-type: none"> <li>Partial onset seizures (adjunct)</li> <li>Post herpetic neuralgia (PHN)</li> </ul> </li> <li>In CCHCS, can be considered in cases with objective evidence of severe neuropathic pain after documented trials of 1st and 2nd line agents (TCA, SNRI)</li> <li>Caution in patients with renal impairment, suicidal behavior and ideation</li> <li>Administer 2 hours after antacids</li> <li>Avoid abrupt discontinuation</li> </ul>
<p>Pregabalin (Lyrica®)</p> <p>Caps: 25 mg, 50 mg, 75 mg, 100 mg, 150 mg, 200 mg, 225 mg, 300 mg</p> <p>Soln: 20 mg/mL</p> <p>\$\$\$\$\$</p> <p><b>DOT/NA</b> <b>Mandatory open and float</b></p>	<p><u>Diabetic neuropathy</u> Initial dose: 50 mg TID Titration: Increase to MAX dose 100 mg TID within 1 week</p> <p><u>Postherpetic Neuralgia</u> Initial dose: 75 mg BID Titration: Increase to 100 mg TID within 1 week. After 2-4 wks on 300 mg/day, may increase to MAX dose 300 mg BID</p> <p><u>Fibromyalgia</u> Initial dose: 75 mg BID Titration: Increase to 150 mg BID within 1 week. MAX dose 450 mg/day</p> <p><u>Neuropathic pain—spinal cord injury</u> Initial dose: 75 mg BID Titration: Increase to 150 mg BID within 1 week. After 2-3 wks on 300 mg/day, may increase to MAX dose 300 mg BID</p> <p>Renal impairment: CrCl 30-60 ml/min: 75-300 mg/day divided BID-TID CrCl 15-30 ml/min: 25-150 mg/day divided QD-BID CrCl &lt;15 ml/min: 25-75 mg QD</p> <p><b>Duration of adequate trial: 4 weeks</b></p>	<ul style="list-style-type: none"> <li>Adverse effects: dizziness, sedation, dry mouth, edema, blurred vision, cognitive impairment</li> <li>Drug interactions: CNS depressants, thiazolidinedione antidiabetic agents (e.g. pioglitazone—may increase risk of edema and weight gain)</li> </ul>	<ul style="list-style-type: none"> <li><b>Schedule V controlled drug</b></li> <li><b>NOT on formulary</b></li> <li><b>Only FDA indications for pregabalin are:</b> <ul style="list-style-type: none"> <li>Partial onset seizures (adjunct)</li> <li>Diabetic peripheral neuropathy</li> <li>Post herpetic neuralgia (PHN)</li> <li>Fibromyalgia</li> <li>Neuropathic pain associated with spinal cord injury</li> </ul> </li> <li>Caution in patients with renal impairment, ocular disease, suicidal behavior and ideation</li> <li>Avoid abrupt discontinuation</li> </ul>

**BOLD= formulary**

\*See prescribing information for complete description of dosing, adverse effects, and drug interactions.

SUMMARY	DECISION SUPPORT	PATIENT EDUCATION/SELF MANAGEMENT	
<b>ADJUVANT MEDICATIONS FOR CHRONIC PAIN</b>			
MEDICATION	DOSING	ADVERSE EFFECTS* / INTERACTIONS	COMMENTS
<b>CORTICOSTEROIDS</b>			
<b>Dexamethasone</b> (Decadron®)  Tab: 0.5 mg, 0.75 mg, 4 mg, 6 mg  \$\$	Varies depending on condition being treated 0.5-10 mg orally 2 to 3 times a day (use lowest effective dose) For palliative management of recurrent or inoperable brain tumors, a dose of 2 mg 2-3 times daily may be effective	<ul style="list-style-type: none"> <li>Caution in patients with congestive heart failure, hypertension, renal insufficiency, GI ulcers, osteoporosis</li> <li>Drug interactions: macrolide antibiotics, anticholinesterase agents, warfarin, antidiabetic agents, isoniazid, cholestyramine, cyclosporine, digoxin, estrogens, ketoconazole, phenytoin, carbamazepine, rifampin, NSAIDs</li> </ul>	<ul style="list-style-type: none"> <li>Minimize duration of high dose therapy to ≤ 72 hours</li> <li>If no benefit, dose can be rapidly tapered after very short term use</li> <li>If pain improves, taper to lowest effective dose</li> <li>Usefulness limited to 2-3 months before steroid induced adverse effects outweigh benefits</li> </ul>
<b>Prednisone</b> (Deltasone®)  Tab: 5 mg, 10 mg, 20 mg  \$	Varies depending on condition and age of patient 5-60 mg orally per day (use lowest effective dose)	<ul style="list-style-type: none"> <li>Fluid retention, changes in glucose tolerance, high blood pressure, behavioral/ mood changes, increased appetite, and weight gain</li> <li>Immunosuppression</li> </ul>	<ul style="list-style-type: none"> <li>Recommend take with food</li> <li>Avoid abrupt discontinuation</li> <li>Monitor intraocular pressure, regular eye exams, blood pressure, glucose, potassium, weight, bone mineral density, CXR, hypothalamic-pituitary-adrenal (HPA) axis suppression, Cushing's syndrome</li> </ul>
<b>MUSCULOSKELETAL RELAXANTS</b>			
<b>Baclofen</b> (Lioresal®)  Tabs: 10 mg, 20 mg  \$-\$\$\$	Initial: 5–10 mg QD Titration: 5–10 mg, QHS x 7 days 10 mg BID x 7 days 10 mg TID x 7 days Increase weekly up to MAX dose 80 mg/day	<ul style="list-style-type: none"> <li><b>Boxed warning:</b> Avoid abrupt discontinuation. Sudden discontinuation is associated with confusion, hallucinations, other psychiatric disturbances, seizures, exacerbations of spasticity</li> <li>Adverse effects: drowsiness, vertigo, dizziness, hypotension, rash, nausea, vomiting</li> <li>Drug interactions: CNS depressants, TCAs, MAOIs</li> </ul>	<ul style="list-style-type: none"> <li>Caution in renal impairment, seizure, and elderly</li> <li>Baclofen may be considered for intractable pain from neurological conditions, such as: trigeminal neuralgia that has been unresponsive to formulary agents</li> </ul>
<b>TOPICALS</b>			
<b>Capsaicin</b>  Cream: 0.025%, 0.075%  \$	Apply to affected area Q 6-8 hours  <b>Duration of adequate trial: 8 weeks</b>	<ul style="list-style-type: none"> <li>Adverse effects: burning sensation where applied to skin</li> <li>Higher concentrations may produce a stronger burning sensation</li> <li>Severity of burning appears to be worse in conditions such as postherpetic neuralgia where the skin is permanently scarred than in pain conditions where skin is normal</li> <li>Burning may decrease with repeated applications</li> </ul>	<ul style="list-style-type: none"> <li>Advise patients to wash hands thoroughly after use and avoid contact of medication with eyes and mucous membranes</li> </ul>
<b>Lidocaine</b>  Patch: 5% \$\$\$\$  Jelly: 2% \$	Apply up to 3 patches for up to 12 hours within a 24-hour period Apply jelly to affected area up to 3-4 times daily  <b>Duration of adequate trial: 4 weeks</b>	<ul style="list-style-type: none"> <li>Adverse effects: burning, itching, depigmentation, edema</li> <li>Indicated for localized postherpetic neuralgia.</li> <li>Do not apply &gt; 3 patches at one time.</li> </ul>	

