# Risk Reduction Strategies for Opioids

## Initiating, Monitoring, and Terminating Opioid Treatment (Including ER/LA Opioids)

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INITIATING, MONITORING, AND TERMINATING OPIOID TREATMENT (ER/LA OPIOIDS)

Goal:
Prescribers of chronic opioid therapy will be able to understand the limited situations in which opioids are indicated, including additional limitations for extended release/long acting (ER/LA) opioids. They will be able to provide appropriate long-term monitoring for their patients who are on chronic opioid therapy in order to minimize risks of addiction and other misuse, determine if there is continued need, and discontinue use safely when it is appropriate.

After completing this module participants will be able to:
- Create an appropriate schedule and plan for monitoring patients on chronic opioid therapy, including ER/LAs
- Order and interpret urine drug testing as needed to decrease risk of use of opioids, including ER/LAs
- Recognize the need for referral to addiction or pain specialists for the high risk patient
- Assess the patient for continued need of chronic opioid therapy, including pain, functioning, underlying pain condition, and side effects/adverse effects; and discontinue treatment safely when indicated
- Apply a comprehensive understanding of the drug information in selecting opioids, determine initial dose while considering any opioid tolerance, titrate to effect individually and safely

Professional Practice Gaps
Acute and chronic pain are commonly encountered in medical practice. Moderate to severe pain affects 10-14% of the population\(^1\). Multiple evidence-based clinical guidelines are available to help healthcare professionals address pain effectively and safely\(^2\text{-}^6\).

Opioid addiction or misuse are frequently encountered in primary care due to the alarming extent of the opioid epidemic: 9.9 million people aged 12 or older surveyed in 2018 misused prescription pain relievers in the past year\(^7\). The incidence of opioid misuse, overdose, diversion, and addiction rose over the past 20 years\(^2\text{-}^7\). Research confirmed that high risk prescribing practices contributed to the opioid epidemic\(^2\).

The AMA, American Association of Medical Colleges, and FDA, concluded from the evidence that healthcare professional training in related clinical skills will help address the opioid epidemic\(^8\text{-}^{10}\). Current evidence-based guidelines for safe prescribing of opioids have been developed to minimize these risks and training in them would decrease exposure of patients with chronic pain to unnecessary risks of opioids\(^2\).

ER/LA Opioids Practice Gaps:
Guidelines for extended-release and long acting opioid (ER/LA) use recommend their use be limited to specific circumstances due to their increased risk for overdose and addiction. ER/LA prescribing increased from 9.3 million in 2000 to 22.9 million prescriptions in 2009\(^11\) This training is needed because primary care providers dispensed almost half of these prescriptions\(^11\) and often left out...
pertinent information about safe use and storage in patient counseling.\textsuperscript{12} The FDA released a blueprint for REMS-related training for this class of opioids.\textsuperscript{8} The CDC’s guidelines on opioid prescribing include specific recommendations for ER/LA opioids, such as not prescribing them in certain circumstances (e.g., acute pain, moderate chronic pain).\textsuperscript{2}

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**INTRODUCTION TO MONITORING**

Treatment structure can reduce and eliminate adverse events. Pain levels should be monitored, as well as the underlying pain condition. Side effects also should be reviewed at each appointment. Aberrant behaviors should be noted and addressed. Patients must be monitored for adverse reactions consistently and indefinitely. Create a schedule for patient monitoring and adapting treatment when the situation warrants it.

As an example, a provider who orders and interprets urine drug tests appropriately can detect some issues in a timely manner. By providing treatment structure via urine drug screens, prescribers can quickly and efficiently deal with indications of misuse or addiction and reduce long-term harmful effects.

Patients may reach the point where medication can and should be discontinued for a variety of reasons. If discontinuation is indicated, it is also important to know how to safely wean patients off opioid use when appropriate, because most patients taking chronic opioids will have some physical dependence, preventing them from stopping opioid use abruptly.

**Monitoring Patients Long-term**

It is essential to create a schedule for patient monitoring when they are on chronic opioid therapy, and to adapt treatment when the situation warrants it. Pain levels and adverse reactions should be monitored, as well as the underlying pain condition. This module is designed to train you to develop and implement a method for monitoring patients on chronic opioid therapy.

**Urine Drug Testing**

Ongoing urine drug testing (UDT) is recommended for all patients on chronic opioid therapy. It is considered to be the best specimen for drug tests due to its relatively long window of detection and non-invasive sample collection. This module will train you how to order and interpret urine drug testing as needed to support safe use of opioids.

