

Opioids and Pain: Assessment and Treatment Planning Prior to Prescribing (ER/LA Opioids)

Table of Contents

Opioids and Pain: Assessment and Treatment Planning Prior to Prescribing (ER/LA Opioids).....5

- Goal:..... 5
- After completing this module participants will be able to:.....5
- Professional Practice Gaps..... 5
- Physical Exam Results and Working Diagnosis.....9
- Case Example: Ms. Ward's Functioning Assessment..... 10
- ORT: Opioid Risk Tool..... 11
- SOAPP: Screener and Opioid Assessment for Patients with Pain..... 12
- DIRE: Diagnosis, Intractability, Risk, Efficacy..... 13
- Mr. Lancaster - Dialog and Risk Assessment..... 13
- Psychiatric History..... 15
- Case Example: Mr. Lancaster's Depression Screening..... 16
- Case Example: Ms. Ward's CAGE-AID..... 18
- Goals For Pain Treatment..... 20
- Treatment Agreement Example..... 23
- Ms. Cobb - Patient Boundaries..... 25
- Ms. Cobb - Patient Expectations..... 28
- Patient Counseling Document..... 32

 - Patient Interview:..... 33

- Poll: Would you conduct urine drug testing on Ms. Edwards before prescribing opioids? 33
- Urine Drug Testing..... 34

 - Basics..... 34
 - Uses of UDTs:..... 34
 - KEY POINT 34

- Ordering Urine Drug Tests..... 34

 - Type of Urine Drug Test..... 34
 - Comparing two types of urine analysis..... 34
 - KEY POINTS..... 35
 - FYI..... 35

Ordering Considerations..... 35

 KEY POINTS..... 36

What Tests to Order..... 36

 Develop a "standard screen"..... 36

Mr. Lewis - Urine Drug Testing..... 36

Conducting UDT..... 37

 Safeguard the sample..... 37

UDT Patient Communication..... 37

 What to tell the patient..... 37

UDT Interpretation..... 38

 46,47..... 38

Case: Terri Part 2..... 38

 Additional Provider-Patient Dialogue..... 38

 Urine Drug Test Results:..... 39

 Choose one..... 39

Ms. Edwards Case Continues:..... 39

 Additional Provider-Patient Dialogue..... 40

 Choose one:..... 40

Specific cutoff levels and detection times..... 40

 KEY POINTS..... 41

False Positive UDTs..... 41

 Common Interpretations..... 41

 Reasons for a positive test for an unprescribed medication..... 41

 Drugs and substances that can cause false positives..... 42

False Negative UDTs..... 43

 Common Causes of a Negative Result..... 43

Recognizing Sample Tampering..... 43

 FYI..... 43

Multidisciplinary Approach to Chronic Pain Treatment..... 43

 The Disciplines Involved in Pain Treatment..... 44

 Pain Treatment Centers..... 44

Mrs. Catell- Medical Home..... 44

 A Medical "Home" for Each Patient Treated for Chronic Pain..... 44

Collaborating on Patient Care..... 44

Case Example: Medical Home for Multi-Modal Pain Treatment..... 44

Documentation - The Patient Record..... 45

Initial Evaluations..... 45

PRACTICE TIPS..... 46

Case Vignette: Mr. Parker..... 46

Past Medical History..... 46

Family/Social History..... 46

Current Medications..... 47

Past Medications..... 47

Labs..... 47

Physical Exam..... 47

Mr. Parker - Patient Interview Questions..... 47

Choose all that apply..... 48

Mr. Parker - Possible Risk Assessment Questions..... 48

Mr. Parker - Example Risk Assessment Questions..... 48

Provider-Patient Dialogue..... 49

Other risk questions include:..... 49

Mr. Parker - Treatment Agreement..... 49

Review Mr. Parker's Pain History:..... 49

History of Present Illness (repeated for convenience):..... 50

Past Medical History..... 50

Family/Social History..... 50

Current Medications..... 50

Past Medications..... 50

Choose all that apply..... 50

Mr. Parker - Case Summary..... 51

Choose one..... 52

Summary and Key Points..... 53

Resources available through this module:..... 53

Module References:..... 55

OPIOIDS AND PAIN: ASSESSMENT AND TREATMENT PLANNING PRIOR TO PRESCRIBING (ER/LA OPIOIDS)

Goal:

Clinicians who prescribe extended release/long-acting opioids will be able to evaluate patients thoroughly prior to prescribing them, including history, physical, and assessments for pain, functioning, psychiatric status, and risk for opioid misuse or addiction.

After completing this module participants will be able to:

- Obtain a comprehensive pain history prior to prescribing opioids, and refer to specialists as needed
- Take a systematic approach to assessing pain and functioning prior to prescribing opioids
- Assess a patient for risk of opioid addiction prior to prescribing opioids
- Screen patients for addiction prior to prescribing opioids
- Screen for psychiatric problems, particularly depression, prior to prescribing opioids

Professional Practice Gaps

Opioid misuse and abuse is a grave health concern in the U.S., and is one that continues to grow. The number of emergency department visits due to the non-medical use of prescription analgesics increased from 145,000 in 2004 to 360,000 in 2010¹ (DAWN, 2012). The number of drug poisoning deaths involving opioid analgesics increased from 4,000 in 1999 to 14,800 in 2008². By 2008, opioid analgesics were involved in 40% of all drug poisoning deaths². Also disturbing, every year starting in 2002, there have been at least 1.9 million new non-medical pain analgesic users³.

Chronic pain is a very common problem encountered in clinical practice. Research shows that 25.3 million (11.2%) adults in the United States experience chronic pain. 40 million (17.6%) of adults in the United States experience severe levels of pain⁴. In a study involving 111 providers (attending physicians, nurse practitioners, physician assistants, and family practice residents), a mean of 37.5% of adult patients seen in a targeted week by any of the participating providers reported having current chronic pain⁵. Furthermore, opioids are very commonly prescribed for chronic pain. In a survey of prescribers (including physicians, physician assistants, and advanced practice nurses), 58% answered that they were “likely” to prescribe opioids for chronic pain. When comparing 2002 to 2012, MEPS estimates showed growth in the total number of outpatient prescription purchases of opioids, rising from 85.9 million to 143.9 million purchases, an increase of 67.5 percent⁶. However, a significant amount of participants disclosed negative beliefs and attitudes about medication abuse and addiction which, they indicated, could complicate patient care and negatively impact clinical practice⁷. In a survey of family physicians, 80% were anxious about prescribing high-dose opioids to persons with chronic nonmalignant pain, and 92.4% did not prescribe opioids to individuals with a history of substance abuse⁸.

Professional organizations of pain specialists, based on expert consensus and review of the research literature, have created clinical guidelines for the use of chronic opioid therapy in chronic non-cancer pain⁹. The guidelines are designed to improve pain treatment outcomes and reduce the risk of prescription drug overdose and diversion. The need for prescribers to do more to prevent diversion

can be inferred from studies showing that a majority of patients do not take their pain medication as prescribed¹⁰ and that the source for the majority of non-medically used prescription drugs is friends or relatives³. The need for education and training in the guidelines to avoid diversion and overdose is evident in research linking "doctor shopping" to increased risk for overdose¹¹. Furthermore, research by the National Center on Addiction and Substance Abuse at Columbia University (CASA) shows that physicians do not follow key recommendations in evidence-based guidelines for avoiding diversion and overdose¹². CASA has concluded from their research that physicians should receive more continuing medical education related to prescribing and administering controlled substances and identifying, diagnosing, and treating substance abuse and addiction¹².

A survey of health care facilities regarding pain management practice standards and education revealed gaps in knowledge of pain management and attitudes that hinder proper acute and chronic pain treatment¹³. While some medical schools have implemented programs that have improved students' attitudes and skills for treating patients with addiction, most medical schools have not¹⁴. From a national survey of residency programs, only 56.3% of programs required substance use disorder training, with the median number of hours ranging from 3 to 12 hours¹⁵. In a survey of family physicians, the majority (60%) believed that their training in medical school did not prepare them to manage pain⁸.

ER/LA Opioids Practice Gaps:

Only a few practice gaps regarding the prescribing of extended release/long-acting (ER/LA) opioids have been identified in the literature, despite risks associated with their use and their frequent use. The risk of overdose and death can be greater for ER/LA opioids than other opioids, and so practice gaps described above regarding these topics are especially relevant for this subclass of opioids. While ER/LA opioids were only 9% of all opioid prescriptions dispensed in 2009, they represented 22.9 million prescriptions, up from 9.3 million in 2000¹⁶. In 2009, 3.8 million patients received a prescription for ER/LA opioids in an outpatient setting¹⁶. Primary care providers are responsible for a large portion of the ER/LA prescriptions: General practice (GP), Family Medicine (FM), D.O.'s plus Internal Medicine, dispense around 44% of these prescriptions¹⁶. Although primary care physicians may be one of the leading prescribers of opioids, they often leave out pertinent information about the safe use and storage of opioid analgesics during patient counseling¹⁷, making PCPs an important target audience of this activity.

GETTING STARTED

About this Module

This module will review a comprehensive approach to assessing the patients':

1. Pain
2. Level of functioning
3. Underlying pain condition
4. Risks for opioid abuse, including current substance abuse



It is important to evaluate all four, thoroughly, before deciding on a treatment and whether or not to include opioid therapy as part of that treatment. A standard approach to elicit information from a patient will assure that critical information is not omitted.

INTRODUCTION TO ASSESSMENT

Components of Evaluation:

- A complete history including:
 - Patient history
 - Family history of substance abuse
 - History of psychiatric disorders
 - Pain and functioning assessment
- Assessment of risk for addiction or substance misuse including screening for current substance abuse
- Physical examination
- Diagnostic tests

PRACTICE TIP

Short-term pharmacological treatment can be provided during the evaluation period. With complete assessments, you will have all the information you need to weigh the benefits vs. risks and provide the most effective and safe pain management.⁹

PAIN HISTORY

Communicating with the Patient

Pain should be assessed at every appointment during chronic pain treatment, as it may change over time.

Let your patients know that you care about their pain and how it affects them and that you will do everything you can to help them.

Note: With chronic pain, finding the pain diagnosis may not always be possible, but an effort to find and treat the underlying cause and assessing its current status is important.

What to ask about in the pain history

Finding risk for substance misuse does not rule out treatment with long-acting opioids; but in these cases, additional monitoring will be helpful. Consulting a specialist in addiction assessment and treatment will be helpful. Some addiction specialists may recommend co-managing the patient to ensure addiction issues are addressed. In some high-risk cases, referral to another pain treatment provider specializing in comorbid pain and addiction might be the best approach.

PAIN HISTORY: A SYSTEMATIC APPROACH

Pain assessment tools allow systematic elicitation of critical facts about pain. The acronym **PQRSTU** is an example of a tool for taking a systematic pain history:

- **Provocation:** What elicits pain or aggravates it/makes it worse?

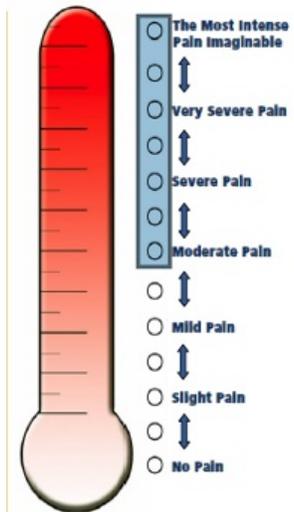
- Palliation:
 - What has been tried, pharmacological (over the counter and prescription) and non-pharmacological?
 - Response to treatment, both positive and adverse?
 - Dosages tried?
- Past: The past history of this problem?

Quality of Pain. For example, sharp or dull, throbbing? The McGill Pain Questionnaire includes a comprehensive list of pain descriptions¹⁸.

Region of Pain/Radiation. Location of pain and whether it radiates or moves to other areas. Use of a body outline diagram, such as in the McGill Pain questionnaire may help.

Severity of Pain. Pain is subjective and can be difficult to express, so use of scales can help rate pain severity.

- *Numeric pain intensity scale:* On a scale of 0 to 10 with 0 being no pain and 10 being the worst pain possible
- *Visual analog rating scales:* Example - the Pain Thermometer, in which higher temperatures correspond to higher pain intensity. For children and those with cognitive impairment, the Faces Pain Rating Scale depicts a range from a very happy face to a very sad face¹⁹.



Timing. Questions about time and pain including the following:

1. **Onset:** When did the pain start? How long after precipitating factors does it start?
2. **Time of day:** When?
3. **Pattern:** Intermittent or constant?
4. **Duration:** How long does it last?

U (How Pain Affects You). Questions about functioning are critical in determining the extent of treatment needed. Routine assessment of Activities of Daily Living can be supplemented with pain-related questions. Start with an open-ended question, for example: "Please tell me whether the pain is affecting your daily life?" and offer empathy when appropriate. Cover the three basic areas of functioning:²⁰

1. Psychological Functioning/Mood
2. Daily Activities
3. Social Functioning

MS. WARD: CASE EXAMPLE



Patient:

Ms. Ward is a 38-year-old new female patient complaining of pain in her left heel that began several months ago and became excruciating after a long run last week. She describes the pain as throbbing and sharp. It bothers her daily, especially after work, where she is on her feet a lot. She is frustrated because she wanted to run a half marathon but had to stop running because of the pain.