BOLD= formulary

\*See prescribing information for complete description of dosing, adverse effects, and drug interactions.

## SUMMARY

## DECISION SUPPORT

## PATIENT EDUCATION/SELF MANAGEMENT

## REFERENCES

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3. Bendelow, G. (2013, May). *Chronic Pain Patients and the Biomedical Model of Pain*. Retrieved May 15, 2018, from AMA Journal of Ethics: <http://journalofethics.ama-assn.org/2013/05/msoc1-1305.html>
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5. The American Chronic Pain Association. (2010). *Living Better with Pain Log*. Retrieved from [www.theacpa.org: https://www.theacpa.org/wp-content/uploads/2017/08/Pain-Log-Rev-2010-V2.pdf](https://www.theacpa.org/wp-content/uploads/2017/08/Pain-Log-Rev-2010-V2.pdf)



## SUMMARY

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**CHRONIC PAIN: WHAT YOU SHOULD DO****IMPORTANT THINGS TO REMEMBER:**

- One of the hardest things to accept may be that there is no cure for your pain.
- You will have good days and bad days, even with treatment.

**TIPS FOR COPING WITH YOUR PAIN:****AVOID NEGATIVE SELF-TALK**

- Studies have shown that what we say to ourselves (inside our heads) can affect our idea of pain.
- Turning negative thoughts into positive ones takes practice, but is worth the effort.

**IMPROVE SLEEP**

- Your primary care provider and mental health clinician will provide therapies to manage problems which may be affecting your sleep.
- Physical activity, avoidance of naps, and regular sleep habits are also helpful.

**MANAGE STRESS**

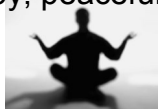
- Do what you can to stay healthy and stay positive.
- Seek and accept support.

**INCREASE PHYSICAL ACTIVITY**

- Many people in pain are afraid to exercise, but physical activity actually helps reduce pain.
- Exercise also improves mood, sleep, and general well being by releasing the body's own "feel good" hormones – called endorphins.
- Exercise has a part to play in weight control too, so it really does have a lot to offer.
- Take your time and don't push through the pain: that's not helpful and can lead to flare-ups.
- Start with a few repetitions and slowly build up.
- Commit to daily practice for three months before judging whether or not this is helping! If you're not fit, it may take this much time to see an improvement. Don't give up!

**PRACTICE RELAXATION**

- Relax your breathing—Breathe in slowly, deeply through your nose, and breathe out slowly, through your mouth, repeat until you feel more relaxed.
- Relax your muscles—Focus on the muscle you want to relax.
- Relax your mind: Create a happy, peaceful place in your mind where you can close your eyes and visit, when you need to relax.
- Listen to soothing, calm music.

**IF YOU ARE ON MEDICATION**

- Take your medication exactly as prescribed.
- Tell your medical provider all of the prescription and over the counter medicines you take.
- Do NOT drink alcohol; use illegal drugs; take sleep aids; or muscle relaxants.
- Never take medications that are not prescribed to you.
- Discuss all side effects and concerns you have with your medical provider.



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**CHRONIC PAIN: PREPARING FOR YOUR HEALTH CARE VISIT PART I**

Many things can affect your pain.