**Aberrant Behaviors**

Monitoring aberrant behaviors should happen at each appointment on some level. It is important to know when to refer high-risk patients and patients exhibiting aberrant behavior. This module will teach you to identify and respond to aberrant behaviors.
MRS. YOUNG – HIGH-RISK PATIENTS

Patient: Mrs. Carlene Young, 28 y/o

Scenario: Mrs. Young came for treatment of an uncomplicated fractured wrist, sustained during a Zumba workout 3 weeks ago and was seen by a physician assistant in an orthopedic practice. Initially over the counter analgesic, ibuprofen or acetaminophen, were recommended. She returned after a day saying they were "not enough." The PA consulted with the orthopedist and prescribed acetaminophen with codeine. Now, a few days later, Mrs. Young returns without an appointment saying that the pain is "unbearable" and she would like something stronger. Mrs. Young mentions she was previously on opioid therapy after surgery to repair a torn ACL. A quick look at her chart reveals that for the previous injury, Mrs. Young often ran out of opioid medication before her prescriptions had run out - which is potentially an indication of substance abuse. A thorough evaluation including additional imaging does not reveal any other problems, but given her complaint of severe pain, further evaluation by the orthopedist as soon as possible is recommended, but it is Friday afternoon and she cannot be seen until Monday morning.

Question: How would you respond to Mrs. Young’s request for stronger pain medication until that evaluation?

1. Tell Mrs. Young to continue with the acetaminophen with codeine or OTC analgesics due to her past history.
   • Feedback: Incorrect. This is not the best answer to managing Mrs. Young’s pain.
2. Prescribe a high dose of a strong opioid to cover the severe pain.
   • Feedback: Incorrect! High doses of strong opioids cannot be given to opioid-naive patients without risking overdose.
3. Prescribe a small quantity of short-acting opioid to be taken on a schedule.
   • Feedback: Correct. Given Mrs. Young’s previous indication of substance misuse, this is the most appropriate answer. A written patient-treatment agreement should be considered as well.
4. Prescribe a small supply of short-acting opioid to be taken as needed.
   • Feedback: Incorrect. This is not the best answer because it is better to take the medication on schedule than as-needed.

CLINICAL GUIDELINES FOR CHRONIC OPIOID THERAPY

The CDC produced clinical guidelines for all patients based on an analysis of the literature and expert input². Following these guidelines would reduce the rate at which opioids are currently prescribed and therefore would likely help decrease the rate of opioid use disorder. The CDC’s guidelines are paraphrased below.
Determine When to Initiate or Continue Chronic Opioids

1. **Use other treatments first if possible:** Non-opioid pharmacologic medication and nonpharmacologic therapy are preferred treatment for chronic pain. Consider opioids only if benefits for *both pain and functioning* are likely to outweigh risks. If opioids are prescribed, minimize their use by combining them with non-opioids and non-pharmacological therapy. Evidence level 3.

2. **Use treatment goals:** Set realistic treatment goals for pain and function at the outset. Explain that treatment will continue only if the risk-benefit ratio is favorable and there is "clinically meaningful improvement." Evidence level 4.

3. **Discuss risks with patient:** Discuss known risks and realistic benefits of opioid therapy before starting. Define patient and clinician responsibilities for managing therapy. Evidence level 3.

**Opioid Selection, Dose, Duration, Follow-up, Discontinuation**

1. **Use immediate release, not extended release/long acting opioids (ER/LAs) when starting opioid therapy for chronic pain.** Evidence level 4. Note that REMS for ER/LA opioids require that the companies provide special training for prescribers of ER/LA opioids.

2. **Use lowest possible dose:** Reassess benefits vs risks carefully when considering a dosage increase to ≥50 morphine milligram equivalents (MME)/day. Avoid increasing the dose to ≥90 MME/day or carefully justify. Evidence level 3.

3. **Prescribe only a 3-day supply for most acute pain, rarely more than a 7-day supply:** The supply should be only for the duration of pain requiring opioids, not the duration of the pain. Prescribe the lowest effective dose of immediate-release opioids. Evidence level 4.

4. **Evaluation of benefits vs. harms/risks is ongoing:** Evaluate benefits and harms/risks with patients within 1 to 4 weeks of starting opioid therapy or a dose increase. Reevaluate at least every 3 months. Taper to a lower dosage or discontinue opioids if benefits do not exceed harm. Evidence level 4. Note that most patients can tolerate around a 10% reduction of the original dose per week.¹³

**Assessing Risk and Addressing Harms of Opioid Use**

1. **Ongoing evaluation for risk of opioid-related harm:** In addition to evaluating risk of opioid-related harm, plan strategies to mitigate risk. Consider offering naloxone when factors that increase risk for opioid overdose are present, e.g., history of overdose, history of substance use disorder, higher opioid dosages (≥50 MME/day), or concurrent benzodiazepine use. Evidence level 4.

2. **Consult prescription drug monitoring database before prescribing and during treatment:** Look at total opioid doses and dangerous drug combinations. Check database at least every 3 months and consider checking at every prescription. Evidence level 4.