Ms. Ward's Pain Interview

Provocation/Palliation/Past

- Provocation: Pain after running, standing, and walking
- Palliation:
 - Ibuprofen 400 to 800 mg orally every 6 to 8 hours reduces pain a little, but it is still "unbearable" at its worst (at night) and first thing in the morning
 - Ice is very effective at reducing the sharpest pain, swelling, and heat after intense use
 - Not running or walking on it for a few days makes pain manageable
 - Guided imagery recording helped her sleep despite the pain
 - Occasional marijuana dulls the pain, but she does not want to use it
- Past: no hx of injury to left lower leg; never had this pain before

Quality of Pain: Sharp on impact, throbbing at rest, no numbness or tingling reported

Region of Pain/Radiation: Left heel, no radiation

Severity of Pain:

- 8 out of 10 after running or being on her feet at work
- 6 out of 10 at rest without medication
- 2 to 4 out of 10 with OTC ibuprofen and acetaminophen

Timing: Pain started 3 months ago. Sharp, intense pain with heel strike when running, immediately after running and working on her feet, and upon first standing and walking in the morning. Moderate-to-severe throbbing constant pain at night and a low level of pain at other times.

U (How Pain Affects You): Covered in the next section on Functioning Assessment.

PHYSICAL EXAM RESULTS AND WORKING DIAGNOSIS

Review Ms. Ward's Clinical Exam Results

The physical examination of Ms. Ward's left heel is currently negative for erythema, heat, and edema of the left heel, but she explains that she has been resting it. Palpation produces tenderness at the insertion of the plantar fascia into the calcaneus. Moderate pain with standing while bearing weight on the heel. Mild pain with dorsiflexion of the foot.

Differential Diagnosis

1. Plantar fasciitis (most common cause of heel pain; pain first thing in the morning in the heel is a symptom)
2. Heel spur

FUNCTIONING ASSESSMENT

What to Assess in Functioning

Functioning is the impact of the pain on the patient's life, including physical and psychosocial functioning. Pain is a perception, a subjective experience, so explore emotional and cognitive components in addition to objective findings.

Include assessment of both Physical and Psychosocial functioning:

Note: Many pain inventories, such as the Brief Pain Inventory, include questions on functioning. See Related Resources, this page.



Questions to Ask

Start with an open-ended question to draw the patient out on functioning, for example: "Please tell me whether the pain is affecting your daily life?"

After listening and providing empathy for this significant part of the chronic pain experience, ask for any further information you need about the following three basic areas of functioning:

1. **Psychological Functioning/Mood:** Does the pain affect your mood or ability to enjoy life?
Note: May need to involve caregivers in this discussion.
2. **Daily Activities:** Does your pain keep you from doing anything, such as daily activities? (e.g., sleeping, walking, cleaning, shopping, work, play, personal hygiene, childcare, or hobbies).
3. **Social Functioning:** Does the pain affect your relationships?

20

An example of a more formal assessment of functioning is the Oswestry Low Back Pain Disability Questionnaire

A quick assessment of pain, functioning, and impact of pain on the patient's life is the 3 question, PEG scale²¹.

(See Related Resources this page).

CASE EXAMPLE: MS. WARD'S FUNCTIONING ASSESSMENT

Patient: Ms. Elizabeth Ward, 38 y/o

History of Present Illness: Mrs. Ward has a 3-month history of moderate to severe heel pain, she answers the functioning questions as follows:

Provider: You said you had to stop running. Is the pain affecting your daily life in other ways?

Ms. Ward: I am having trouble getting through my workday. My job requires standing and walking. I have to limp to avoid walking on my heel, and that is tiring.

Provider: How does it affect your mood?

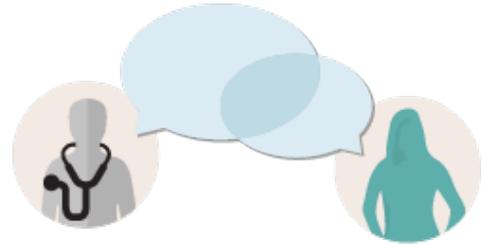
Ms. Ward: I've been pretty bummed about not being able to run a marathon.

Provider: How does it affect your relationships?

Ms. Ward: I don't go out with friends as much, and I miss being able to do activities with my daughter.

SCREENING TOOLS FOR RISK OF OPIOID MISUSE

A number of other screening tools specifically screen for risk of opioid misuse in the context of chronic pain treatment. Research supporting their use has shown inconsistent benefits; however, these may still be helpful to start a conversation about risks, along with the medical history intake forms, patient interview, laboratory results, and physical examination.



More research is needed to determine the extent to which risk assessment tools predict clinical outcomes⁹. A review of several self-completed opioid risk assessment tools by the APA rated their validity as being "good"⁹; however, a later review by the CDC described them as "inconsistent" and rated their specificity and sensitivity as being "average-to-modest"²²:

- **Opioid Risk Tool (ORT)** - sensitivity .2 to .99, specificity .16 to .88 for a cutoff of >e; 4.
- **Screeener to Predict Opioid Misuse Among Chronic Pain Patients (SOAPP - R)** - sensitivity 0.68, specificity 0.38 for a cutoff of >e; 8.
- **Diagnosis, Intractability, Risk, Efficacy (DIRE)**

If you do choose to use these tools, also consider that basic guidelines recommended for all patients should be applied for all patients, regardless of results. Also, because results for risk assessment tools have been reviewed as showing inconsistent utility in the research that has been completed, ongoing monitoring and a strategy for stopping opioids when necessary is needed²².

The health professional should:

- introduce the instrument to the patient
- explain the reason for its use
- ask the patient to briefly and honestly answer the questions by marking his or her responses.
-

ORT: OPIOID RISK TOOL

The CDC's review found the evidence evaluating this tool "extremely inconsistent", with the positive likelihood ration ranging from noninformative to moderately useful²².

- **Questions:** The questions asks whether there is
 1. Family history of substance misuse with alcohol, illegal drugs, or prescription drugs
 2. Personal history of substance misuse with alcohol, illegal drugs, or prescription drugs
 3. History of preadolescent sexual abuse (only statistically significant for females, as a group)
 4. Psychiatric disorder
- **Purpose:** Assesses risk of aberrant behaviors when patients are prescribed opioid medication for chronic pain
 1. Evidence
 2. Advantages/Limitations
- **Test features:**
 1. Time: Less than one minute to administer
 2. Length: 5 items

3. Administered by: Patient self-administration
 4. Target Population: Adults
 5. Intended Settings: Primary care
 6. Developed by: Lynn Webster, MD
- **Scoring and interpretation:**
 1. The ORT can be scored by hand, either by the patient or the health professional. Each item that the patient answers positively is awarded a value; values for the entire assessment are added to obtain a patient's opioid risk score, which is broken down into low (0-3), moderate (4-7), and high (>7) risk.
 - **Available Formats:**
 1. Printable ORT (see related resources)
 2. Printable ORT with Scoring Interpretation (see related resources)

SOAPP: SCREENER AND OPIOID ASSESSMENT FOR PATIENTS WITH PAIN

- **Purpose:** Patients at high risk for opioid misuse
 - Evidence
 - **Questions:** Ten questions cover the following topics:
 1. Mood swings
 2. Smoking upon waking
 3. Family substance misuse
 4. Personal or close friend substance misuse
 5. Others viewing substance use as a problem
 6. Attending AA or NA
 7. Substance use treatment
 8. Medications lost or stolen
 9. Others express concern over you substance use
 10. Non-prescribed use of medications (We do not have permission to reproduce this test, so please visit the external link to view questions.)
 11. Advantages/Limitations
- **Test features:**
 - Time: 5-10 minutes to administer and score
 - Length: Short and Long-item formats are available, including three formats of 5, 14 and 24 items. A revised version (SOAPP-R) includes a toxicology report.
 - Administered by: Patient self-administration
 - Target Population: Adults
 - Intended Settings: Primary care
 - Developed by: Stephen F. Butler, 2003 for Inflexxion, Inc.
- **Scoring and interpretation:**
 - The SOAPP can be scored by the health professional by adding the ratings for 14 of the 24 questions. A score of 7 or above indicates increased risk for misuse.
- **Available Formats:**
 - View SOAPP on Pain.EDU.org (requires registration) - see related resources
 -

DIRE: DIAGNOSIS, INTRACTABILITY, RISK, EFFICACY

- **Purpose:** Assesses drug use, risk of opioid misuse, and suitability of candidates for long-term opioid therapy
 - Evidence
 - Advantages/Limitations
- **Test features:**
 - Time: less than 2 minutes to administer and score
 - Length: 7 items
 - Administered by: Patient interview
 - Target Population: Adults
 - Intended Settings: Primary care
 - Developed by: Dr. Miles J. Belgrade in 2005
- **Scoring and interpretation:**
 - Patient's score on the DIRE (between 7 and 21) correlates with efficacy of opioid therapy and compliance²³.
- **Available Formats:**
 - Printable DIRE (see related resources)
 - Online Format (see related resources)

MR. LANCASTER - DIALOG AND RISK ASSESSMENT

Note: This case is used in other modules to illustrate the guidelines for minimizing risk of chronic opioid therapy.



Patient: Mr. Ron Lancaster, 75 y/o

Chief Complaint: Pain from bilateral hip bursitis

History of Present Illness: Mr. Lancaster's medical history is significant for onset of bilateral hip bursitis around age 60. The pain has been mild to moderate now for the past 6 months during the day, but moderate to severe at night despite all evidence-based, non-opioid, first and second line treatments of tricyclic antidepressants and anti-epileptic drugs.

Mr. Lancaster became addicted to cocaine in his twenties. He completed three counseling-based treatment, and finally achieved abstinence 30 years ago. He also has a history of several episodes of treatment for anxiety attacks, which have not recurred since his 50s. Otherwise, he has no other significant medical history.

Patient Interview:

Provider: *In order for me to treat your pain effectively and safely, it is very important that you answer some questions I have as honestly as possible. I will treat your pain no matter what you answer, but I need you to be open and honest.*

Mr. Lancaster: *Alright.*

Provider: *Ok. [Referring to medical history] I see you used cocaine as a young adult and were treated several times in substance misuse treatment centers, finally being successful 30 years ago. How has your recovery gone since then? [asks about personal history of substance misuse]*

Mr. Lancaster: I haven't used cocaine or anything since then. I don't even get near it.

Provider: Good! Have you had any surgeries, acute injuries or illnesses or dental pain for which you needed pain medication? **[asks about use of opioids for medical reasons]**

Mr. Lancaster: No, I haven't had much of that, fortunately. Besides, doctors would never give me opioids because of my history with addiction.

Provider: Do you have any other personal history of substance misuse with alcohol, illegal drugs, or other prescription drugs? **[asks about personal history of substance misuse]**

Mr. Lancaster: No, I've been clean with everything since I got off cocaine years ago. I only drink 2-3 drinks on weekends.

Provider: How about any of your relatives or anyone else in your life? Do you know anyone else with substance use problems? **[asks about family/friends' history of substance misuse]**

Mr. Lancaster: To my knowledge, no one in my family or none of my current friends have any substance misuse problems. I know to stay clear of people that do.

Provider: Have you had any mental health problems? **[asks about mental health problems]**

Mr. Lancaster: I have been treated for anxiety and panic attacks several times, and I haven't had any problems in the past 20 years or so. I do get anxious sometimes now from all the pain.

Provider: That's certainly understandable. Let's see what we can do to help you with that. Is your family supportive? **[social problems: asks about social support]**

Mr. Lancaster: Yes, very supportive.

Provider: Have you had any motor vehicle accidents or legal problems in the past few years? **[social problems: asks about accidents, legal problems]**

Mr. Lancaster: No. None.

Provider: And you're still working as a chemistry professor? **[asks about employment]**

Mr. Lancaster: Yes, I am.

Question: Apply the Opioid Risk Tool²⁴, which was described in previous pages, to this interview transcript to find Mr. Lancaster's ORT score and an indication of his risk for opioid misuse or addiction. Reminder of ORT: 1) Family history of substance misuse with alcohol, illegal drugs, or prescription drugs; 2) Personal history of substance misuse with alcohol, illegal drugs, or prescription drugs; 3) History of preadolescent sexual abuse (females); 4) Psychiatric disorder

Choose one

1. 0-3: Low Risk

- Feedback: Incorrect
- Mr. Lancaster scores 4 points for his history of cocaine use. He is over 45 so does not receive a risk point for age. He scores an additional 1 point for history of anxiety and currently feeling "down" for a total of 5 points or Moderate Risk according to the Opioid Risk Tool.

2. 4-7: Moderate Risk

- Feedback: Correct
- Mr. Lancaster scores 4 points for his history of cocaine use. He is over 45 so does not receive a risk point for young age. He scores an additional 1 point for history of anxiety and currently feeling "anxious" at times for a total of 5 points or Moderate Risk according to the Opioid Risk Tool.

3. ≥ 8 : High Risk

- Feedback: Incorrect
- Mr. Lancaster scores 4 points for his history of cocaine use. He is over 45 so does not receive a risk point for young age. He scores an additional 1 point for history of anxiety and currently feeling "anxious" for a total of 5 points or Moderate Risk according to the Opioid Risk Tool.

COMORBID MENTAL HEALTH PROBLEMS

Current research shows that 25.3 million (11.2%) adults in the United States experience chronic pain. 40 million (17.6%) of adults in the United States experience severe levels of pain⁴. Chronic pain conditions are significantly associated with certain mental health conditions, especially:

- depression
- anxiety

In people with chronic pain, there is a 30%-60% co-occurrence rate with depression and about a 35% co-occurrence rate with anxiety²⁵. Depression and chronic pain interact due to some shared neurological pathways²⁶.