These can include:

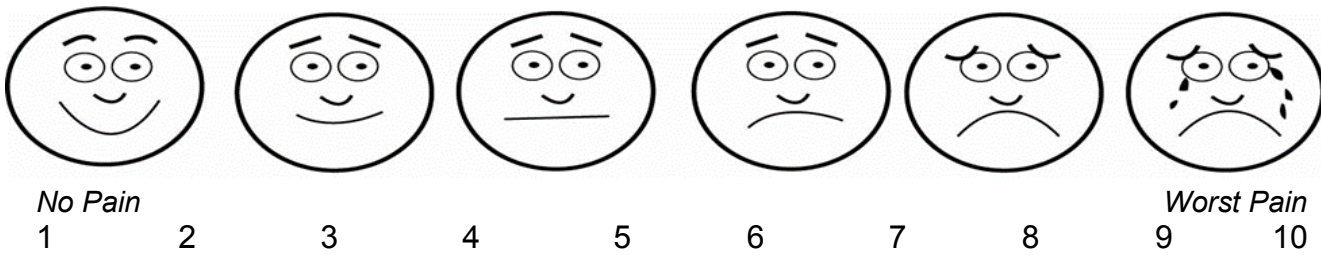
- Stress
- Poor Sleep
- Depression
- Anger
- Feeling alone
- Sadness
- Fear
- Being worried/anxious

When you visit with your Health Care Team, be ready to talk about:

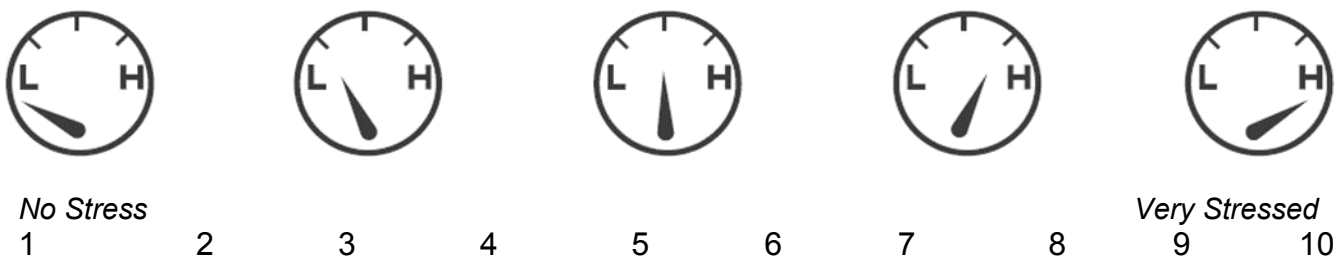
1. What do you think is wrong?
2. Any new symptoms or improvements since your last visit?
3. How is the pain affecting your daily life?
4. Any other questions?

Before your visit, look at each section below and circle the number that most closely matches how you have felt in that area over the last 2-3 weeks.

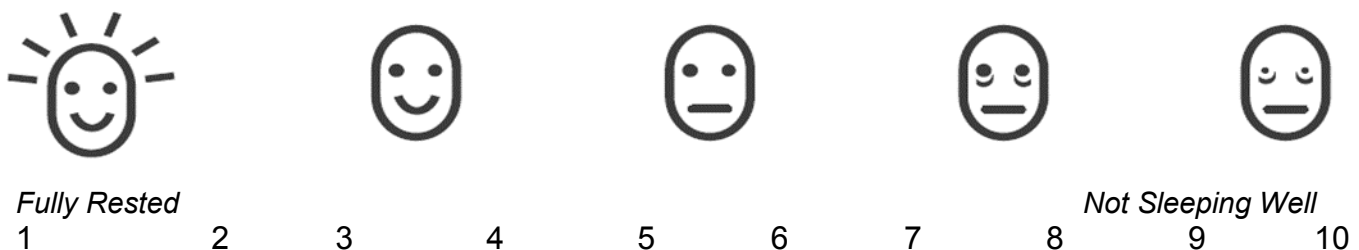
**Pain Level**



**Stress**



**Sleep**



SUMMARY

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**CHRONIC PAIN: PREPARING FOR YOUR HEALTH CARE VISIT PART 2**

Look at each section below and circle the number that most closely matches how you have felt in that area over the last 2-3 weeks.

**Fear of Pain**



No Fear

Very Afraid

1 2 3 4 5 6 7 8 9 10

**Hunger**



Eating Normal Meals

Not Hungry

1 2 3 4 5 6 7 8 9 10

**Mood**



Happy & Calm

Sad, Depressed, or Anxious

1 2 3 4 5 6 7 8 9 10

**Activity**

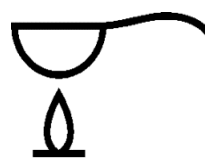


Normal Activity

No Activity

1 2 3 4 5 6 7 8 9 10

**Using Medications as Prescribed**



Always Take As Directed

Do Not Take As Directed

1 2 3 4 5 6 7 8 9 10

## RESUMEN

## APOYO PARA TOMAR DECISIONES

## EDUCACIÓN PARA EL PACIENTE/CONTROL PERSONAL DEL CASO

**DOLOR CRÓNICO: QUÉ DEBE HACER****COSAS IMPORTANTES QUE DEBE RECORDAR:**

- Una de las cosas más difíciles de aceptar podría ser que no existe cura para su dolor.
- Usted tendrá días buenos y días malos, incluso con el tratamiento.

**CONSEJOS PARA AFRONTAR SU DOLOR:****EVITE EL DIÁLOGO INTERNO NEGATIVO**

- Los estudios demuestran que lo que nos decimos a nosotros mismos (dentro de nuestras cabezas) puede afectar nuestro concepto del dolor.
- Convertir los pensamientos negativos en reflexiones positivas requiere de práctica, pero vale la pena.