3. **Use urine drug testing before and during treatment:** Test prior to prescribing and at least annually for the prescribed medications, controlled prescription drugs, and illicit drugs. This recommendation may vary depending on the individual clinician, clinic and/or patient situation. Evidence level 4
4. **Avoid prescribing opioids together with benzodiazepines:** Avoid concurrent prescribing whenever possible. Evidence level 3

5. **Treat opioid use disorder:** Treat or arrange treatment for opioid use disorder. Treatment is usually with medication assisted treatment, i.e., buprenorphine or methadone, in combination with behavioral therapy. Evidence level 2.

-Level 2 evidence means evidence from clinical trials with limitations or exceptionally strong evidence from observational guidelines.
-Level 3 evidence means evidence from observational studies or randomized clinical trials with notable limitations.
-Level 4 evidence means it comes from clinical experience or observations or studies with important or major limitations.

**APA CLINICAL GUIDELINES FOR CHRONIC OPIOID THERAPY**

Clinical guidelines for the use of chronic opioid therapy overlap to a large extent with the more recent CDC guidelines presented on the previous page, but do include a few additional guidelines:

1. **Pain should be moderate or severe** in order to prescribe opioids

2. **Patient/provider treatment agreements:** Consider use of written agreements that describe responsibilities of both the patient and prescribing provider and the treatment structure that helps prevent addiction, misuse, and diversion. Include patient education on using as directed, safe storage, keeping appointments, etc.

3. **Increase treatment structure for higher risk patients:** For example, more frequent appointments and urine drug testing with higher risk

4. **Plan for stopping opioid treatment before starting:** Describe a plan that includes the conditions under which treatment will be stopped, and a plan for tapering and providing psychosocial supports when stopping.

These guidelines will be described further in the following pages.

*UPDATE on Tapering Opioids: 10/2019.*

Subsequent to the publishing of the above guidelines by the CDC and APA, and publication of this module, the U.S. Department of Health and Human Services released a guideline: **HHS Guidelines for Clinicians on the Appropriate Dosage Reduction of Discontinuation of Long-Term Opioid Analgesics**. This guideline should be followed carefully when tapering patients’ opioid dosage as it is based on experience of some harmful misinterpretations of the CDC’s opioid prescribing guidelines.

**POLL:**

I consult with the laboratory regarding urine drug test results what percent of the time?

**Poll Responses:**

1. 0-10%
   1. 28% (156 votes)
INITIATING TREATMENT WITH OPIOIDS

Guidelines for Prescribers In Chronic Pain
- **Chronic pain is almost never completely eliminated.** Pain is typically reduced by opioids several points on a scale of one to ten.
- **Use written, signed Patient/Provider Treatment Agreements** that describe the responsibilities of both patient and healthcare provider, including terms of treatment, prohibited behavior, and points for termination.
- **Adjust treatment structure as needed for risk**, with a higher level of treatment structure for high risk patients (including an increased monitoring of medication use, more frequent drug-screenings, and a more stringent Treatment Agreement).
- **Patient education** should include information on how to take the medication, drug interactions, withdrawal symptoms, safe storage and disposal, and safety risks.
- **Use caution in an opioid naive patient.** For the initial trial dose, choose the dose based on efficacy and tolerability.
- **Minimize diversion**, by educating patients on the proper storage and disposal of opioids.

Initial (Acute Pain) Prescriptions That Increase Risk of Chronic Opioid Use
A study of the patient records of over a million patients with acute pain who had been prescribed opioids aimed to identify the characteristics of prescription circumstances most likely to lead to chronic opioid use and found the following:\(^\text{17}\):

- The odds of long term opioid use increased sharply after a 5 day or longer initial prescription, even at low doses
- Chance of long term opioid use inceas if there is a 2nd prescription or refill
- Starting with a long acting opioid is associated with greater risk of long term opioid use than oxycodone or hydrocodone. Tramadol (Ultram) was the second most likely.
DOCUMENTATION IN THE PATIENT RECORD

What to Include
Accurate, complete documentation is essential in order to provide proper patient care and to meet regulatory and legal requirements regarding chronic opioid therapy. In addition to a written treatment plan, thorough records should be kept of each visit. Keeping complete records of the following elements is important for tracking treatment progress and to be prepared in the event of a government audit:

Initial Evaluations
1. 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
2. Pain severity, type of pain, location, and other pain assessment results
3. Physical examination results
4. Diagnostic, therapeutic, and laboratory results
5. Underlying condition responsible for the pain; co-existing conditions that affect pain
   - Poorly controlled depression or anxiety
6. Effect of pain on physical and psychological functioning
7. History of substance abuse, results of risk assessment
8. 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
9. Evaluations and consultations

Treatment
1. Treatment objectives
   - Planned change in pain relief
   - Planned change in physical or psychosocial functioning
   - Any further diagnostic evaluation or treatments
2. Risks and benefits
3. Informed consent
4. Medications (including indication, date, type, dosage and quantity prescribed)
5. Other treatments
6. Medical indications for use of a controlled substance
7. Treatment agreements, patient education and instructions
8. Action plans, including plan for ongoing monitoring
Ongoing Monitoring

1. Periodic reviews, include treatment outcomes, updates
2. Treatment adherence
3. Side effects ("adverse events")

(FSMB, 2013; Chou et al., 2009)

A Clinical Tool for Pain Record Keeping
The Pain Assessment and Documentation Tool (PADT) is a tool that can be used to document visits.