The relationship between depression and chronic pain is cyclical, with one reinforcing the other, both neurologically and behaviorally. For example, depression can interfere with motivation to participate in treatment. Cognitive behavioral therapy (CBT), is effective in reducing depression and anxiety.



PSYCHIATRIC HISTORY

To properly treat a patient it is essential to gather his or her Psychiatric History.

Is the patient psychiatrically stable?

- Does the patient have any psychiatric diagnoses? If so, are the other conditions being treated by you? By another professional?
- What is the patient's mental health history, including past substance abuse?
- Does the patient exhibit suicidal/homicidal ideation?

Initially, ask your patient open-ended questions:

- Have you ever had a problem with emotional or mental illness?

Then move to more specific questions:

- Have you ever visited a counselor or psychotherapist?
- Have you ever been prescribed medication for emotional issues?
- Has anyone in your family ever been hospitalized for an emotional or mental health problem?

Screening for current depression is critical in all patients with chronic pain initially and during ongoing monitoring. The next page describes depression screening in more detail.

ASSESSING FOR DEPRESSION

Why Assess for Depression

Screening your patients for depression will increase the likelihood that you will recognize and diagnose depression. Identifying and treating depression is an important component of pain management because it can have a direct effect on pain severity. Treating depression could improve pain.

Suicidal ideation should also be assessed. Consider limiting supplies of medications to help prevent overdose attempts.

The USPSTF has indicated that all adults should be screened for depression. This recommendation has been expanded from past suggestions to now include pregnant and postpartum women, as well as those who do not indicate prior evidence of depression²⁷.

Example Depression Screening Tool

To screen for depression you can use the Patient Health Questionnaire (PHQ-2). This questionnaire includes two questions taken from the PHQ-9 regarding depression:

Over the past 2 weeks, have you felt little interest or pleasure in doing things?

Over the past 2 weeks, have you felt down, depressed, or hopeless?

If your patient answers yes to either of these questions the patient should receive further evaluation for depression. The PHQ-9 is typically used to follow-up the PHQ-2 as needed. The PHQ-9 is available free in over 30 languages.

CASE EXAMPLE: MR. LANCASTER'S DEPRESSION SCREENING

Mr. Lancaster's case summary



Patient: Mr. Ron Lancaster, 75 y/o

Chief Complaint: Pain from bilateral hip bursitis

History of Present Illness (repeated for convenience): Mr. Lancaster's medical history is significant for onset of bilateral hip bursitis around age 60. The pain has been mild to moderate now for the past 6 months during the day, but moderate to severe at night despite all evidence-based, non-opioid, first and second line treatments of tricyclic antidepressants and anti-epileptic drugs.

Mr. Lancaster became addicted to cocaine in his twenties. He completed three counseling-based treatment and finally achieved abstinence 30 years ago. He also has a history of several episodes of treatment for anxiety attacks, which have not recurred since his 50s. Otherwise, he has no other significant medical history.

Note: While using the Opioid Risk Tool, we learned that Mr. Lancaster does have some opioid risk related to depression: He has a history of past depression and says he "feels down sometimes from all the pain." So the provider follows up with the two PHQ-2 questions, to screen for depression that may need to be treated.

Patient Interview:

Provider: Over the past 2 weeks, have you felt little interest or pleasure in doing things?

Mr. Lancaster: No, most of the time I'm ok.

Provider: Over the past 2 weeks, have you felt down, depressed, or hopeless?

Mr. Lancaster: No, I've been fine.

The PHQ-9 set of questions are not used because he answered negatively to the PHQ-2 questions.

SCREENING TOOLS FOR ASSESSING CURRENT SUBSTANCE MISUSE

Why Assess for Substance Misuse

Although a patient may never have misused prescription medications in the past, any type of substance misuse could impact the effectiveness of opioid treatment. Current drug or alcohol misuse, or a history of substance misuse, significantly raises the patient's risk of future misuse of opioid prescription medications.

All patients should be assessed for current substance use problems prior to prescribing chronic opioid therapy, but especially if opioid use is anticipated for more than a few days or if the patient is unknown to the prescriber.



The proper use of a substance misuse screening tool should reveal a patient's vulnerabilities to the clinician. However, the initial substance abuse assessment tools for substance misuse offers no guarantee of successful opioid treatment.

Screening Tools To Use

There are multiple screening and assessment tools that can be used quickly to assess for current substance misuse.

- The CAGE-AID, which screens for alcohol and drug use is widely known and is described in more detail on the next page.
- NIDA Drug Screening Tool - An online screening tool produced by NIDA, the NIDA-Med, screens a wider range of substances, including alcohol and drugs, and provides immediate feedback on the next step to take based on results. Additional substance misuse screening and assessment tools are described in our Screening and Assessment Instruments Key Info Guide (See Related Resources this page).

CAGE-AID

- **Purpose:** The CAGE-AID (Adapted to Include Drugs) is a version of the CAGE alcohol screening questionnaire, adapted to include drug use. It assesses likelihood and severity of alcohol and drug misuse.
- **Target population:** Adults and adolescents

CAGE-AID Questions

Evaluation should be preceded by the following two questions:

1. Do you drink alcohol?
2. Have you ever experimented with drugs?

If the patient only drinks alcohol, then ask the CAGE questions. If the patient has experimented with drugs, ask the CAGE-AID questions.

- **C Cut down** - Have you ever felt you ought to cut down on your drinking or drug use?
- **A Annoyed** - Have people annoyed you by criticizing your drinking or drug use?
- **G Guilty** - Have you ever felt bad or guilty about your drinking or drug use?
- **E Eye Opener** - Have you ever had a drink or used drugs first thing in the morning to steady your nerves or get rid of a hangover?

CASE EXAMPLE: MS. WARD'S CAGE-AID

Patient: Mrs. Elizabeth Ward, 38 y/o

Chief Complaint: heel pain

History of Present Illness: Mrs. Ward has a 3 month history of moderate to severe heel pain answers the first two CAGE-AID questions as follows:



Provider: *Do you drink alcohol?*

Ms. Ward: *Sometimes a glass of wine.*

Provider: *How often is that?*

Ms. Ward: *Oh, just on a date, maybe once per week.*

Provider: *Have you experimented with drugs?*

Ms. Ward: *I tried once or twice, it dulled the pain. But I stopped, my health is too important.*

She is then asked the four CAGE-AID questions focusing on alcohol only:

Provider: *Have you ever felt you ought to cut down on your drinking?*

Ms. Ward: *No.*

Provider: *Have people annoyed you by criticizing your drinking?*

Ms. Ward: *No.*

Provider: *Have you ever felt bad or guilty about your drinking or drug use?*

Ms. Ward: *No*

Provider: *Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover?*

Ms. Ward: *No.*

The whole process takes 30 seconds.

Further Information on CAGE-AID

- **Evidence:**
 - Easy to administer, with good sensitivity and specificity²⁸.
 - More sensitive than original CAGE questionnaire for substance misuse²⁹
 - Less biased in term of education, income, and sex than the original CAGE questionnaire²⁹.
- **Advantages**
 - Well suited for use in a primary care facility
 - Quick and easy to administer

- Screening for alcohol and drug usage conjointly rather than separately
- Easily incorporated into a medical history protocol or intake procedure
- CAGE-AID is valid for pain patients³⁰
- **Limitations**
 - Be cautious in prescribing to a patient who answers yes to any one question. Individuals who answer yes to 2 or more questions should be subject to a psychosocial assessment prior to prescription²⁸.
- **Test Features**
 - *Estimated time:* brief, approximately 1 minute to administer and score
 - *Length:* 4 items
 - *Administered by:* Patient Interview or Self-Report
 - *Intended settings:* Primary care
 - *Scoring and Interpretation:* Of the 4 items, one or more positive responses (a "yes" answer) is considered a positive screen, and substance use should be further addressed with the patient.

CONDUCTING A THOROUGH PHYSICAL EXAM

Pain Examination

Key elements involved in the clinical examination of pain include:

- A functional assessment of the part of the body where the pain is located
- Eliciting pain gently and minimally, guided by your knowledge of the affected area and what the patient has told you about aggravating and relieving factors
- Observing the patient's responses to pain:
 - guarding
 - abnormal movements while sitting down or walking
 - facial expressions
 - alterations in vital signs



A full description of the clinical examination for pain is beyond the scope of this training activity and is covered in other clinical training.

Physical Examination and Diagnostic Tests

The physical examination and laboratory testing should include:

- Evaluation of any physical condition underlying the chronic pain
- Examination for signs of addiction
- Urine drug testing (discussed in detail in Module 4)
- Evaluation for conditions that would increase opioid side effects, for example, sleep apnea increases risk of death in an overdose; constipation is a common side effect, so someone with pre-existing problems with constipation is likely to suffer more with this problem.
- Evaluation for diseases (HIV infection/AIDS, tuberculosis, malnutrition, and hepatitis B and C)

TREATMENT PLANNING FOR PAIN

Use a Patient-Centered Approach

Collaborating with the patient in joint decision-making can enhance patient self-efficacy and improve outcomes. Patients in pain may not hear what you are saying or might interpret "treating pain" as "removing pain." These misperceptions can hinder treatment. Be sure to consider the patient's perspective, confirm their understanding, and have them participate and "buy-in" to the treatment.

Basis for Choosing a Pain Treatment

- Pain history, especially:
 - Pain severity
 - Severity of functional problem(s)
 - Responses to past treatment(s)
- Diagnosis, physical examination, laboratory and other diagnostic tests.
- Pain category: The approach to pain treatment varies with the pain category (acute vs. chronic, nociceptive vs. neuropathic)
- Pain-causing condition. Evidence-based, first-line therapies for any specific pain diagnosis, e.g. for lower back pain
- Existing pharmacological treatment: Instruct patients to describe all of the medications he or she is currently taking.
- Risks for specific treatments, for example, substance use disorder as a risk for using narcotics



GOALS FOR PAIN TREATMENT

1. **Treatment of the underlying diagnosis** if there is one. Note that pain may need to be treated even in the absence of a clearly identified underlying cause.
2. **Improved functioning** - Improvements in ability to perform activities of daily living, working, and being independent are important goals.
3. **Pain reduction** - Improvement is often only several points on the pain scale of 1 to 10; complete pain control may not be possible.
4. **Treatment of secondary effects** of pain or treatment - Includes, for example, treatment of mood disorders related to chronic pain and side effects of medications.
 - Adequate sleep is an important part of pain management. Sleep is disrupted in chronic pain both from the pain itself and from sleep irregularities caused by chronic opioids³¹. Sleep needs to be supported through patient education regarding sleep hygiene rather than benzodiazepines, due to the risk of overdose.

9,32

THE ROLE OF TREATMENT AGREEMENTS

Overview

Clinical guidelines recommended the use of a written chronic opioid treatment management plan (weak recommendation/low-quality evidence)^{9,22} also known as a treatment agreement. Agreements describe the boundaries of



treatment, expectations of the patient, role of the provider, objectives that will be used to determine if treatment was a success, and other criteria for determining that treatment needs to be stopped and how to stop treatment³³. They should be based on mutual trust and honesty³⁴. A treatment agreement should be discussed with the patient before initiating treatment in order to enhance the effectiveness of treatment and minimize risk of developing a substance use problem⁹. They are often put in writing and signed by both the patient and the clinician. Treatment agreements go beyond the goals, risks/benefits, and alternative treatments that are required in the informed consent, however, informed consent may be included in the agreement because of overlapping purposes and content.

Note that some states, such as New Hampshire, require written treatment agreements when prescribing chronic opioids. They may also be called "Opioid Management Plans." Be sure to check your state board's requirements for opioid prescribing, if any.

Purpose

- Improve patient care through dissemination of information
- Facilitate a mutually agreed-upon plan
- Enhance compliance
- Act as a form of ongoing patient education
- Maintain accountability while taking these potentially hazardous medications
- Ensure the provider's ability to prescribe the drugs
- Support open communication with not only the patient but also the patient's family and other providers
- Avoid confusion during the treatment plan
- Clarify responsibilities when a patient is co-managed by more than one provider.

9,33

FYI

On opioid misuse: Simple misunderstanding of how opioids are supposed to be used is a common cause of misuse that may be reduced with the use of clear written instructions.

CONTENT OF PATIENT-PROVIDER TREATMENT AGREEMENTS

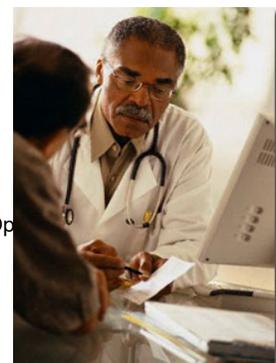
What to Include

1. Terms of treatment: What appointments must be kept, limits on drug refills, correct use of medications, safe storage of medication, and non-pharmacological treatments to be followed
2. Prohibited behavior: Improper use of medications and refraining from obtaining or sharing medication with others
3. Points of termination: If the medications no longer needed or can no longer be prescribed safely, it is important to plan for humane detoxification or tapering

33

Expectations of the Patient and Healthcare Provider

Written Patient-Provider Treatment Agreements are an important part of managing the risk of opioids. Former research⁹ and in-practice experience have noted that these agreements should have the following specific components:



Patient Expectations

- Patient's agreement to take medication as prescribed
- What is expected from the patient in order to minimize risk, including clinical follow-up and monitoring as well as use of other concomitant therapies
- Use of only one pharmacy with which you have an established relationship
- Only one provider prescribes the opioid
- Urine drug testing when requested by healthcare provider
- A specific interval for office visits
- Bringing in original pill bottle to appointments for pill counts when requested
- Patient agrees not to abuse alcohol or use other substances not medically authorized

Patient Education

- How the medication will be prescribed and taken
- Realistic expectations of outcome
- Importance of not quitting abruptly and use of appropriate precautions
- Safe storage of medications at home

Office Policies

- Protocol and policy for prescription refills during certain situations (lost med, emergencies, out-of-town, etc.)
- Limited prescription pill load, e.g. enough for a week or two
- What behaviors may result in tapering or termination of opioid prescribing (stockpiling or selling the drugs, use of illicit drugs, etc.)