**MEJORE SU SUEÑO**

- Su médico general y su clínico de salud mental le recomendarán terapias para manejar los problemas que podrían afectar su sueño.
- La actividad física, evitar las siestas y tener hábitos regulares de sueño también ayudan.

**CONTROLE EL ESTRÉS**

- Haga lo posible por mantenerse saludable y positivo.
- Busque y acepte ayuda.

**AUMENTE SU ACTIVIDAD FÍSICA**

- A muchas personas con dolor les da miedo ejercitarse, pero la actividad física en realidad puede ayudar a disminuir el dolor.
- El ejercicio también mejora el estado de ánimo, el sueño y el bienestar general porque se secretan las hormonas de “sensación de bienestar” propias del cuerpo, llamadas endorfinas.
- El ejercicio también desempeña un papel en el control de peso, así que realmente tiene mucho que ofrecer.
- Tómese su tiempo y no aguante el dolor: esto no ayuda y puede hacer que se intensifique. Empiece con unas cuantas repeticiones y poco a poco vaya aumentándolas.
- ¡Comprométase a practicarlo diariamente durante tres meses antes de decidir si está ayudando o no! Si usted no está en forma, podría llevar todo ese tiempo para notar una mejoría; no se dé por vencido.

**PRACTIQUE LA RELAJACIÓN**

- Relaje su respiración: Inhale despacio y profundo por la nariz, y exhale despacio por la boca; repítalo hasta que se sienta más relajado.
- Relaje los músculos: concéntrese en el músculo que desee relajar.
- Relaje su mente: cree un lugar feliz y pacífico en su mente a donde pueda ir al cerrar los ojos cuando necesite relajarse.
- Escuche música relajante y tranquila.

**SI ESTÁ TOMANDO MEDICAMENTOS**

- Tome sus medicamentos exactamente como se le indicó.
- Informe a su proveedor médico de todos los medicamentos que toma, con y sin receta médica.
- NO consuma alcohol, drogas ilegales, pastillas para dormir ni relajantes musculares.
- Nunca tome medicamentos que no le recetaron.
- Dígale a su proveedor médico todos los efectos secundarios e inquietudes que tenga.



**DOLOR CRÓNICO: CÓMO PREPARARSE PARA SU CONSULTA DE ATENCIÓN MÉDICA, 1° PARTE**

Muchas cosas pueden afectar su dolor, por ejemplo:

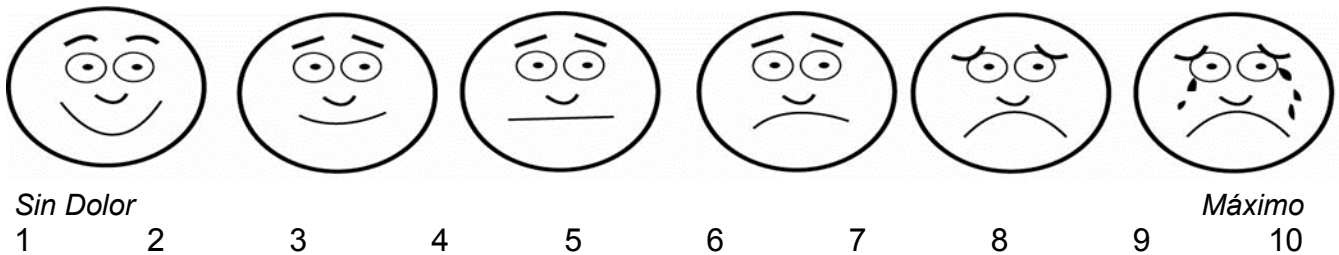
- Estrés
- Falta de sueño
- Depresión
- Enojo
- Sentirse solo
- Tristeza
- Miedo
- Preocupación o ansiedad

Cuando visite a su equipo de atención médica, esté preparado para hablar sobre:

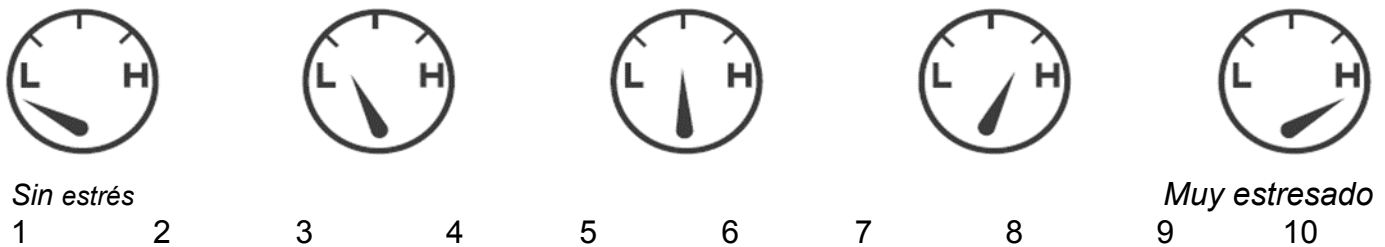
1. ¿Qué considera que está mal?
2. ¿Si tiene algún síntoma nuevo o mejoría desde su última consulta?
3. ¿Cómo afecta su vida diaria el dolor?
4. ¿Otras preguntas que tenga?

Antes de su consulta, revise cada una de las siguientes secciones y marque con un círculo el número que más se acerque a cómo se ha sentido sobre ese tema en las últimas 2 o 3 semanas.