OPIOID SELECTION -SPECIAL CONSIDERATIONS FOR ER/LA AND RAPID ONSET OPIOIDS

Understand the Unique Pharmacology of Each Drug
Understand the variability of opioid pharmacology. Two potent classes of opioids that are particularly important in this regard are:

Extended-release/long-acting (ER/LA) opioids are used for the minority of patients who require around-the-clock opioid therapy. These opioids are not appropriate for managing acute pain and should not be prescribed to an opioid-naive patient due to the risk of overdose. The extended-release/long-acting opioids have a Risk Evaluation and Mitigation Strategy (REMS) that includes prescriber training in their use supplied indirectly by the manufacturer. If a patient is a good candidate for ER/LA opioids and is opioid-naive, best practice suggests that providers start by prescribing immediate release opioids in small amounts on a strict schedule, adjusting to the lowest dose that adequately manages the patient's pain, then switching to a comparable dose of ER/LA opioids for 24-hour coverage. The specific opioid should be chosen according to its relative potency (morphine equivalents are useful in this regard) and matched to the patient's pain severity.

Rapid onset opioids (ROO): Due to the high amount of opioid available in these formulations, they are only appropriate for the opioid tolerant individual and should be titrated carefully because of variations among opioids and individuals. ROO are often used for break-through pain. This class of drug includes a Risk Evaluation and Mitigation Strategy (REMS), too.

Establish Tolerance Before Prescribing Relatively Potent or High Doses of ER/LA Opioids
Before prescribing high potency extended-release/long-acting (ER/LA) opioids, patients must have developed enough tolerance to be able to take these medications. Ask patients who are already on opioids what dose they take regularly to see if they are tolerant. Even with tolerance built up, variations between opioid medications and between individual patients mean that each new medication should be carefully titrated as if the patient had never taken that medication, to avoid an overdose. Follow product information carefully for opioid naive patients. Before initiating any strength of transdermal fentanyl or ER hydromorphone, the patient MUST be opioid tolerant. The tolerance level needed varies for different ER/LA opioid doses and strengths, so be sure to check the product information.
Drug Interactions – ER/LA Opioids
With most ER/LA opioids, the consumption of alcohol can have serious adverse effects, as alcohol can further depress the respiratory system. Providers should perform a thorough assessment and not prescribe ER/LA opioids if patients abuse alcohol or are on CNS depressants, MAOIs, or, in some cases, cytochrome P450 inhibitors.8

"INHERITED" PATIENTS ON OPIOID THERAPY

Chronic Pain Patients Coming from Other Practices
Strategies for managing inherited pain patients include triaging patients into one of three groups:

1. Patients who are doing well and are being managed on a course of therapy that is both reasonable and appropriate for the diagnosis.
2. Patients who have been managed in a fashion that is not totally consistent with the new caregiver’s experience and resources, and may reflect a clinical picture that can be optimized.
3. Patients whose course of therapy is, for a variety of reasons, indefensible, and so not something the new provider feels he or she is able to support.

The inherited chronic pain patient recommendations also emphasize:

• Provider understanding of the federal regulations to safely treat this patient population. For example, providers can provide several months worth of Schedule II drug prescriptions at a single visit, with a "Do Not Fill Until" notice preventing the patient from abusing or diverting the medication.
• Individualized Opioid Therapy. This includes considering the concepts of opioid rotation and tapering the patient if current opioid therapy is not effective.

PATIENT EDUCATION FOR THE SPECIFIC OPIOID
In addition to routine patient education about opioids, it is crucial to provide product-specific information (found on the drug label), including:

• How to take the medication (is it a patch or tablet/capsule)
• The dosing regimen
• What to do if a dose is missed8
• Emphasize that tablets/capsules should not be crushed or broken, nor patches torn, as this may release potentially lethal doses of the opioids
• Potential side or adverse effects of particular opioids. Patients should be advised to call their provider if they experience serious side effects8.
TOLERANCE

Individuals who repeatedly use opioids are likely to develop a **tolerance** for opioids. Tolerance is a decrease in the drug's effects such that ever-increasing doses of the drug are required to produce the same effect\(^\text{21}\). As a result, the opioid user needs increasingly larger opioid doses in order to achieve the same effects\(^\text{22}\). Tolerance is a normal consequence of being on chronic opioid therapy.