Provider Role

- What they can expect from the health care provider

Variations According to Risk

The extent to which these expectations are included in a particular treatment agreement is determined by the results of risk stratification which was based on the assessment results; higher risk patients require tighter time intervals between office visits, drug testing, pill counts, and prescription writing.

APPROPRIATE USE OF TREATMENT AGREEMENTS

<i>How Treatment Agreements Should Be Used</i>	<i>How Treatment Agreements Should NOT be Used</i>
Facilitate patient-centered care, dialogue, and education	Should not be presented as "rules that must be followed or else you will not be treated."
Provide structure to help provide safe and effective treatment	
Clarify situations in which opioids will be terminated. Humane tapering or detoxification plus alternative treatments should always be offered.	Patients should not be terminated from treatment when opioids are discontinued.
Should be called "agreements"	Should not be called "contracts." Agreements do not have the force of a contract.

MS. COBB - INFORMED CONSENT



Patient: Ms. Paula Cobb, 29 years old

Chief Complaint: Needs additional medication to treat hip bursitis

History of Present Illness: Ms. Cobb is a long-distance runner who developed bursitis in her right hip and buttock last year. In the past 6 months her condition has been treated with various NSAIDs, and yet she still had moderate pain and limited range of motion in her leg and hip. Earlier in her treatment, she had several cortisone injections, which helped "about 50%", but she does not want to continue them long term because of side effects. She requests help for her undertreated pain.

TREATMENT AGREEMENT EXAMPLE

Patient's name: _____ Date: _____

Provider's name and location: _____

The purpose of this agreement is to protect your access to controlled substances and to protect our ability to prescribe for you. The long-term use of such substances as opioids (narcotic analgesics), benzodiazepine tranquilizers, and barbiturate sedatives is controversial because of uncertainty regarding the extent to which they provide long-term benefit. There is also the risk of an addictive disorder developing or of relapse occurring in a person with a prior addiction. The extent of this risk is not certain. Because these drugs have potential for abuse or diversion, strict accountability is necessary when use is pro-longed. For this reason the following policies are agreed to by you, the patient, as consideration for, and a condition of, the willingness of the provider whose signature appears below to consider the initial and/or continued prescription of controlled substances to treat your chronic pain.

General Agreements

1. All controlled substances must come from the provider whose signature appears below or, during his or her absence, by the covering provider, unless specific authorization is obtained for an exception.
(Multiple sources can lead to untoward drug interactions or poor coordination of treatment.)
2. You are expected to inform our office of any new medications or medical conditions, and of any adverse effects you experience from any of the medications that you take.
3. These drugs should not be stopped abruptly, as an abstinence syndrome will likely develop.
4. Original containers of medications should be brought in to each office visit.
5. It should be understood that any medical treatment is initially a trial, and that continued prescription is contingent on evidence of benefit.
6. The risks and potential benefits of these therapies are explained elsewhere [and you acknowledge that you have received such explanation].

Safeguarding your medication

1. You may not share, sell, or otherwise permit others to have access to these medications.

2. Because the drugs may be hazardous or lethal to a person who is not tolerant to their effects, especially a child, you must keep them out of reach of such people.
3. Prescriptions and bottles of these medications may be sought by other individuals with chemical dependency and should be closely safeguarded. It is expected that you will take the highest possible degree of care with your medication and prescription. They should not be left where others might see or otherwise have access to them.

Exceptions to confidentiality

1. The prescribing provider has permission to discuss all diagnostic and treatment details with dispensing pharmacists or other professionals who provide your health care for purposes of maintaining accountability.
2. If the responsible legal authorities have questions concerning your treatment, as might occur, for example, if you were obtaining medications at several pharmacies, all confidentiality is waived, and these authorities may be given full access to our records of controlled substances administration.

Refills

1. Renewals are contingent on keeping scheduled appointments.
2. Please do not phone for prescriptions after hours or on weekends.
3. Early refills will generally not be given.
4. Medications may not be replaced if they are lost, get wet, are destroyed, left on an airplane, etc. If your medication has been stolen and you complete a police report regarding the theft, an exception may be made.
5. Prescriptions may be issued early if the provider or patient will be out of town when a refill is due. These prescriptions will contain instructions to the pharmacist that they not be filled prior to the appropriate date.

Consequences of not adhering to this agreement: It is understood that failure to adhere to these policies may result in cessation of therapy with controlled substance prescribing by this provider or referral for further specialty assessment.

By signing below, you affirm that you have full right and power to sign and be bound by this agreement and that you have read, understand, and accept all of its terms.

Provider's Signature: _____; Patient

Signature: _____

Question: Which of the following elements of **informed consent** did the provider **completely** include in the above treatment agreement?

Choose one

1. This treatment agreement includes all of the elements of informed consent that are required for chronic opioid therapy.
 - Feedback: Incorrect
 - The treatment agreement included a discussion of some of the risks and a realistic idea of the benefits, which are elements of informed consent, however, other elements of informed consent were not included in this treatment agreement, such as the goals or purpose of chronic opioid therapy, its potential benefits, alternative forms of treatment,

and risks of side effects such as constipation, nausea, sedation. In this case, the doctor took care of informed consent separately, but many offices combine the two purposes in a single document.

2. This treatment agreement includes only some of the required elements of informed consent, such as how the medication will be prescribed and taken and other treatments that are part of the treatment plan.
 - Feedback:
 - The treatment agreement included a discussion of some of the risks and a realistic idea of the benefits, which are elements of informed consent, however, other elements of informed consent were not included in this treatment agreement, such as the goals or purpose of chronic opioid therapy, its potential benefits, alternative forms of treatment, and risks of side effects such as constipation, nausea, sedation. In this case, the doctor took care of informed consent separately, but many offices combine the two purposes in a single document.

MS. COBB - PATIENT BOUNDARIES

Patient: Ms. Paula Cobb, 29 years old

Chief Complaint: Needs additional medication to treat hip bursitis

Summary of Her History of Present Illness:

- Long-distance runner (bursitis in her right hip and buttock)
- Treated with various NSAIDs with little relief.
- Cortisone injections help a little, but concerned with long-term use
- Requesting help for undertreated pain

Treatment Agreement

Patient's name: _____ Date: _____

Provider's name and location: _____

The purpose of this agreement is to protect your access to controlled substances and to protect our ability to prescribe for you. The long-term use of such substances as opioids (narcotic analgesics), benzodiazepine tranquilizers, and barbiturate sedatives is controversial because of uncertainty regarding the extent to which they provide long-term benefit. There is also the risk of an addictive disorder developing or of relapse occurring in a person with a prior addiction. The extent of this risk is not certain. Because these drugs have potential for abuse or diversion, strict accountability is necessary when use is prolonged. For this reason, the following policies are agreed to by you, the patient, as consideration for, and a condition of, the willingness of the provider whose signature appears below to consider the initial and/or continued prescription of controlled substances to treat your chronic pain.

General Agreements

1. All controlled substances must come from the provider whose signature appears below or, during his or her absence by the covering provider, unless specific authorization is obtained for

an exception.

(Multiple sources can lead to untoward drug interactions or poor coordination of treatment.)

2. You are expected to inform our office of any new medications or medical conditions, and of any adverse effects you experience from any of the medications that you take.
3. These drugs should not be stopped abruptly, as an abstinence syndrome will likely develop.
4. Original containers of medications should be brought to each office visit.
5. It should be understood that any medical treatment is initially a trial and that continued prescription is contingent on evidence of benefit.
6. The risks and potential benefits of these therapies are explained elsewhere [and you acknowledge that you have received such explanation].

Safeguarding your medication

1. You may not share, sell, or otherwise permit others to have access to these medications.
2. Because the drugs may be hazardous or lethal to a person who is not tolerant to their effects, especially a child, you must keep them out of reach of such people.
3. Prescriptions and bottles of these medications may be sought by other individuals with chemical dependency and should be closely safeguarded. It is expected that you will take the highest possible degree of care with your medication and prescription. They should not be left where others might see or otherwise have access to them.

Exceptions to confidentiality

1. The prescribing provider has permission to discuss all diagnostic and treatment details with dispensing pharmacists or other professionals who provide your health care for purposes of maintaining accountability.
2. If the responsible legal authorities have questions concerning your treatment, as might occur, for example, if you were obtaining medications at several pharmacies, all confidentiality is waived, and these authorities may be given full access to our records of controlled substances administration.

Refills

1. Renewals are contingent on keeping scheduled appointments.
2. Please do not phone for prescriptions after hours or on weekends.
3. Early refills will generally not be given.
4. Medications may not be replaced if they are lost, get wet, are destroyed, left on an airplane, etc. If your medication has been stolen and you complete a police report regarding the theft, an exception may be made.
5. Prescriptions may be issued early if the provider or patient will be out of town when a refill is due. These prescriptions will contain instructions to the pharmacist that they not be filled prior to the appropriate date.

Consequences of not adhering to this agreement: It is understood that failure to adhere to these policies may result in cessation of therapy with controlled substance prescribing by this provider or referral for further specialty assessment.

By signing below, you affirm that you have full right and power to sign and be bound by this agreement and that you have read, understand, and accept all of its terms.

Provider Signature: _____; Patient Signature: _____

Question: Which of the following **additional patient expectations/boundaries** did the doctor **correctly include** in the treatment agreement? (Check all that apply)

Choose all that apply

1. Use of only one pharmacy with which you have an established relationship
 - Feedback: Incorrect. This was not included
Use of just one pharmacy was incorrectly excluded from the agreement.
2. Only one provider prescribes the opioid
 - Feedback: Correct. This was included
Prescribing controlled substances was correctly limited to just the one doctor.
3. Urine drug testing when requested by provider
 - Feedback: Incorrect. This was not included.
Unannounced urine drug testing was incorrectly excluded from the agreement.
4. Prescription refills during certain situations (emergencies, out-of-town, etc)
 - Feedback: Correct. This was included
Prescription refills during special situations were correctly described.
5. A specific interval for office visits
 - Feedback: Incorrect. This was not included.
Office visit intervals were not described and should be considered for treatment agreements.
6. Bringing original pill bottle into appointments for pill counts
 - Feedback: Correct. This was included
 - Bringing their original pill bottle to appointments for pill counts was correctly included.
7. Limited prescription pill load (e.g. enough for a week or two)
 - Feedback: Incorrect. This was not included
 - Limited pill load was not described in the treatment agreement. This might be an appropriate limitation for patients at risk for diversion or misuse.
8. Descriptions of aberrant behaviors for which opioid treatment would be discontinued (stockpiling or selling the drugs, use of illicit drugs, etc.)
 - Feedback: Correct. This was included.
 - Behaviors that might result in cessation of therapy with controlled substances or referral were correctly described.

MS. COBB - PATIENT EXPECTATIONS

Patient: Ms. Paula Cobb, 29 years old

Chief Complaint: Needs additional medication to treat hip bursitis

Summary of Her History of Present Illness:

- Long-distance runner (bursitis in her right hip and buttock)
- Treated with various NSAIDs with little relief.
- Cortisone injections help a little, but concerned with long-term use
- Requesting help for undertreated pain

Treatment Agreement

Patient's name: _____ Date: _____

Provider's name and location: _____

The purpose of this agreement is to protect your access to controlled substances and to protect our ability to prescribe for you. The long-term use of such substances as opioids (narcotic analgesics), benzodiazepine tranquilizers, and barbiturate sedatives is controversial because of uncertainty regarding the extent to which they provide long-term benefit. There is also the risk of an addictive disorder developing or of relapse occurring in a person with a prior addiction. The extent of this risk is not certain. Because these drugs have the potential for abuse or diversion, strict accountability is necessary when use is prolonged. For this reason, the following policies are agreed to by you, the patient, as consideration for, and a condition of, the willingness of the provider whose signature appears below to consider the initial and/or continued prescription of controlled substances to treat your chronic pain.

General Agreements

1. All controlled substances must come from the provider whose signature appears below or, during his or her absence, by the covering provider unless specific authorization is obtained for an exception.
(Multiple sources can lead to untoward drug interactions or poor coordination of treatment.)
2. You are expected to inform our office of any new medications or medical conditions, and of any adverse effects you experience from any of the medications that you take.
3. These drugs should not be stopped abruptly, as an abstinence syndrome will likely develop.
4. Original containers of medications should be brought to each office visit.
5. It should be understood that any medical treatment is initially a trial and that continued prescription is contingent on evidence of benefit.
6. The risks and potential benefits of these therapies are explained elsewhere [and you acknowledge that you have received such explanation].

Safeguarding your medication

1. You may not share, sell, or otherwise permit others to have access to these medications.
2. Because the drugs may be hazardous or lethal to a person who is not tolerant to their effects, especially a child, you must keep them out of reach of such people.