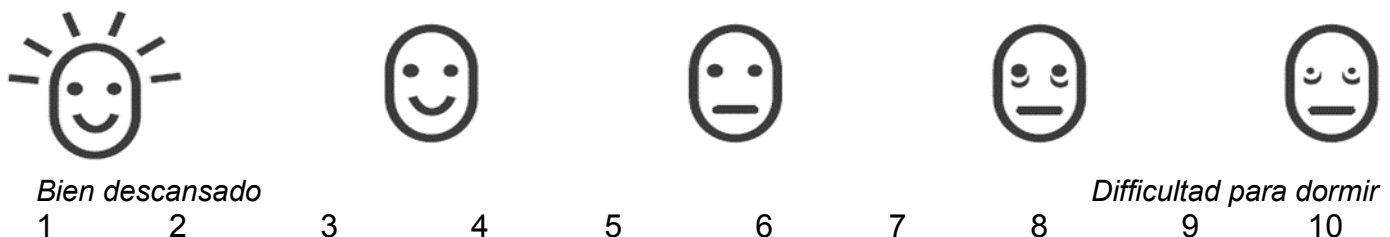
**Nivel de dolor**



**Estrés**



**Sueño**



DOLOR CRÓNICO: CÓMO PREPARARSE PARA SU CONSULTA DE ATENCIÓN MÉDICA, 2º PARTE

Revise cada una de las siguientes secciones y marque con un círculo el número que más se acerque a cómo se ha sentido sobre ese tema en las últimas 2 o 3 semanas.

**Miedo de sentir dolor**



Sin miedo

1 2



3 4



5 6



7 8



Mucho miedo

9 10

**Hambre**



Come alimentos normales

1 2



3 4



5 6



7 8



Sin hambre

9 10

**Estado de ánimo**



Contento y tranquilo

1 2



3 4



5 6



7 8



Triste, deprimido, o ansioso

9 10

**Actividad**



Actividad normal

1 2



3 4



5 6



7 8



Sin actividad

9 10

**Uso de los medicamentos según lo prescrito**

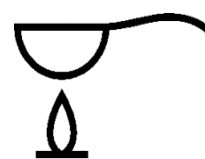


Siempre los toma según lo indicado

1 2



3 4



5 6

7 8



No los toma según lo indicado

9 10

Attachment A

**PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)**

(Patient Completes)

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

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

Add columns: \_\_\_\_\_ + \_\_\_\_\_ + \_\_\_\_\_ + \_\_\_\_\_  
= Total Score: \_\_\_\_\_

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

Not difficult at all

Somewhat difficult

Very difficult

Extremely difficult

Attachment B

**NIDA Quick Screen V1.0**

*(Provider Completes)*

Name: \_\_\_\_\_ Sex: ( ) F ( ) M Age: \_\_\_\_\_

Interviewer: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

**Introduction (Please read to patient)**

Hi, I'm \_\_\_\_\_, nice to meet you. If it's okay with you, I'd like to ask you a few questions that will help me give you better medical care. The questions relate to your experience with alcohol, cigarettes, and other drugs. Some of the substances we'll talk about are prescribed by a doctor (like pain medications). But I will only record those if you have taken them for reasons or in doses other than prescribed. I'll also ask you about illicit or illegal drug use—but only to better diagnose and treat you.

**Instructions:** For each substance, mark in the appropriate column. For example, if the patient has used cocaine monthly in the past year, put a mark in the "Monthly" column in the "illegal drug" row.

NIDA Quick Screen Question:	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
In the past year, how often have you used the following?					
Alcohol For men, more than 5 drinks a day For women, more than 4 drinks a day					
Tobacco Products					
Prescription Drugs for Non-Medical Reasons					
Illegal Drugs					

If the patient says "NO" for all drugs in the Quick Screen, reinforce abstinence.  
**Screening is complete.**

If the patient says "YES" to any drugs on the Quick Screen, refer to MAT Care Guide.

More in depth screening may also be done using the NIDA Modified Assist Tool.

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This guide is designed to assist clinicians serving adult patients in screening for drug use. The NIDA Quick Screen was adapted from the single-question screen for drug use in primary care by Saitz et al. (available at <http://archinte.ama-assn.org/cgi/reprint/170/13/1155>) and the National Institute on Alcohol Abuse and Alcoholism's screening question on heavy drinking days (available at [http://pubs.niaaa.nih.gov/publications/Practitioner/CliniciansGuide2005/clinicians\\_guide.htm](http://pubs.niaaa.nih.gov/publications/Practitioner/CliniciansGuide2005/clinicians_guide.htm)).



## Attachment C

### NIDA Modified Assist (Provider Completes)

Please answer the following questions:

1. In your LIFETIME, which of the following substances have you ever used? (Yes/No)

Cannabis	Methamphetamine	Hallucinogens
Cocaine	Inhalants	Street opioids
Prescription stimulants	Sedatives or sleeping pills	Prescription opioids

2. In the past 3 months, how often have you used the following substances? (Never, once or twice, monthly, weekly, almost daily)
3. In the past three months, how often have you had a strong desire or urge to use (first drug, second drug, etc.)? (Never, once or twice, monthly, weekly, almost daily)
4. During the past three months, how often has your use of (first drug, second drug, etc.) led to health, social, legal or financial problems? (Never, once or twice, monthly, weekly, almost daily)
5. During the past 3 months, how often have you failed to do what was normally expected of you because of your use of this substance? (Never, once or twice, monthly, weekly, almost daily)
6. Has a friend or relative or anyone else ever expressed concern about your use of (first drug, second drug, etc.)? (Never; yes, but not in the past 3 months; yes, in the past 3 months)
7. Have you ever tried and failed to control, cut down, or stop using this substance? (Never; yes, but not in the past 3 months; yes, in the past 3 months)
8. Have you ever used any drug by injection (NONMEDICAL USE ONLY)? (Never; yes, but not in the past 3 months; yes, in the past 3 months)