It is critical to consider whether or not the patient is opioid tolerant when prescribing opioids. Some opioids require that the patient already have some tolerance and should not be used in opioid-naive patients.

It is important to assess a patient's tolerance before prescribing opioids.

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MR. LEWIS – OPIOID SELECTION

Recall the following case first introduced in the assessment module:

**Patient:** Mr. Raymond Lewis, 72 y/o

**Scenario:** Mr. Lewis's medical history is significant for onset of type 2 diabetes at 48 y/o. He has been insulin dependent for 7 years, and his diabetic peripheral neuropathy started with gradual onset of numbness, tingling, and then pain in his feet about 4 years ago. The neuropathy is now constant and mild to moderate 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. He says he's interested in trying opioids.

**Question:** Would you prescribe extended release/long-acting opioids (ER/LA) to Mr. Lewis for his peripheral neuropathy pain at this time?

1. Yes, ER/LA opioids should be prescribed at this time because of the severity of his pain.
   - Feedback: **Incorrect!** Opioids are a consideration because Mr. Lewis does have severe, chronic pain, at night. Currently, he only has mild to moderate pain in the day. So ER/LA opioids are not indicated. Furthermore, he is currently opioid naive, which is a contraindication for ER/LA opioids. Immediate-release opioids should be titrated to effect during periods of severe pain (nighttime).

2. Yes, they should be prescribed at this time because he needs round-the-clock opioid therapy.
   - Feedback: **Incorrect!** Although around-the-clock opioid therapy may ultimately be the best and least addictive choice for Mr. Lancaster, he has not taken any opioids in more than 20 years and should be considered opioid-naive. Also, extended-release/long-acting opioids should be avoided in opioid-naive patients until a stable dose is established.

3. No, they should not be prescribed because he is opioid-naive.
   - Feedback: **Correct.** Extended-release and long-acting opioids should not be prescribed for an opioid-naive individual. Mr. Lewis has not taken any opioids in more than 20 years and should be considered opioid-naive.
**INITIAL TRIAL DOSE**

When first prescribing opioid therapy, use a trial prescription/test dose and re-evaluate. Titrate the opioid dose by adjusting the dosage while regularly assessing the patient’s pain and functioning. The following principles are important while titrating dose:

- Using short-acting/immediate release opioids during dose titration is safer than long-acting opioids. ER/LA opioids should not be used to manage uncontrolled pain.
- Choose the dose based on efficacy and tolerability.
- Use caution in an opioid-naive patient to not overdose. Follow product recommendations for a starting dose.
- Track improvements in functioning as well as pain, because complete pain resolution is unlikely.
- Prescribe the lowest effective dose.
- Take a multi-modal approach including adjunct medications, non-opioid medications, and non-pharmacological treatments, such as physical therapy, in order to minimize the opioid dose.

**PRACTICE TIP**

Adjust dosage around every 3 days and no more than once per 24 hours [For methadone dosage increases should not be done more frequently than 7 days due to the risk for respiratory depression.]

**HIGH RISK PATIENTS FOR ANY OPIOID**

Includes patients with a history of drug abuse/addiction, comorbid psychiatric conditions, and patients who exhibit aberrant behaviors such as diversion.

- The 2009 APS/AAPM guidelines strongly recommend that the treatment and monitoring structures need to be tightened for high-risk patients, and physicians should only treat these patients if they are equipped to provide the higher level of structure necessary (e.g., increased frequency of urine drug testing, unannounced pill counts).
- Multidisciplinary care involving consultation with a mental health or addiction specialist is also strongly recommended for these patients.
- If aberrant behaviors are occurring while on chronic opioid therapy (COT), re-assess the patient and decide whether a change in treatment is necessary (referral, change in structure, taper from opioids).
- There is little evidence guiding COT in high-risk CNCP (Chronic Non-Cancer Pain) patients. Anecdotal experience has shown that COT with tighter structure can be successful in patients who exhibit minor aberrant behaviors. For major problems, (e.g., use of illicit drugs), significant
changes may need to be made in the treatment strategy.

16,20

MR. CHAN – HIGH RISK PATIENT
Patient: Mr. Kevin Chan, 20 y/o

Scenario: Kevin Chan has chronic neck pain from a motor vehicle accident injury 2 years ago. He uses marijuana and has a history of amphetamine addiction but has been clean for two months. He lives in a high-risk environment, but currently needs chronic opioid therapy because all other options have been explored for treating his pain.