3. Prescriptions and bottles of these medications may be sought by other individuals with chemical dependency and should be closely safeguarded. It is expected that you will take the highest possible degree of care with your medication and prescription. They should not be left where others might see or otherwise have access to them.

Exceptions to confidentiality

1. The prescribing provider has permission to discuss all diagnostic and treatment details with dispensing pharmacists or other professionals who provide your health care for purposes of maintaining accountability.
2. If the responsible legal authorities have questions concerning your treatment, as might occur, for example, if you were obtaining medications at several pharmacies, all confidentiality is waived, and these authorities may be given full access to our records of controlled substances administration.

Refills

1. Renewals are contingent on keeping scheduled appointments.
2. Please do not phone for prescriptions after hours or on weekends.
3. Early refills will generally not be given.
4. Medications may not be replaced if they are lost, get wet, are destroyed, left on an airplane, etc. If your medication has been stolen and you complete a police report regarding the theft, an exception may be made.
5. Prescriptions may be issued early if the provider or patient will be out of town when a refill is due. These prescriptions will contain instructions to the pharmacist that they not be filled prior to the appropriate date.

Consequences of not adhering to this agreement: It is understood that failure to adhere to these policies may result in cessation of therapy with controlled substance prescribing by this provider or referral for further specialty assessment.

By signing below, you affirm that you have full right and power to sign and be bound by this agreement and that you have read, understand, and accept all of its terms.

Provider's Signature: _____; Patient
Signature: _____

Question: Which of the following **patient expectations** did the doctor **completely** include in the treatment agreement? (Check all that apply)

Choose all that apply

1. What is expected from the patient in order to minimize risk, including clinical follow-up and monitoring as well as use of other concomitant therapies
 - Feedback: Correct
 - These are all possible elements of a treatment agreement. Other elements might describe boundaries and expectations of the patient and provider as well as appropriate use.
2. What they can expect from the health care provider
 - Feedback: Corred

- These are all possible elements of a treatment agreement. Other elements might describe boundaries and expectations of the patient and provider as well as appropriate use.
3. What behaviors may result in tapering or termination of opioid prescribing (achieved with appropriate precautions)
- Feedback: Correct
 - These are all possible elements of a treatment agreement. Other elements might describe boundaries and expectations of the patient and provider as well as appropriate use.

PATIENT EDUCATION AND OTHER STEPS TO REDUCE RISKS

Educating the patient can help reduce risks. Patient education should include the following points on the specific opioid product:

How to take the medication	<ul style="list-style-type: none"> • Explain how to take the opioid as prescribed. • Describe the importance of adhering to dosing regimen and explain how to handle missed doses. • Advise against tampering with opioid medications, such as crushing tablets or cutting patches, as this may lead to too rapid release causing overdose and death.
Drug interactions	<ul style="list-style-type: none"> • Opioids should not be taken with other CNS depressants, alcohol, or illegal drugs as this could cause overdose and death.
Withdrawal symptoms	<ul style="list-style-type: none"> • Describe withdrawal symptoms and warn that they can occur if the opioid is stopped suddenly. • Warn patients not to abruptly stop or reduce their ER/LA opioid
Safe storage and disposal	<ul style="list-style-type: none"> • Counsel patients to: <ul style="list-style-type: none"> • Store opioid in a safe and secure place away from children and pets • Read the product-specific disposal information • Not share with others, as it is against the law and potentially dangerous to them. • Provide information on how to dispose of drugs safely, for example the web page available from the FDA.
Safety risks	<ul style="list-style-type: none"> • Caution patients regarding safety risks, such as driving, using machinery, etc, especially with dose initiation and changes.
Potential side effects and management	<ul style="list-style-type: none"> • Caution patients regarding potentially serious side effects with long-acting/extended-release opioids. • They should report side effects to the prescriber. Side effects may be reported to the FDA at 1-800-FDA-1088.
Emergencies	<ul style="list-style-type: none"> • SAMHSA's updated Opioid Overdose Toolkit (2014) recommends: <ul style="list-style-type: none"> • Considering the prescribing of naloxone along with the patient's initial opioid prescription

	<ul style="list-style-type: none"> • Train persons at high risk and their family members learn how to prevent and manage overdose • They should seek emergency medical help with symptoms of overdose or respiratory depression, stomach or intestinal blockage, or allergic reactions.
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35

PATIENT EDUCATION: MINIMIZING RISKS OF DIVERSION

Educating Patients

It is important to educate patients about how to minimize risks of diversion, including proper storage, drug take-back programs, and appropriate disposal of medications.

A guideline by the AMA recommends that providers:

1. Talk to their patients about opioid misuse, letting them know that 70% of misused opioids come from family and friends
2. Remind their patients they should never share their prescriptions and should keep their medications out of reach of children.
3. Urge patients to dispose of medications properly, through their pharmacies, law enforcement programs, or other local "take back" programs.

36

Educate Patients: Risk of Diversion by Family and Friends

A common method of diversion is to use prescribed medication from family, relatives, friends, and classmates. Teens use controlled prescription drugs for non-medical purposes because they are often more easily accessible than illicit drugs, alcohol or tobacco³⁷.



Medicine cabinets: A rising threat

The abundance of prescription opioids and drugs has made the medicine cabinet a great threat to children. Young children may take medications, thinking of them as candy. Older children and teens may steal their parents' controlled medication to sell or use themselves. Parents need to understand the dangers of the medications in their possession and the importance of preventing diversion by putting opioids and other potentially dangerous medications in a locked container.

Storage in purses and other locations also must be secure from others, including small children and pets. Proper storage and disposal of medications should be spelled out in the signed *Patient/Provider Treatment Agreement*.

Educate Patients: Proper Disposal of Medications

Educate patients on local opportunities for drug take-back or disposal (See Related Resource).

Patients should read any product-specific disposal information included, for example, with extended release/long-acting opioid products. When disposing:

- Do not flush or rinse the drug down the drain unless the label or patient information sheet instructs you to do so.

- Find a community drug take-back program or hazardous waste collection program by calling your local government
- If a drug take-back program is not available, you should³⁸:
 - Remove the drugs from their containers
 - Mix the drugs with an undesirable substance such as cat litter
 - Put the mixture in a disposable container with a lid or resealable bag
 - Remove or conceal personal information and Rx number from the container
 - Dispose all of the above in the trash

PATIENT COUNSELING DOCUMENT

A Patient Counseling Document should be used when discussing prescribing opioids. It should be given to the patient at the time of prescribing and reviewed. This document contains important safety information about the ER/LA opioids:

- The DOs and DON'Ts of ER/LA Opioids
- When to call 911
- Instructions for follow-ups
- Space to write patient-specific information

35

MRS. THOMAS - PATIENT EDUCATION



Patient: Mrs. Louise Thomas, 58 y/o

Scenario: Mrs. Thomas has chronic neck pain. We decided earlier that ER/LA opioids were indicated:

Review Mrs. Thomas' Pain History

Question: Before prescribing ER/LA opioids which topics would you discuss with her?

Choose all that apply

1. How to take the medication
 - Feedback: Correct
2. Drug Interactions
 - Feedback: Correct
3. Withdrawal Symptoms
 - Feedback: Correct
4. Safe storage and disposal
 - Feedback: Correct
5. Safety Risks
 - Feedback: Correct
6. How to crush ER/LA opioids so she can take 1/2 a dose

- Feedback:
Incorrect: Crushing ER/LA Opioids can be dangerous. Some capsule-based ER/LA opioids can be opened and sprinkled on applesauce, only if product information specifies this - but not crushed.

7. Potential side effects and management

- Feedback: Correct

MS. EDWARDS - DRUG TESTING



Patient: Ms. Terri Edwards, 32 years old

Chief Complaint: Back pain

History of Present Illness: Ms. Edwards is a new patient to your practice. She is a young single woman who is seeking treatment for chronic back pain she relates to standing all day and lifting in her job at a fast food restaurant.

Patient Interview:

Provider: You said you sometimes take oxycodone when the pain gets bad. Who prescribes that for you?

Ms. Edwards: I actually get it from my mom. She's got a bad back, too. I used to have a prescription from a provider where I used to live, but it ran out.

Provider: Would it be all right if I talked with that provider about your treatment?

Ms. Edwards: Sure.

[Provider verifies with a prescription drug monitoring program and the previous provider that Ms. Edwards was receiving monthly prescriptions for 20 mg oxycodone tablets from just the one prescriber in the town where she used to live until 3 months ago.]

Question: On the next page, answer the poll as to whether you would do urine drug testing before prescribing opioids for Ms. Edwards.

POLL: WOULD YOU CONDUCT URINE DRUG TESTING ON MS. EDWARDS BEFORE PRESCRIBING OPIOIDS?

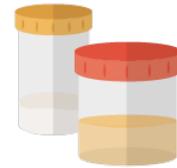
- Yes
 - 93% (556 votes)
- No
 - 4% (23 votes)
- Unsure
 - 3% (17 votes)

Total votes: 596

URINE DRUG TESTING

Basics

Urine drug testing (UDT) is recommended for all patients having opioid therapy for chronic pain^{22,39}. The high rate of prescription drug misuse: roughly 5.3 million Americans reported using off-label painkillers in the past year, which supports this approach⁴⁰. UDT alone cannot determine whether a patient has a drug use disorder, but it provides objective information to help physicians make informed decisions about treatment. Urine is considered to be the best specimen for drug tests due to its relatively long window of detection (1-3 days vs. hours for serum) and non-invasive sample collection⁴¹.



Uses of UDTs:

1. To establish a baseline for later comparison
2. To assess for current prescription opioid or illicit drug use throughout treatment
3. To determine compliance with current prescribed medication regimen
4. To help predict future compliance and illicit drug use problems

5. 9

KEY POINT

Use a urine drug screen to detect substance use with patients being considered for chronic opioids; use periodically to monitor during treatment.

ORDERING URINE DRUG TESTS

Type of Urine Drug Test

1. **Screening.** Screening or "presumptive" tests are initial, qualitative drug tests conducted to identify classes of drugs present in the urine. Immunoassay is typically used.
2. **Confirmatory.** Confirmatory tests are used for further analysis of a sample – to confirm a positive or sometimes, negative, result. Confirmatory testing can identify a specific drug and is useful for synthetic drugs not detected in screening tests. Gas chromatography/mass spectrometry (GC/MS) or high pressure liquid chromatography (HPLC) are typically used.

Note that requirements for testing vary with the health insurance, with respect to reimbursement for UDT. For example, requirements have been shifting for Medicare and will likely continue to shift⁴². For example, insurance may vary as to which codes they will reimburse; some may not reimburse multiple individual substances. Therefore, we recommend that providers consult with the insurance company in question before ordering drug tests.

Comparing two types of urine analysis

	Screening (Point of Care Testing)	Confirmatory
Analysis Technique	Immunoassay	Gas Chromatography-Mass Spectrometry (GC-MS) or High Performance Liquid Chromatography (HPLC)

	Screening (Point of Care Testing)	Confirmatory
Power to detect a class of drugs	Low or none when testing for semi-synthetic or synthetic opioids, e.g., fentanyl, hydrocodone	High
Specificity (power to detect an individual drug)	Varies based on assay used – can result in false positives and false negatives	High
Use	Qualitative analysis; detects <i>classes of drugs</i> <small>43</small>	Detects of amounts of <i>specific drugs</i> above cutoff levels
Cost	Inexpensive; (for example, FDA approved 10-drug testing kit ~ \$9 tests for cocaine, amphetamine, methamphetamine, marijuana (THC), methadone, opiates, phencyclidine, barbiturate, benzodiazepine, and tricyclics.)	More expensive, may not be paid for by insurance
Turnaround	On-site-rapid	Slow
Other	Intended for use in drug-free population; may not be useful in pain medicine context	Legally defensible results

43–45

KEY POINTS

1. Consider UDT for all patients prior to opioid therapy.
2. Test before onset of opioid treatment; subsequently test on an unannounced basis.
3. Use patient's behavior and prior history to determine UDT frequency during treatment.

FYI

Opioid treatment for palliative cancer pain (as opposed to end-of-life care) often involves the same issues as treatment for chronic non-cancer pain. Cancer pain is a complex topic, however, and is not the focus of this training activity.

ORDERING CONSIDERATIONS

1. Be aware of what you are looking for because there are different UDTs to detect different substances.
2. Screening test kits are the most widely used and called “point of care” tests, which are not as sensitive or specific as laboratory tests.
3. Use confirmatory laboratory tests when there is an unexpected result in the screening test.
4. Communicate clearly with the laboratory:
 1. about what substances you are looking for
 2. ask for their help in interpreting results
 3. specify if you have a reason to suspect an illicit substance, prescription drug misuse, or the presence of a prescribed medication.
4. Specifying gas chromatography-mass spectrometry (GCMS) or High-Performance Liquid Chromatography (HPLC) when testing for opioids is recommended. Immunoassays do not reliably detect semisynthetic or synthetic opioids.

5. a "no threshold test" at the limit of detection (LOD) should be requested. This enables the test to pick up on a drug (especially a prescribed medication) that may be in the urine at a lower concentration⁴⁶.

KEY POINTS

1. Routine urine drug screening with many immunoassay tests identifies classes of drugs but often does not detect synthetic or semisynthetic opioids. It is important to specify specific drugs to test for if that is the purpose of the screen.
2. Use screening UDTs routinely and follow up any abnormal/unexpected results with a confirmatory UDT.