Attachment D

**Screener and Opioid Assessment for Patients with Pain (SOAPP)  
 (Patient Completes)**

**SOAPP Version 1.0**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

*Please answer each question as honestly as possible. This information is for our records and will remain confidential. Your answers alone will not determine your treatment.*

**Please answer the questions below using the following scale:**

**0=Never, 1=Seldom, 2=Sometimes, 3=Often, 4=Very Often**

1. How often do you have mood swings? 0 1 2 3 4
2. How often do you smoke a cigarette within an hour after you wake? 0 1 2 3 4
3. How often have any of your family members, including parents and grandparents, had a problem with alcohol or drugs? 0 1 2 3 4
4. How often have any of your close friends had a problem with alcohol or drugs? 0 1 2 3 4
5. How often have others suggested that you have a drug or alcohol problem? 0 1 2 3 4
6. How often have you attended an AA or NA meeting? 0 1 2 3 4
7. How often have you taken medication other than the way that it was prescribed? 0 1 2 3 4
8. How often have you been treated for an alcohol or drug problem? 0 1 2 3 4
9. How often have your medications been lost or stolen? 0 1 2 3 4
10. How often have others expressed concern over your use of medication? 0 1 2 3 4
11. How often have you felt a craving for medication? 0 1 2 3 4
12. How often have you been asked to give a urine screen for substance abuse? 0 1 2 3 4
13. How often have you used illegal drugs (marijuana, cocaine, etc.) in the past 5 years? 0 1 2 3 4
14. How often, in your lifetime, have you had legal problems or been arrested? 0 1 2 3 4

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

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Attachment E

**Clinical Opiate Withdrawal Scale (COWS)**

*(Provider Completes)*

For each item, circle the number that best describes the patient's signs or symptoms. Rate on just the apparent relationship to opiate withdrawal. For example, if heart rate is increased because the patient was jogging just prior to the assessment, the increase pulse rate would not add to the score.

Patient's Name: _____		Date and Time: _____	
<b>Reason for this assessment:</b> _____			
<b>Resting Pulse Rate:</b> _____ beats/min <i>Measured after patient is sitting or lying for 1 minute</i> 0 pulse rate 80 or below 1 pulse rate 81-100 2 pulse rate 101-120 4 pulse rate greater than 120		<b>GI Upset: Over last ½ hour</b> 0 no GI symptoms 1 stomach cramps 2 nausea or loose stool 3 vomiting or diarrhea 5 multiple episodes of diarrhea or vomiting	
<b>Sweating: Over past ½ hour not accounted for by room temperature or patient activity</b> 0 no report of chills or flushing 1 subjective report of chills or flushing 2 flushed or observable moistness on face 3 beads of sweat on brow or face 4 sweat streaming off face		<b>Tremor: Observation of outstretched hands</b> 0 no tremor 1 tremor can be felt, but not observed 2 slight tremor observable 4 gross tremor or muscle twitching	
<b>Restlessness: Observation during assessment</b> 0 able to sit still 1 reports difficulty sitting still, but is able to do so 3 frequent shifting or extraneous movements of legs/ arms 5 unable to sit still for more than a few seconds		<b>Yawning: Observation during assessment</b> 0 no yawning 1 yawning once or twice during assessment 2 yawning three or more times during assessment 4 yawning several times/minute	
<b>Pupil Size</b> 0 pupils pinned or normal size for room light 1 pupils possibly larger than normal for room light 2 pupils moderately dilated 5 pupils so dilated that only the rim of the iris is visible		<b>Anxiety or Irritability</b> 0 none 1 patient reports increasing irritability or anxiousness 2 patient obviously irritable or anxious 4 patient so irritable or anxious that participation in the assessment is difficult	
<b>Bone or Joint Aches: If patient was having pain previously, only the additional component attributed to opiates withdrawal is scored</b> 0 not present 1 mild diffuse discomfort 2 patient reports severe diffuse aching of joints/ muscles 4 patient is rubbing joints or muscles and is unable to sit still because of discomfort		<b>Gooseflesh Skin</b> 0 skin is smooth 3 piloerection of skin can be felt or hairs standing up on arms 5 prominent piloerection	
<b>Runny nose or tearing: Not accounted for by cold symptoms or allergies</b> 0 not present 1 nasal stuffiness or unusually moist eyes 2 nose running or tearing 4 nose constantly running or tears streaming down cheeks		Total Score: _____ The total score is the sum of all 11 items  Initial of person completing assessment: _____	

Score 5-12 = mild; 13-24 = moderate; 25-36 = moderately severe; more than 36 = severe withdrawal

Modified from: Wesson, D. R., & Ling, W. (2003). The Clinical Opiate Withdrawal Scale (COWS). *J Psychoactive Drugs*, 35(2), 253-9. <https://echo.unm.edu/wp-content/uploads/2014/10/IAP-Clinical-Opiate-Withdrawal-Scale.pdf>

# Attachment F

# CCHCS Care Guide: Pain Management

Below are InterQual (IQ) guidelines for cervical, thoracic and lumbar spine imaging

- CT scan can assess osseous structures better than either plain radiography or MRI and is therefore helpful in assessing for bony disease. However, a CT alone is unable to visualize nerve roots, so it is not helpful in the direct imaging of a radicular process. If MRI cannot be done because of metal fragments, etc. use CT Myelogram
- Why not to image early:
  - Abnormal imaging findings often do not correlate with location and type of pain, or clinical severity/improvement.
  - Radiation, unnecessary work-ups, contrast reactions
  - 2009 systematic meta-analysis of 6 trials with MRI and CT in acute and subacute LBP- NO significant differences at 3 months or 6-12 months.