Question: Of the following, the best schedule for monitoring him after his opioid dose is stable is:

1. Weekly
   • Feedback: Correct. With his history of illicit drug use, Mr. Chan is at risk for opioid abuse or addiction. Therefore, weekly monitoring is the best of the choices offered.
2. Monthly
   • Feedback: Incorrect. With his history of illicit drug use, Mr. Chan is at risk for opioid abuse or addiction. Therefore, weekly monitoring is the best of the choices offered.
3. Every 3 months
   • Feedback: Incorrect With his history of illicit drug use, Mr. Chan is at risk for opioid abuse or addiction. Therefore, weekly monitoring is the best of the choices offered.
4. He cannot be prescribed chronic opioid therapy
   • Feedback: Incorrect. Even people with a history of drug use may have pain that would benefit from chronic opioid therapy as part of a comprehensive pain treatment. But it should only be prescribed with a high level of structure. With his history of illicit drug use, Mr. Chan is at risk for opioid abuse or addiction. Therefore, weekly monitoring is the best choice because it offers the highest structure.

MS. MARTINEZ – HIGH RISK PATIENT

Patient: Ms. Diana Martinez, 24 y/o
Chief Complaint: Chronic pain syndrome/post-surgical neuralgia

Scenario: Ms. Martinez has a high risk for opioid abuse due to a past history of alcohol abuse and occasional self-medicating with non-prescribed opioids. She needs treatment of constant, severe, lower back pain that did not respond to surgery.

Question: Of the following, the best treatment modification due to Ms. Martinez's risk for opioid addiction or abuse is:

1. Prescribe short-acting opioids to use as needed.
Risk Reduction Strategies for Opioids

• Feedback: Incorrect. Ms. Martinez’s pain is constant rather than intermittent and so if opioids are used, they should be on a schedule rather than as needed. There is some thinking that intermittent use of opioids is more reinforcing and more likely to lead to addiction.

2. Ms. Martinez cannot be treated with opioids under any circumstances
• Feedback: Incorrect. Even though Ms. Martinez has struggled with alcohol abuse and self-medicating with opioids, she still has a right to have her pain treated adequately. It is true that opioids should be avoided if possible, but if she requires chronic opioid therapy, it should be managed by a specialist due to her high risk.

3. Require regularly scheduled urine drug testing
• Feedback: Partially correct. Urine drug testing should be part of the structure provided during chronic opioid therapy, but it should be random, not regularly scheduled. Also, her treatment will need to be managed by a specialist due to her high risk.

4. Start using a provider-patient treatment agreement
• Feedback: Partially correct. A signed treatment agreement is a consensus-recommended tool for use with any patient on chronic opioid therapy, so should have been used from the start with her opioid therapy. Due to her risk for opioid abuse/addiction it is extra important and can serve to provide supportive structure and reinforce communications about special precautions and office policies. However, at this point, her treatment would ideally be managed by a specialist due to her high risk, who would be likely to use this instrument.

5. Referral to a pain and addiction specialist
• Feedback: Correct. At this point, her treatment would ideally be managed by a specialist due to her high risk. A multidisciplinary approach to pain management, one that included non-opioid and non-pharmacological treatment is the eventual goal. If specialist management is not an option, such as in some rural areas, then more frequent appointments, random urine drug testing performed more frequently, and careful, regular checking of the prescription drug monitoring data base would be important measures.

MS. MARTINEZ – HIGH RISK PATIENT MEDICAL HOME

Patient: Ms. Diana Martinez, 24 y/o

Scenario: Ms. Martinez was referred to an addiction specialist, a counselor, and a physical therapist by her primary care provider. She will require a "medical home."

Question: Which of the following is correct?

1. The addiction treatment specialist, must be the medical home for Diana's overall medical care.
• Feedback: Incorrect. The primary care provider can provide the role of medical home even if he or she is not prescribing the opioid treatment.

2. The provider who first prescribed the opioids should be the one responsible for Diana's overall medical care.
• Feedback: Incorrect. It could be the current primary care provider even if he or she is not prescribing the opioid treatment.
3. The primary care provider could provide the medical home for Diana, even if he or she did not prescribe the opioids.
   • Feedback: Correct. The primary care provider can provide the role of medical home even if he or she is not prescribing the opioid treatment.
4. The primary care provider can only provide the medical home for patients who are at low risk for substance use problems.
   • Feedback: Incorrect. The primary care provider can provide the role of medical home even if the patient is at moderate or high risk for substance use problems. It will be even more important for these patients with high risk to have a medical home.

REQUIREMENTS FOR SPECIFIC POPULATIONS

Opioid therapy may vary depending on the patient being treated. This section will teach the prescriber how to treat and manage specific populations with opioids.

Treatment can vary based on:

- "Inherited" Patients
- High Risk Patients
- Barriers
- Age
- Gender

PAIN MANAGEMENT IN OLDER PATIENT POPULATIONS

General Pain Management in Older Patients
In 2009, the American Geriatrics Society (AGS) released an updated version of their clinical guidelines for chronic pain, entitled "Pharmacological Management of Persistent Pain in Older Persons" (See Related Resources).