WHAT TESTS TO ORDER

Develop a "standard screen".

Have a standard set of drugs for which to screen in place, and then conduct further confirmatory testing if necessary. As a starting point, one recommended set of drugs to include in a urine screen is the following⁴¹:

1. Cocaine
2. Amphetamines (including ecstasy)
3. Opiates
4. Oxycodone
5. Methadone
6. Marijuana
7. Benzodiazepines



10. Other potentially abused prescription drugs, e.g., barbiturates, carisoprodol (muscle relaxant), and tramadol³⁹

Note, that a standard screen may not detect all opioids and benzodiazepines that might be abused. A panel of experts recently suggested that in addition to illicit drugs and commonly prescribed opioids that other prescription drugs of potential abuse also be included, such as barbiturates, carisoprodol (muscle relaxant), and tramadol³⁹.

MR. LEWIS - URINE DRUG TESTING



Patient: Mr. Raymond Lewis, 72 y/o

Scenario: Mr. Lewis is on chronic opioid therapy for diabetic neuropathy. He has a history of using heroin long ago but has been drug-free for many years.

Question: When should you order UDTs for Mr. Lewis, based on his moderate risk?

Choose one

1. Test at each appointment, but only if aberrant behaviors are demonstrated

1. Feedback:

2. All patients should be tested at least at baseline and every 3 months. UDTs should be performed more frequently if there are aberrant behaviors.
2. At baseline, and every 3 months
 1. Feedback:
 2. All patients should be tested at least at baseline and every 3 months. UDTs should be performed more frequently if there are aberrant behaviors.
3. Start after 6 months, then annually
 1. Feedback:
 2. All patients should be tested at least at baseline and every 3 months. UDTs should be performed more frequently if there are aberrant behaviors.

CONDUCTING UDT

For screening purposes, tamper-resistant, commercially-available urine collection cups can be used for urine drug tests (UDTs). These are relatively inexpensive and easy to use in office practice and provide immediate and clear results. If screening is positive, the clinician may choose to proceed with more costly confirmatory (GCMS) testing in an outside laboratory to identify specific drugs and verify their presence. Quantitative testing is being developed and may become available.

1. **Obtain patient information:** Ask the patient about any substances he or she is taking that may affect the results of the UDT, including over-the-counter medications and herbal supplements, noting the last time each medication was taken⁴⁶.
2. **Optimum sample size:** 30 mL or more⁴⁶.
3. **Detection time:** Most drugs have a window of detection in urine of 1 to 3 days after ingestion⁴⁶.
4. **Discuss cost:** It is helpful to discuss the costs of laboratory testing at the beginning of treatment even if covered by insurance as this is sometimes lost or changed over the course of treatment. If UDTs are a requirement for treatment, this should be put in writing in the treatment agreement from the outset.

Safeguard the sample

Limit opportunities for changing the sample by noting the sample temperature and limiting sources of water⁴⁷. For more stringent testing, a patient may need to empty pockets and leave anything like a purse in a locker as chemicals or even soap may alter test results. Dilution or alteration of the sample can be checked by checking specific gravity or creatinine.

UDT PATIENT COMMUNICATION

What to tell the patient

The patient should be told diplomatically how the test helps you provide the safest and most effective care possible. For example:

Provider: *You have shared with me before that at times you have been tempted to take your boyfriend's methadone. UDT is a way to help both of help you not do that*

Provider: *You have probably heard about problems with people becoming addicted to their opioid medication. It can affect anyone, even the healthiest, most well-adjusted people. So in order to reduce the risk in prescribing this medication, it is my policy to test everyone periodically.*

UDT and treatment agreements. UDT policies and expectations should be written into the patient's treatment agreement⁴⁶. A statement of the consequences of substance misuse or underuse of the prescribed medication can be put into a written treatment agreement⁴⁶. For example:

"Presence of unauthorized substances in urine or serum toxicology screens will result in increased requirements you will have to fulfill in order to continue to receive your prescriptions here. Failure to fulfill these requirements could result in a change of medication in order to support safer pain treatment. If the problem still cannot be resolved, it could result in your discharge from the facility, its physicians, and its staff."

UDT INTERPRETATION

UDT results fall in the following categories:

- Prescribed drug is not detected
- An illicit drug is detected
- A nonprescribed scheduled drug or drug of concern (such as the muscle relaxant, carisoprodol) is detected

39

- Obviously, patients on chronic opioid therapy should test positively for opioids, but they should not test positive before the start of their therapy or screen positive for illicit drugs or drugs they have not been prescribed.
- Before acting on UDT screening result, order confirmatory testing, and work with laboratory regarding interpretation. This is very important because an incorrect interpretation could negatively effect treatment and significantly harm the patient.

46,47



CASE: TERRI PART 2



Patient: Terri Edwards, 32 years old

Chief Complaint: Back pain

Brief History: Ms. Edwards is seeking treatment for chronic back pain she relates to standing all day and lifting in her job at a fast food restaurant.

Additional Provider-Patient Dialogue

Provider: *Before deciding on a treatment, we'll need an initial urine sample.*

Ms. Edwards: *Is that really necessary?*

Provider: *Urine drug tests are a requirement for all of my patients before starting long-term opioid therapy; you are not being singled out. The test is not punitive; rather, the intention is to help provide better care for you and to monitor your progress over time. However, it is important for you to know*

that I will discuss any results with you and we will need to address any results that could affect your health.

Ms. Edwards: *Well, I just don't know...*

Provider: *You seem to have some concern about doing a urine drug screen. Is there something that you haven't shared with me?*

Ms. Edwards: *No, I just don't have a lot of time today.*

Urine Drug Test Results:

Ms. Edwards then reluctantly agrees to take the urine drug test, a screening immunoassay, and the results are as follows:

- Positive for cannabinoids
- Negative for opioids and all other drugs screened

Question: Which of the following can be said with certainty?

Choose one

- Ms. Edwards has not taken any synthetic opioids
 - Feedback: Incorrect. This cannot be said with certainty.
 - Because this is a screening test, you cannot conclude that the patient did not take any opioids. Some screening tests do not readily detect synthetic opioids.
- Ms. Edwards has not taken any morphine in the past 3 days
 - Feedback: Incorrect. This cannot be said with certainty.
 - Because this is a screening test, you cannot conclude that the patient did not take any opioids. It is unlikely that she used morphine in the past 3 days, but screening tests only detect opioid above the threshold cutoff point, so lower amounts may go undetected.
- Ms. Edwards has not taken oxycodone in the past 3 days
 - Feedback: Incorrect. This cannot be said with certainty.
 - Because this is a screening test, you cannot conclude that the patient did not take any opioids. Some screening tests do not readily detect synthetic opioids. Screening tests only detect opioid above the threshold cutoff point, so lower amounts may go undetected.
- Ms. Edwards has used marijuana in the past 3 days, but not opioids
 - Feedback: Incorrect. This cannot be said with certainty
 - It is likely that she did use marijuana because of the positive screening test and, at this point, no known cross-reactivity would produce a false positive. This is the only fairly certain conclusion at this point.
- None of the above can be said with certainty, based on these screening results.
 - Correct

MS. EDWARDS CASE CONTINUES:

Terri Edwards, 32 years old

Brief History: Ms. Edwards is seeking treatment for chronic back pain she relates to standing all day and lifting in her job at a fast food restaurant.



ADDITIONAL PROVIDER-PATIENT DIALOGUE

Provider: Your urine test was positive for cannabinoids.

Terri Edward: If you mean like marijuana, I can explain that. A friend told me that ibuprofen can make it look like you used marijuana in your drug test and I took some ibuprofen that day.

Question: What should you do next?

Choose one:

- Confirmatory testing
 - Feedback: Correct
 - Confirmatory testing may be indicated. She is correct that ibuprofen might cause a false positive for cannabinoids. Aside from a positive screening result, there were a couple of "yellow flags" (obtaining medication without a prescription, resisting drug testing), but asking her directly if she smoked marijuana in weeks before testing is a first step that might save the need for further testing if she answers "Yes."
- Ask her if she smoked marijuana in the weeks before testing
 - Feedback: Correct
 - Asking her directly if she smoked marijuana in the weeks before testing is a first step that might save the need for further testing if she answers "Yes." She is correct that ibuprofen might cause a false positive for cannabinoids. This should be discussed with the laboratory as to whether it could account for her test results.
- Ask a significant person in her life, such as her mom, if she knows if Terri used marijuana
 - Feedback: Incorrect.

Talking with collaterals with permission, such as her mom, can be a useful step if you know that they can be trusted. In this case, her mother supplied her with medication for a controlled substance without a prescription. Keep in mind that collateral sources of information may abuse drugs themselves. She is correct that ibuprofen might cause a false positive for cannabinoids. This should be discussed with the laboratory as to whether it could account for her test results.

SPECIFIC CUTOFF LEVELS AND DETECTION TIMES

Substance	Screening Lower Limit	Confirmation Lower Limit	Duration of Detection	False Positives
Alcohol	20 mg/dL	20 mg/dL	7-12 hours	N/A
Amphetamines	500 ng/mL	125 ng/mL	48 hours	Phenylpropanolamine (PPA), ephedrine, products with L-methamphetamine like Vicks Nasal Inhaler, clobenzorex, fenproporex, selegiline
Barbiturates	200 ng/mL	100 ng/mL	24 hours (short-	N/A

Substance	Screening Lower Limit	Confirmation Lower Limit	Duration of Detection	False Positives
(short-acting)			acting); 3 weeks (long-acting)	
Cannabis	15 ng/mL	4 ng/mL	3 days-4 weeks	Ibuprofen, dronabinol, hemp seed products over 12 oz, food products with hemp oil
Cocaine and its metabolites	150 ng/mL	10 ng/mL	6-8 hours (cocaine), 2-4 days (metabolites)	Ampicillin, amoxicillin
Codeine	50 ng/mL	100 ng/mL	2-3 days	N/A
Hydrocodone	50 ng/mL	100 ng/mL	Varies by lab	N/A
Hydromorphone	50 ng/mL	100 ng/mL	Varies by lab	N/A
Methadone	300 ng/mL	100 ng/mL	72 hours	N/A
Morphine	300 ng/mL	100 ng/mL	48-72 hours	Foods with poppy seeds, dextromethorphan, pyrilamine, quinine water, amitriptyline, codeine, heroin
Phencyclidine	25 ng/mL	25 ng/mL	3-10 days	Diazepam, dextromethorphan

(Data from: Center for Substance Abuse Treatment, 1993; Heit & Gourlay, 2004; Substance Abuse and Mental Health Services Administration, 2005, 2007; Shurman & Backer, 2006)

(Adapted from ⁴⁴)

KEY POINTS

- Routine urine drug screening with many immunoassay tests often does not detect synthetic or semisynthetic opioids very well; hence, specify specific drugs if that is the purpose of the test.
- Screen your patients; use confirmatory testing to validate suspicious results and identify specific drugs.

FALSE POSITIVE UDTs

Common Interpretations

Unexpected Positive Results	<ul style="list-style-type: none"> • Abuse, addiction, or undertreated pain • Lab error, test overly sensitive • Cross-reactivity with the patient's medications • Metabolite of a prescribed drug
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Reasons for a positive test for an unprescribed medication

1. a metabolite of the prescribed drug

Some drugs have metabolites that may suggest the patient is taking something other than prescribed. For example, codeine may show up as morphine. Similarly, hydrocodone metabolizes to

hydromorphone. If a screening test is used, a confirmation study done with GCMS should also be done to verify unexpected findings.

Other possible explanations include

- laboratory error
- cross-reactivity
- Certain medications may affect metabolism of a drug, for example, enzyme-inducers and inhibitors such as HIV medication, antiepileptics, psychotropics, and nicotine
- self-medication driven by undertreated pain or continued use after the pain condition resolves, due to therapeutic physical dependence, that is it developed during the course of prescribed treatment
- intentional misuse of the medication, whether prescribed or not prescribed
- addiction to the unprescribed medication
- Certain conditions can alter metabolism or excretion of medication, for example, liver disease, renal function

46

Findings should be discussed with a toxicologist or a medical review officer (MRO) if the clinician is uncertain how to interpret them⁴⁶.

Use the complete medication history to rule out false positives⁴⁶.

Drugs and substances that can cause false positives

Substance	False Positives
Alcohol	N/A
Amphetamines	Phenylpropanolamine (PPA), ephedrine, products with L-methamphetamine like Vicks Nasal Inhale, clobenzorex, fenproporex, selegiline, ranitidine, trazodone
Barbiturates (short-acting)	phenytoin
Cannabis	Ibuprofen, dronabinol (a prescription cannabinoid), hemp seed products over 12 oz., food products with hemp oil, Rimonabant TM (an anti-obesity drug)
Cocaine and its metabolites	Ampicillin, amoxicillin
Codeine	N/A
Hydrocodone	N/A
Hydromorphone	N/A
Methadone	N/A
Morphine/Opiates	Foods with poppy seeds, dextromethorphan, pyrillamine, quinine water, amitriptyline, codeine, heroin, levofloxacin, ofloxacin, rifampicin
Phencyclidine (Adapted from ⁴⁴)	Diazepam, dextromethorphan

FALSE NEGATIVE UDTs

Common Causes of a Negative Result

<p>Unexpected Negative Results</p>	<ul style="list-style-type: none"> • Patient is not taking the drug, whether for innocent reasons or because of diversion • Test is not sensitive enough [urine too dilute] • Urine belonged to someone else, was diluted or adulterated to avoid an illicit drug being detected
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A **negative** UDT test result could also mean:

1. the patient binged on the medication and then ran out early
2. the patient did not take the full prescribed amount
3. the urine was intentionally falsified
 - it belonged to someone else and was used to avoid being tested
 - the urine was diluted or adulterated by the patient to try to prevent detection of another substance

46,47

RECOGNIZING SAMPLE TAMPERING

Variations in normal temperature, concentration and other values of urine may mean the sample has been altered. Normal values include:

- **Temperature:** 90° to 100°F (4 minutes after deposited). Temperature-sensitive cups can help identify abnormal samples.
- **pH:** 4.5 to 8.0
- **Creatinine Concentration:** 20 mg/dL
- **Specific Gravity:** Between 1.003 and 1.020
- **Nitrates:** Greater than or equal to 500 mcg/mL

41

To decrease the risk of tampering ask the patient to leave coats and other articles in a secure location in your clinic rather than bringing them into the bathroom with them.