## InterQual Cervical, Thoracic and Lumbar Imaging Summary Table

\*\* Obtained from IQ Version 2017.2—Please refer to the most current IQ guidelines

Suspected Disease Entity	Clinical Features and Clues	Study of Choice as per IQ guidelines
<i>Somatic neck, upper back and lumbar back pain</i>	<ul style="list-style-type: none"> <li>• <i>Without neurologic deficits</i></li> <li>• <i>Other causes above ruled out by history and physical AND</i></li> <li>• <u>Conservative therapy failure:</u> <ul style="list-style-type: none"> <li>▶ NSAIDS or Acetaminophen trial ≥ 3 wks</li> <li>▶ PT or home exercise ≥ 6 wks</li> <li>▶ Activity modification ≥ 6 wks</li> <li>▶ Patient Ed: pain management, posture, lifting, self-care</li> </ul> </li> </ul>	<p>X-Rays</p> <p><i>(Flexion and extension generally not needed)</i></p>
<i>Cervical, Thoracic or Lumbar disc herniation or foraminal stenosis</i>	<ul style="list-style-type: none"> <li>• <u>Acute symptoms without severe or progressive neurologic deficits do not need imaging</u></li> <li>• Unilateral radicular pain with sensory or motor and reflex deficits in a nerve root distribution</li> <li>• Pain and weakness most indicative</li> <li>• Weakness generally ≤ 3/5 (unable to withstand any resistance, but can withstand gravity or worse)</li> <li>• Motor weakness generally indicates more severe compression</li> <li>• Worsening (intensified pain or more distal extension) symptoms and/or weakness or motor deficit on clinical re-evaluation</li> <li>• Continued severe pain (≥ 8-10/10 after NSAIDS or Acetaminophen ≥ 3 days)</li> <li>• Pain ≥ 7/10 on pain scale and at least ≥ 3/10</li> <li>• Pain unrelieved by change in body position</li> <li>• Pain interferes with function/ADLs</li> </ul> <p><b>AND</b></p> <ul style="list-style-type: none"> <li>• <u>Conservative therapy failure</u> <ul style="list-style-type: none"> <li>▶ NSAIDS or Acetaminophen trial ≥ 3 weeks</li> <li>▶ PT or home exercise ≥ 6 weeks</li> <li>▶ Activity modification ≥ 6 weeks</li> <li>▶ Patient Ed: pain management, posture, lifting, self-care</li> <li>▶ Psychosocial evaluation done</li> </ul> </li> </ul> <p><b>OR</b></p> <ul style="list-style-type: none"> <li>• Excruciating unremitting symptoms <u>totally unresponsive</u> to treatment and interferes significantly with function (<i>partial relief does not qualify</i>)</li> </ul>	<p><i>MRI without contrast/ CT/MYL-CT If MRI N/A or not feasible</i></p>
<i>Cervical Spinal stenosis</i>	<p><i>For Cervical Spinal Stenosis:</i></p> <ul style="list-style-type: none"> <li>• Numbness, weakness, or tingling in hand, arm, foot, or leg</li> <li>• Neck pain</li> <li>• Symptoms interfere with function/ADLs</li> </ul>	<p><i>MRI without contrast CT/MYL-CT If MRI N/A or not feasible</i></p>