A summary of the very strong recommendations with moderate quality evidence is provided here as well as a link to the full guidelines.

NSAIDs and COX-2 Inhibitors in Older Patients
Non-opioid medications

- Acetaminophen continues to be the recommended drug to manage chronic pain in these patients.
- NSAIDs should only be used in rare circumstances in this population due to their potential to cause serious cardiovascular and gastrointestinal problems
- Patients should not take more than one nonselective NSAID or COX-2 selective inhibitor for pain control (Low Quality of Evidence)

When taking NSAIDS or COX-2 selective inhibitors
Risk Reduction Strategies for Opioids

- Protein pump inhibitors or histamine H2 blockers may reduce GI problems when NSAIDs must be taken.
- Older persons taking nonselective NSAIDs should use a proton pump inhibitor or misoprostol for gastrointestinal protection (High Quality of Evidence)
- Patients taking a COX-2 selective inhibitor with aspirin should use a proton pump inhibitor or misoprostol for gastrointestinal protection (High Quality of Evidence)
- All patients taking nonselective NSAIDs and COX-2 selective inhibitors should be routinely assessed for gastrointestinal and renal toxicity, hypertension, heart failure, and other drug–drug and drug–disease interactions (Weak Quality of Evidence)

Adjuvant Medications in Older Patients

All patients with neuropathic pain are candidates for adjuvant analgesics (Strong Quality of Evidence)

Patients with fibromyalgia are candidates for a trial of approved adjuvant analgesics (Moderate Quality of Evidence)

Tertiary tricyclic antidepressants (amitriptyline, imipramine, doxepin) should be avoided because of higher risk for adverse effects (e.g., anticholinergic effects, cognitive impairment) (Moderate Quality of Evidence)

Treatment strategy

- Agents may be used alone, but often the effects are enhanced when used in combination with other pain analgesics and nondrug strategies (Moderate Quality of Evidence)
- Therapy should begin with the lowest possible dose and increase slowly based on response and side effects, with the caveat that some agents have a delayed onset of action and therapeutic benefits are slow to develop. For example, gabapentin may require 2 to 3 weeks for onset of efficacy (Moderate Quality of Evidence).
- An adequate therapeutic trial should be conducted before discontinuation of a seemingly ineffective treatment (Weak Quality of Evidence)

Other Pain Medications in Older Patients

Long-term systemic corticosteroids should be reserved for patients with pain-associated inflammatory disorders or metastatic bone pain. Osteoarthritis should not be considered an inflammatory disorder (Moderate Quality of Evidence)

All patients with localized neuropathic pain are candidates for topical lidocaine (Moderate Quality of Evidence)

Opioid Therapy In Older Patients

As confirmed in the 2009 AGS guidelines, acetaminophen remains the first-line treatment for CNCP in older patients, except in patients with liver conditions.
It is important to note that no specific studies have been conducted in the elderly on the use of opioids in CNCP\textsuperscript{25}. However, in general, there is increasing evidence that opioids are effective in treating CNCP and CNCP is commonly the result of diseases of older patients. Based on its pharmacological profile (half-life of the drug and its metabolites are not increased in the elderly, minimal immunosuppressive effects), buprenorphine has been recommended as the primary opioid medication for treating chronic pain in the elderly\textsuperscript{25}.

- If opioids are used, it is recommended that prescribers:
  - Begin with a low dose of oral opioids
  - Slowly titrate up to the dose that adequately relieves pain

These treatment alterations are recommended due to pharmacokinetic and pharmacodynamic differences in older patients, as well as due to the increased risk of adverse effects of opioid use, such as constipation and respiratory depression in this population\textsuperscript{26,27}. Due to the risk of falls, it is recommended that alcohol and other CNS depressants not be used concurrently with opioids\textsuperscript{28}.

**ER/LA Opioids** Pain should be severe, constant and not responsive to other therapies to prescribe the extended release or long-acting forms of opioids\textsuperscript{29}. Additionally, the guidelines recommend monitoring carefully patients who are elderly, infirm, or debilitated when on ER/A opioids, because of increased risk for respiratory depression. Given their higher level of risk that immediate release opioids, additional caution is warranted for this class of opioids in this population.

**Recommendations on Opioid Treatment for Older Patients from the AGS, 2009:**

All patients with moderate to severe pain, pain-related functional impairment, or diminished quality of life due to pain should be considered for opioid therapy (Low Quality of Evidence)

Clinicians should anticipate, assess for, and identify potential opioid-associated adverse effects (Moderate Quality of Evidence)

Maximal safe doses of acetaminophen or NSAIDs should not be exceeded when using fixed-dose opioid combination agents as part of an analgesic regimen.