FYI

Urine drug testing can be used to validate a patient's self-reports of prescribed drug use during treatment to rule out diversion.

MULTIDISCIPLINARY APPROACH TO CHRONIC PAIN TREATMENT

Multidisciplinary treatment approaches including medications, physical interventions, and psychobehavioral interventions are often needed for chronic pain³².

A multidisciplinary approach to chronic pain treatment optimizes treatment effectiveness and minimizes risk of addiction to pain medication by involving the coordinated efforts of different specialists.

Multiple modalities are particularly necessary when there are psychological or medical co-morbidities or impaired function⁹.

The Disciplines Involved in Pain Treatment



Pain Treatment Centers

Few multidisciplinary pain clinics exist, and they are primarily located in major medical center hospitals and rehabilitation centers. Thus, some patients have to travel long distances for pain treatment. Cost, availability, and lack of insurance coverage are other potential barriers to interdisciplinary care⁹. Alternatively, providers can create and coordinate a multi-modal treatment team. A key element that must be in place if a patient is co-managed outside of a pain center is a "home" clinician, to coordinate care.

MRS. CATELL- MEDICAL HOME

A Medical "Home" for Each Patient Treated for Chronic Pain

Patients with chronic non-cancer pain use health care services more frequently and have more comorbidities than other patients⁹. As a result, they often need a "medical home" clinician to coordinate communications among the health care professionals who are involved. The "home" provider may or may not prescribe the pain medication. Thus, primary care providers can serve as the patient's medical home.

Collaborating on Patient Care

Communication, collaboration, and shared decision-making are effective for coordination of care³³. This can be supported by a written agreement that ideally would describe:

- Roles for each clinician and treatments provided
- Communication protocol
- Schedule of visits

Case Example: Medical Home for Multi-Modal Pain Treatment



Patient: Mrs. Donna Cattell, A 62 y/o female with lower back pain.

- **DR. GREY - Mrs. Cattell's Primary Care physician, and medical home**
 - Prescribed first-line therapies for Mrs. Cattell's pain and determined more pain control was needed
 - Referred Mrs. Cattell to a pain and addiction specialist due to her moderate risk factors for addiction and his relatively low level of expertise at the interface of pain and addiction
 - Gathers information from each specialist, summarizes it, and informs the team
 - **DR. BLUE - Pain and Addiction specialist**
 - Prescribed chronic opioid therapy and physical therapy and follows Mrs. Cattell monthly
 - Referred Mrs. Cattell to a psychologist, to help her cope with her pain
 - **DR. GREEN - Psychologist**
 - provided 10 weeks of cognitive behavioral therapy to develop pain-coping skills
 - **MS BLACK - Physical therapist**
 - Sees Mrs. Cattell weekly for therapeutic manipulations
 - Recommended exercises for Mrs. Cattell to do at home that both strengthen surrounding muscles and correct imbalances
 - Taught Mrs. Cattell some yoga stretches for stress relief to release guarding of the painful area.
 - **DR. BROWN - Orthopedic surgeon**
 - Was consulted when Mrs. Cattell's pain worsened to assess the need for surgery. Dr. Brown determined it is not needed currently, but would like to re-assess the situation bi-annually
1. **DR. GREY - Continues to act as Mrs. Cattell's medical home and coordinates communications among all five providers.**

DOCUMENTATION - THE PATIENT RECORD

Initial Evaluations

Accurate and complete documentation of a diagnosis and unrelieved pain is essential in order to provide proper patient care and to meet regulatory and legal requirements regarding chronic opioid therapy⁴⁸.



- Medical history (include current and past pain treatment)
 - Include indication, date, type, dose, and quantity prescribed for current medications
 - Be sure to include concomitant use of benzodiazepines, alcohol or other CNS meds
- Pain severity, type of pain, location, and other pain assessment results
- Physical examination results, objective findings
- Diagnostic, therapeutic, and laboratory results
- Underlying condition responsible for the pain; co-existing conditions that affect pain
 - Poorly controlled depression or anxiety
- Effect of pain on physical and psychological functioning, quality of life; patient's subjective complaints
- History of substance abuse, results of risk assessment
- Any evidence of risks for significant adverse events, including:
 - History of falls or fractures
 - Sleep apnea or other respiratory risk factors
 - Possible or current pregnancy
 - Allergies or intolerances to pain medications
- Evaluations and consultations

9,33

PRACTICE TIPS

1. **A Clinical Tool for Pain Record Keeping:** The Pain Assessment and Documentation Tool (PADT) is one tool that can be used to document visits.
2. Records must be current, accessible, and available for review³³
3. Use records to spot trends over time

CASE VIGNETTE: MR. PARKER



New Patient

Name: Mr. Charles Parker

Age: 68 years old

Reason for visit: Chronic lower back pain

History of Present Illness:

He re-injured his back 2 years ago lifting furniture, which exacerbated his lower back pain. For 2 months immediately after the re-injury, he received physical therapy and a prescription for oxycodone that was not prescribed again. He stopped exercising after the re-injury and has not resumed it since.

Prior to that, he had a 25-year history of mild left lower back pain post MVA, managed by maintaining core body strength through exercise and with OTC NSAIDs, acetaminophen, and heat as needed.

The pain has gradually worsened over the past 2 years and has gotten especially bad recently. Pain worsens with walks of over one block, going down stairs, getting up after sitting long periods, lifting more than 10 pounds, and initially lying down. Sharp, constant, severe pain in left lumbosacral region after one of these triggering events, lasting up to an hour or two, sometimes radiating down left leg.

Recently, he manages daily pain with prescribed celecoxib (or naproxen when he runs out), and acetaminophen. It lowers the pain level a couple of points, but it is still severe. Immediate release oxycodone, obtained from a friend, lowers the pain level to a moderate level but "does not last long enough."

Vital Signs					
Height:	Weight:	Pulse:	Blood Pressure:	Respiration Rate:	Temperature:
5'11"	188 lbs	80	120/70	14	98.7° F

Past Medical History

Medical Illnesses: 25 year history of lower back pain post MVA

Surgeries: Open vertebroplasty of L3-L4 25 years ago

Allergies: NKDA

Family/Social History

Relatives: Mother, age 76 – Hypertension; Father – deceased from lung cancer age 65

Occupation: Parking Garage Attendant

Marital/Family Status: Divorced; two estranged, grown children

Alcohol/Tobacco/Recreational Drug Use: He occasionally has a "couple of beers." Smokes cigarettes: pack and a half per day, 50 pack years

Current Medications

-Celecoxib: 100 mg bid, discontinued occasionally when he cannot afford it.

-Naproxen: 500 mg bid. Taken when he runs out of celecoxib or cannot afford it.

-Acetaminophen: 500 mg bid ("2 extra strength Tylenol per day")

-Oxycodone: 10 mg immediate release. Not prescribed for him; obtained from a friend. 1 to 2 capsules taken intermittently prn pain. He takes it two to three times per day now -Other treatments: Dry heat for occasional muscle spasms from overuse

Past Medications

-Oxycodone: 20 mg immediate-release taken for two months following surgery 2 years ago. Not refilled despite requests. 6 month taper.

Labs

Lab values within normal limits

Physical Exam

- Musculoskeletal: Leg muscles appear symmetrical and well-developed; No tenderness to palpation in low back
- Neurological: Lying straight-leg and femoral nerve stretch tests are positive on the left and negative on the right. Nerve function tests (muscle strength, sensation, deep tendon reflexes) suggest some lumbosacral nerve-root compression that will require further evaluation with MRI
- All other findings within normal limits

Questions at the end of the case pertain to summarizing the results of his assessment for opioid risk.

MR. PARKER - PATIENT INTERVIEW QUESTIONS

Patient: Mr. Charles Parker

Scenario: Mr. Parker presents as a new patient with a long history of bilateral, non-radiating lower back pain. Initially, he was prescribed NSAIDs and exercise. In the past 2 years, since a re-injury, his back pain is not responding sufficiently to NSAIDs and occasional oxycodone obtained from a friend.

The pain is constant and severe and ranges from sharp to a dull ache. Mr. Parker rated his pain as 9 out of 10 in the past month, after any back stress; even with celecoxib and acetaminophen, and a 6 at rest. He said that with oxycodone, the maximum pain when he added celecoxib/acetaminophen was a 4 to 5. Pain is aggravated to severe (8 or 9 out of 10) by walking and standing and relieved down to a rating of 6 to 7 out of 10 after an hour of constant rest. The inability to walk places is affecting his mood, but he is not depressed.

Question: After obtaining the above pain history, which of the following are the THREE best initial provider-directed questions to ask before prescribing chronic opioid therapy for his back pain? (Choose all that apply)

Choose all that apply

- Have you ever abused opioids?
 - Feedback: Incorrect
 - This wording is rather abrupt and judgmental sounding. It could be worded with a less accusing word than "abused" such as "used opioids for non-medical purposes."
- It will help me to get a complete picture of how your treatment is going. Have you been using the exercises that were recommended?
 - Feedback: Correct
 - This is a good question to ask before completing the treatment plan, which should involve multiple modalities in order to prescribe the lowest possible dose. If Mr. Parker has not been doing the prescribed exercises, a return to physical therapy for reassessment and a review of the exercises might be indicated.
- How much alcohol do you drink per day? Per week?
 - Feedback: Correct
 - This is a good question to ask before prescribing opioids. Alcohol abuse is associated with an increased risk of opioid abuse and because alcohol interacts with many opioid medications.
- Are you willing to sign an agreement to only take opioids that I prescribe?
 - Feedback: Correct
 - A signed, written treatment agreement developed before prescribing medications is a good way to address aberrant behaviors, such as obtaining opioids from a friend.

MR. PARKER - POSSIBLE RISK ASSESSMENT QUESTIONS

Assume that you have determined that Mr. Parker has sufficiently severe and chronic pain to warrant consideration of chronic opioid therapy and that first-line therapies have been tried.

Learning Task: Write at least two questions that you can ask to assess Mr. Parker's risk for opioid misuse.

Answer

CORRECT ANSWER

Include the following: Current or past use/abuse/addiction to opioids or any substances; family history of same; mental health problems. For women: sexual abuse as a youth

MR. PARKER - EXAMPLE RISK ASSESSMENT QUESTIONS

The following are examples of some of the possible questions/statements to present to Mr. Parker to assess his risk for opioid misuse, if, after considering the poor response to other therapies both pharmacological and non-pharmacological, and the severe, constant nature of his pain, you determine that opioids might be considered. This will involve immediate-release opioids initially until a stable dose is established and then change to extended-release/long-acting opioids.



Provider-Patient Dialogue

Provider: *Have you ever used tobacco, alcohol, prescription drugs not prescribed for you, or illegal drugs?*

Mr. Parker: *I did get some oxycontin from a friend, but that was for medical reasons. I needed it for my pain. I drink a couple of drinks a night on weekends sometimes. And I do smoke. I started smoking a little in my teens, and now it's a pack and a half per day.*

Discussion: This is an important part of the risk assessment. His use of a friend's oxycontin is one risk for opioid use disorder and will need to be addressed in his treatment agreement. He should be asked to agree only to take opioids that are prescribed for him by a single provider. Some evidence shows that smoking cigarettes are another risk factor.

Provider: *Does anyone in your family or any close friends have a history, current or past, of any substance abuse?*

Mr. Parker: *No, no one. Not for many years.*

Provider: *Have you had any mental health problems such as depression or anxiety? ADHD or bipolar?*

Mr. Parker: *Nope, not me.*

Discussion: Mental health screening is an important part of the risk assessment.

Other risk questions include:

1. History of pre-adolescent sexual abuse (female)
2. Younger age (18 to 45 years)
3. Being male
4. Social problems: legal problems, motor vehicle accidents, poor family support, or high-risk subculture.
5. Tobacco use*

*There has been limited research done on the effects of smoking and smoking cessation on chronic pain. Contradictory evidence shows that nicotine has analgesic properties, and also shows that

smokers are at an increased risk of developing back pain and other chronic pain disorders. It is thought that smokers have much higher pain intensity scores and lower social and occupational functioning as a result. A recent population study shows that current and former heavy smokers are more likely to use prescription analgesic drugs than never-smokers. Because of the lack of consistency in the literature, more studies are needed to determine the relationship between smoking and pain treatment⁴⁹.