## Attachment F (Continued)

InterQual Cervical, Thoracic & Lumbar Imaging Summary Table		
Suspected Disease Entity	Clinical Features and Clues	Study of Choice as per IQ guidelines
<p><i>Thoracic spinal stenosis</i></p> <p><i>Lumbar spinal stenosis</i></p> <p><i>(single or multi-level narrowing of the spinal canal)</i></p>	<p><i>For Thoracic Spinal Stenosis:</i></p> <ul style="list-style-type: none"> <li>• Pain in the ribs and affected area of the back radiating down the back or legs</li> <li>• Pain in one or more internal organs</li> <li>• Bilateral symptoms- “spinal claudication” in buttocks, thighs, or calves</li> <li>• Symptoms worsen with prolonged standing</li> <li>• Symptoms interfere with function/ADLs</li> </ul> <p><i>For Lumbar Spinal Stenosis:</i></p> <ul style="list-style-type: none"> <li>• Bilateral symptoms- “spinal claudication” in buttocks, thighs, or calves</li> <li>• Pain and/or paresthesias improve with forward flexion/worsen with walking</li> <li>• Symptoms worsen with prolonged standing</li> <li>• Symptoms interfere with function/ADLs</li> </ul> <p><i>Additionally for Cervical, Thoracic and Lumbar Spinal Stenosis:</i></p> <p><b>AND</b></p> <ul style="list-style-type: none"> <li>• <u>Conservative therapy failure:</u> <ul style="list-style-type: none"> <li>▶ NSAIDS or Acetaminophen trial ≥ 3 wks</li> <li>▶ PT or home exercise ≥ 6 wks</li> <li>▶ Activity modification ≥ 6 wks</li> <li>▶ Patient Ed: pain management, posture, lifting, self-care</li> <li>▶ Psychosocial evaluation done</li> </ul> </li> </ul> <p><b>OR</b></p> <ul style="list-style-type: none"> <li>• Excruciating unremitting symptoms <u>totally unresponsive</u> to treatment and interfere significantly with function (<i>partial relief does not qualify</i>)</li> </ul>	<p><i>MRI without contrast</i></p> <p><i>CT/MYL-CT</i></p> <p><i>If MRI N/A or not feasible</i></p>
<p>Cervical Myelopathy/ Cord compression (Urgent)</p>	<ul style="list-style-type: none"> <li>• Bilateral upper or lower extremity pain, numbness, or weakness</li> <li>• Bowel and bladder dysfunction (other etiologies excluded)</li> <li>• Spasticity by physical exam (other etiologies excluded)</li> <li>• B/L loss of dexterity</li> <li>• Unsteady gait (other etiologies excluded)</li> </ul>	<p><i>MRI</i></p> <p><i>MYL-CT</i></p> <p><i>If MRI N/A or not feasible</i></p>
<p>Thoracic Myelopathy/ Cord compression</p>	<ul style="list-style-type: none"> <li>• Bilateral upper or lower extremity pain, numbness, or weakness</li> <li>• Bowel and bladder dysfunction (other etiologies excluded)</li> <li>• Spasticity by physical exam (other etiologies excluded)</li> <li>• Diminished rectal sphincter tone by physical examination (other etiologies excluded)</li> </ul>	<p><i>MRI</i></p> <p><i>MYL-CT</i></p> <p><i>(If MRI N/A or not feasible)</i></p>
<p><i>Cauda equina syndrome</i></p>	<ul style="list-style-type: none"> <li>• Bilateral lower extremity weakness, numbness or pain</li> <li>• Sensory pattern often diffuse with overlapping nerve roots, asymmetric or unilateral. <i>Almost never isolated sensory</i></li> <li>• Perianal or perineal “saddle” anesthesia, ↓ anal sphincter tone</li> <li>• Progressive lower spinal stenosis</li> <li>• Bowel or bladder dysfunction (retention, frequency, hesitancy, urgency or incontinence) without known etiology – <u>late ominous</u></li> </ul>	<p><i>MRI</i></p> <p><i>CT/MYL-CT</i></p> <p><i>(If MRI N/A or not feasible)</i></p>

## Attachment F (Continued)

InterQual Cervical, Thoracic & Lumbar Imaging Summary Table		
Suspected Disease Entity	Clinical Features and Clues	Study of Choice
<i>Suspected epidural abscess</i>	<ul style="list-style-type: none"> <li>• Classic – spinal pain or neurologic deficit with fever and elevated ESR</li> <li>• <b>Risk factor(s)</b> – IVDA, immunosuppression, recent spinal or epidural procedure, vertebral trauma, diabetes, cancer, ESRD, AIDs, transplant medications</li> <li>• Axial/localized spine pain (but symptoms can be nonspecific)</li> <li>• Pain increases with movement</li> <li>• Temp &gt; 100.4° F (38° C)</li> <li>• Positive blood culture, ↑WBC ↑CRP, ESR &gt;30 mm/hr</li> </ul> (Note: Fever and WBC may be misleadingly low in immunosuppressed)	<i>MRI with gadolinium</i>  <i>CT/MYL-CT (If MRI N/A or not feasible)</i>
<i>Spinal tumor</i>	<ul style="list-style-type: none"> <li>• Known spinal tumor with indication to re-image</li> <li>• Localized spine pain</li> <li>• Palpable mass on the spine</li> <li>• Nocturnal pain and unresponsive to rest</li> </ul>	<i>MRI with and without gadolinium</i> <i>MYL-CT (If MRI N/A or not feasible)</i>
<i>Bony metastases</i>	<ul style="list-style-type: none"> <li>• History of cancer (most common: primary breast, lung and prostate, renal, thyroid and multiple myeloma)</li> <li>• Spine pain over bone</li> <li>• X-Ray or bone scan bone lesion</li> <li>• Neurologic deficit on exam (nerve root: weakness, paralysis, or paresthesias)</li> </ul>	<i>MRI with and without gadolinium</i> <i>CT/MYL-CT/ Bone scan (If MRI N/A or not feasible)</i>
<i>Osteomyelitis</i>	<ul style="list-style-type: none"> <li>• <b>Risk factors:</b> Chronic indwelling catheters (Thoracic/Lumbar), recent (especially orthopedic) surgery, Intravenous Drug Abuse (VDA), open fracture, penetrating trauma, local soft tissue ulceration, immunosuppressed</li> <li>• Diagnosed by X-Ray and need further evaluation for treatment decisions (X-Rays often negative in early otitis media)</li> <li>• Continued symptoms/findings after antibiotics Rx and need evaluation for preoperative/other treatment</li> <li>• Localized neck pain (cervical) or spine pain (Thoracic/Lumbar), myalgias, swelling, drainage</li> <li>• T&gt; 100.4° F, + blood culture, ↑ WBC, ↑ESR &gt; 30 mm/hr, ↑ CRP</li> </ul>	<i>MRI /CT (If MRI N/A or not feasible)</i>
<i>Disc Space Infection</i>	<ul style="list-style-type: none"> <li>• <b>Risk Factors:</b> Advanced age, immunosuppression, recent spinal surgery, vascular access, IVDA</li> <li>• Localized spine pain</li> <li>• Temperature &gt; 100.4° F</li> <li>• Positive blood culture</li> <li>• ESR &gt; 30 mm/hr, ↑WBC ↑CRP</li> </ul>	<i>MRI /CT (If MRI N/A or not feasible)</i>