MR. PARKER - TREATMENT AGREEMENT

Review Mr. Parker's Pain History:

Name: Mr. Charles Parker

Age: 68 years old

Reason for visit: Chronic lower back pain

History of Present Illness (repeated for convenience):

He re-injured his back 2 years ago lifting furniture, which exacerbated his lower back pain. For 2 months immediately after the re-injury, he received physical therapy and a prescription for oxycodone that was not prescribed again. He stopped exercising after the re-injury and has not resumed it since.

Prior to that, he had a 25-year history of mild left lower back pain post MVA, managed by maintaining core body strength through exercise and with OTC NSAIDs, acetaminophen, and heat as needed.

The pain has gradually worsened over the past 2 years and has gotten especially bad recently. Pain worsens with walks of over one block, going down stairs, getting up after sitting long periods, lifting more than 10 pounds, and initially lying down. Sharp, constant, severe pain in left lumbosacral region after one of these triggering events, lasting up to an hour or two, sometimes radiating down left leg and moderately severe pain with medications, but severe constant pain if not taking medications

Recently, he manages daily pain with prescribed celecoxib (or naproxen when he runs out), acetaminophen, and oxycodone, obtained from a friend.

Past Medical History

Medical Illnesses: 25 year history of lower back pain post MVA

Surgeries: Open vertebroplasty of L3-L4 25 years ago

Allergies: NKDA

Family/Social History

Relatives: Mother, age 76 Hypertension; Father deceased from lung cancer age 65

Occupation: Parking Garage Attendant

Marital/Family Status: Divorced; two estranged, grown children

Alcohol/Tobacco/Recreational Drug Use: He occasionally has a "couple of beers." Smokes cigarettes: pack and a half per day, 50 pack years

Current Medications

-Celecoxib: 100 mg bid, discontinued occasionally when he cannot afford it.

- Naproxen: 500 mg bid. Taken when he runs out of celecoxib or cannot afford it.
- Acetaminophen: 500 mg bid ("2 extra strength Tylenol per day")
- Oxycodone: 10 mg immediate release oxycodone. Not prescribed for him; obtained from a friend. 1 to 2 capsules taken intermittently prn pain. He takes it two to three times per day now
- Other treatments: Dry heat for occasional muscle spasms from overuse

Past Medications

-Oxycodone: 20 mg immediate release taken for two months following surgery 2 years ago. Not refilled despite requests. 6 month taper.

Mr. Parker's prescription is now being changed to extended release oxycodone.

Question: What stipulation(s) should be included in his patient-provider agreement?

Choose all that apply

1. More frequent and random urine drug testing
 - Feedback:
Correct. Random urine drug testing, as well as a baseline test, is recommended for all patients according to several recent evidence-based guidelines for opioid prescribing, such as the CDC's ⁽²²⁾. In this case additional and careful testing is indicated.
2. That he will not take prescription opioids that are not prescribed for him.
 - Feedback:
Correct. With Mr. Parker' history of taking opioids prescribed for a friend, the problem with this should be discussed and putting directions not to do this anymore specifically in the patient-provider agreement underscores the importance of this direction. He also needs a special stipulation in his patient-provider agreement that he will not share his medication with anyone else given his past history.
3. That he will use only medications from a single prescriber
 - Feedback:
Correct. Although, he does NOT have a history of obtaining medications from more than one prescriber, his prior seeking (and receiving) opioid medications places him at risk of seeking medications from other providers rather than discussing the issue with you. You should make it clear that all opioids should be prescribed by you. In general, this is a good guideline to include for all patients.
4. Not to use alcohol while he is taking extended-release oxycodone
 - Feedback:
Correct. Because he does admit to drinking alcohol, it is important to discuss with Mr. Parker the potential for overdose or increased sedation. Agreeing to not drink alcohol in combination with ER/LA opioids can be made part of the signed patient-provider agreement.
5. He must notify the prescribing provider of any other medications that are prescribed.
 - Feedback:
Correct. In order to avoid dangerous over-medication and drug interactions, the prescribing provider must be advised of any medications prescribed by other providers. Similarly, the other providers should be advised of his pain medications.

MR. PARKER - CASE SUMMARY

Patient information

Mr. Parker - 68-year-old white male

Case Summary

Left lower back pain, occasionally radiating down left leg

Onset: 25 years ago, post-MVA; exacerbated 2 years ago by re-injury caused by lifting a heavy piece of furniture

Severity: Mild to moderate; 9 out of 10 after any back stress

Eliciting factors: walks of over one block, going down stairs, getting up after sitting long periods, lifting more than 10 pounds, and initially lying down

Duration: constant pain after a trigger, lasting 1-2 hrs Managed with OTC NSAIDs and rest/avoiding triggers: severity is 6 out of 10 with celecoxib and acetaminophen; 2-3 out of 10 after an hour of rest

Physical Examination

Musculoskeletal: Leg muscles appear symmetrical and well-developed; No tenderness to palpation in low back

Neurological: Lying straight-leg and femoral nerve stretch tests are positive on the left and negative on the right. Nerve function tests (muscle strength, sensation, deep tendon reflexes) suggest some lumbosacral nerve-root compression that will require further evaluation with MRI. All other findings within normal limits

Working Diagnosis

Musculoskeletal low back pain with possible radiculopathy

Risk Assessment

No current or past history of substance abuse; alcohol consumption is within recommended limits. No family or close friend history of substance abuse Smokes cigarettes: pack and a half per day, 50 pack-years and always smokes upon awakening Used oxycontin that was not prescribed for him to relieve unmanaged pain No psychiatric problems No family or close friend history of substance abuse

Question: What is Mr. Parker's level of opioid risk?

Choose one

- None
 - Feedback: Incorrect
 - Mr. Parker does have some level of opioid risk.
- Mild/Low
 - Feedback: Correct
 - Mr. Parker does have mild or low level of opioid risk.
- Moderate
 - Feedback: Incorrect
 - Mr. Parker has mild or low level of opioid risk.

Treatment Plan

Oxycontin titrated slowly to effect, co-analgesic to minimize opioid dose, physical therapy evaluation.

Terms of Treatment: Discuss why the use of his friend's oxycontin is problematic. A written, signed treatment agreement will be used to define the roles and responsibilities of patient and provider. For example, Mr. Parker will be asked to agree only to take opioids that are prescribed for him by a single

provider and to follow directions for taking them safely. Points of (safe) opioid termination will be described, for example, failing a urine drug test, repeatedly needing early refills on medication, filling his prescription at more than one pharmacy, being prescribed opioids by another clinician, etc.

Follow-Up

Question: What is an appropriate time for Mr. Parker to return for follow-up?

Choose all that apply

- Weekly
 - Feedback: Incorrect
 - Mr. Parker should return monthly.
- Monthly
 - Feedback: Correct
 - Mr. Parker should return monthly.
- Every 6 months
 - Feedback: Incorrect
 - Mr. Parker should return monthly.
- Annually
 - Feedback: Correct
 - Mr. Parker should return monthly.

SUMMARY AND KEY POINTS

- Prior to prescribing opioids, obtain a detailed history, physical examination, and diagnostic testing.
- Prior to prescribing opioids, complete a comprehensive assessment of pain and functioning.
- Assess the risk for opioid use problems, including addiction, misuse, and diversion, for each patient using a standardized approach.
- Assess each patient for current addiction.
- Screen for current depression and obtain a psychiatric history.
- Refer patients at high risk for addiction or substance abuse or with complex pain treatment needs.
- Determine current physical dependence on opioids and level of opioid tolerance.
- Detail accurate and complete documentation of a patient's diagnosis and unrelieved pain.

RESOURCES AVAILABLE THROUGH THIS MODULE:

- [AMA Guide: Promote safe storage and disposal of opioids and all medications](#)
AMA Task Force to Reduce Opioid Abuse produced a brief flier with 3 steps providers should take to promote safe storage and disposal of opioids and all medications with links to resources for patients.
- [American Pain Society: Pain - Current Understanding of Assessment, Management, and Treatments](#)

The American Pain Society in 2006 published this guideline "Pain: Current Understanding of Assessment, Management, and Treatments". The guideline provides common assessment tools used to assess types of pain.

- [Assessing Substance Abuse in Patients with Chronic Pain](#)
A continuing education course about diagnosing and treating chronic pain.
- [BPI: Brief Pain Inventory](#)
Patients to rate their pain and ability to complete daily living activities in nine sections. Created by University of Texas MD Anderson Cancer Center.
- [CAGE-AID Screening Tool](#)
A quick drug and alcohol assessment tool for determining whether a patient may be currently abusing drugs or alcohol. It can be used to detect existing substance use problems prior to prescribing opioid therapy.
- [CDC Guideline for Prescribing Opioids for Chronic Pain](#)
Clinical guidelines, literature review, and analysis of the evidence on the use of opioids for chronic pain. Recommendations are also made for prescribing opioids for acute pain.
- [Clinical Guidelines for the Use of Chronic Opioid Therapy in Chronic Noncancer Pain \(APS/AAPM\)](#)
Recommendations published in 2009 for chronic opioid therapy based on a review of the evidence. Provide guidance on patient selection, risk stratification, informed consent, opioid management plans, and more. Authors: Chou R, Fanciullo GJ, Fine PG, et al.
- [DIRE Score](#)
Assessment of a patient on selection for Chronic Opioid management
- [Disposal of Unused Medicines: What You Should Know](#)
Describes programs to dispose of unused pain medications and other prescription medications.
- [Drug Cutoff Concentrations](#)
This document lists the Federal urine drug testing cutoff concentrations for the "Federal Five" drugs (marijuana, cocaine, opiates, PCP and amphetamines/methamphetamines).
- [Faces Pain Scale – Revised](#)
A visual analog pain scale using pictures of faces that can be used with children and those who have difficulty with numerical scales.
- [Facilities - Drug Rehab, Alcohol Rehab and Drug Addiction Treatment and Recovery Programs](#)
Provides drug and alcohol addiction treatment, recovery programs and center listings.
- [FSMB Model Policy for the Use of Controlled Substances for the Treatment of Pain](#)
This document, first published in 2004 and revised in July 2013, is a model policy for state medical boards to use in developing their guidelines for use of opioids in treating chronic pain. These Model Guidelines provide the FSMB's policy on proper treatment of pain and the use of opioids when necessary to manage pain.
- [McGill Pain Questionnaire](#)
Printable verbal pain assessment questionnaire.
- [NIDA Quick Screen - Online](#)
The NIDA quick screen is an online screening tool for substance abuse filled out by the patient. Based on the patient's responses, it generates a substance involvement score that suggests the level of intervention needed. This is the short, online version of the longer screening tool, the NIDA Modified ASSIST.
- [NINDS Chronic Pain Information Page](#)

Defines chronic pain, giving treatment suggestions and prognosis. Lists relevant organizations and relevant publications.

- [Opioid Risk Tool \(ORT\) with Scoring Interpretation](#)
This questionnaire developed by Dr. Lynn Webster, to be filled out by the patient, allows health care professionals to determine risk of addiction to prescription opioid medication. Total Score Risk Category information is provided.
- [ORT: Opioid Risk Tool](#)
This questionnaire developed by Dr. Lynn Webster, to be filled out by the patient, allows health care professionals to determine risk of addiction to prescription opioid medication.
- [Oswestry Low Back Pain Disability Questionnaire](#)
Oswestry Low Back Pain Disability Questionnaire
- [Pain Evaluation Form](#)
A clinical pain evaluation form for the use of physicians or other healthcare providers. The form will help to better understand the type of pain a patient is experiencing and how to best treat the pain.
- [Patient Counseling Document - English](#)
Patient Counseling Document - English
- [Patient Counseling Document - Spanish](#)
Patient Counseling Document - Spanish
- [Patient Health Questionnaire \(PHQ\) Screeners](#)
The PHQ-9 and PHQ-2, components of the longer Patient Health Questionnaire, offer psychologists concise, self-administered tools for assessing depression. They incorporate DSM-IV depression criteria with other leading major depressive symptoms into a brief self-report instruments that are commonly used for screening and diagnosis, as well as selecting and monitoring treatment.
- [Patient Health Questionnaire \(PHQ-9\) English](#)
Patient Health Questionnaire (PHQ-9) English
- [Patient Health Questionnaire \(PHQ-9\) Spanish](#)
PHQ 9 Depression Assessment Questionnaire
- [Patient Health Questionnaire-2 Instructions for Use](#)
The PHQ-2 includes the first 2 items of the PHQ-9. Short assessment for depression
- [PEG: A Three-Item Scale Assessing Pain Intensity and Interference](#)
See title
- [Registered Nurses Association of Ontario: Assessment and Management of Pain](#)
The Registered Nurses Association of Ontario offered an updated version of their “Assessment and Management of Pain” guidelines in 2007. The RNAO guidelines offer recommendations for patient practice related to pain assessment and management.
- [SAMHSA Opioid Overdose Prevention Toolkit](#)
This resource on SAMHSA's website includes several resources: Facts for Community Members; Essentials for First Responders; Safety Advice for Patients; Information for Prescribers; and Resources for Overdose Survivors and Family Members
- [Sample Treatment Agreement for Long-term Controlled Substances Therapy for Chronic Pain](#)
A written patient agreement for patients and physicians about to begin treatment with the use of controlled substances. The agreement includes patient and physician responsibilities, realistic expectations, and possible consequences if the agreement is broken.

- [Screener and Opioid Assessment for Patients in Pain \(SOAPP®\)](#)
Screener and Opioid Assessment for Patients in Pain (SOAPP) is a brief assessment of chronic pain patients to help in deciding on and planning long-term opioid treatment. Predicts a patient's susceptibility to developing drug-abusive behaviors.

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