Consider increased cardiovascular/cerebrovascular and gastrointestinal risk vs. benefits when prescribing NSAIDs\textsuperscript{30}.

When long-acting opioid preparations are prescribed, breakthrough pain should be anticipated, assessed, and prevented or treated using short-acting immediate-release opioid medications (Moderate Quality of Evidence)

Only clinicians well versed in the use and risks of methadone should initiate it and titrate it cautiously (Moderate Quality of Evidence)

Patients taking opioid analgesics should be reassessed for ongoing attainment of therapeutic goals, adverse effects, and safe and responsible medication use (Moderate Quality of Evidence)

**OPIOID TREATMENT IN CHILDREN**

While it was once believed that neonates, infants, and children do not experience pain, recent research has overturned this misconception. Despite advances in the treatment of pediatric pain,
reports of inadequate pediatric pain management persist\textsuperscript{31,32}. Therefore, due to the risk of abuse, toxicity, and other adverse effects, the use of opioids in children poses a dilemma\textsuperscript{32}.

When first line treatment fails, weak opioids may be prescribed in addition to medications, such as acetaminophen or other nonsteroidal anti-inflammatories. When prescribing medications that combine acetaminophen and opioids, prescribers need to avoid exceeding the maximum daily dose of acetaminophen\textsuperscript{32}.

Strong opioids may also be used in cases of hospitalized patients experiencing severe pain and postoperative pain relief. The opioids should be dosed to maintain effective analgesia. Non-opioid adjunctive medications may also be used to decrease the dose of opioids\textsuperscript{32}.

Both weak and strong opioids should be prescribed as part of a multifactorial approach to pain rather than as the only intervention\textsuperscript{31}.

**OPIOID TREATMENT IN PREGNANCY**

**Pregnant Women or Women of Childbearing Potential**

In a boxed warning for long acting and extended release opioids released in September 2013, the FDA warns:

"For patients who require opioid therapy while pregnant, be aware that infants may require treatment for neonatal opioid withdrawal syndrome. Prolonged use during pregnancy can result in life-threatening neonatal opioid withdrawal syndrome...which may be life threatening..."

There is little evidence on the use of opioids for CNCP\textsuperscript{*} during pregnancy. Due to the lack of evidence and the potential for neonatal complications, the 2009 APS/AAPM guidelines strongly recommend that physicians avoid using opioids for CNCP in pregnant women. Only if there is a clear necessity or benefit that would outweigh the potential for harm or risks to the mother and fetus, should providers consider prescribing chronic opioid therapy. These women should be counseled on the risks and benefits of COT during and after childbirth\textsuperscript{14}. (\textsuperscript{*}CNCP=Chronic Non-Cancer Pain)

Evidence on the use of opioids in this population include the following:

- Opioid use before conception and during the first trimester has been associated with birth defects, such as neural tube defects. Use of opioids during pregnancy may also lead to the fetus being born with neonatal abstinence syndrome\textsuperscript{33}.

**CRITICAL OUTCOMES AND OTHER FACTORS TO ASSESS REGULARLY IN PATIENTS TAKING OPIOIDS**

**Aberrant Behaviors**

Aberrant behaviors have been conceptualized as one of the "5 As" for assessment of clinical outcomes in patients with pain who are on chronic opioid therapy.
Critical Outcomes to Assess at Every Visit:
Regularly repeated patient monitoring that covers a variety of domains is likely to be more effective than occasional, focused monitoring\textsuperscript{18}.

Therefore, every patient on chronic opioid therapy should be assessed on the following critical outcomes (5 "As") at every visit:

1. **Analgesia**: Pain relief, pain intensity (average, worst) and progress towards therapeutic goals
2. **Activities**: Activities of daily living including: 1) physical functioning; 2) psychosocial functioning
3. **Adverse effects**: e.g., constipation, nausea or vomiting, sedation, etc.
4. **Aberrant behaviors**: related to misuse/abuse/addiction
5. **Affect**: observed emotions/mood and other psychological issues

(Source: 1st 4 "As": 34; 5th "A": 35)

"Adherence" to the treatment agreement might be considered another "A" for regular evaluation.

Document the items represented by "As" at each appointment. The Pain Assessment Documentation Tool (see Resources at end of module) can be helpful in ongoing tracking of pain and response to opioid therapy.

Other Factors to Assess Periodically and Adjust the Treatment Plan Accordingly:

1. Pain diagnosis
2. Changes in health status
3. Current risk vs. benefit ratio of opioid therapy

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EXIT PLAN: PLAN FOR HOW YOUR PATIENT WILL STOP TAKING OPIOIDS

Before starting opioid therapy, there should be an "exit plan" for stopping treatment if indicated. The plan should describe how stopping would be accomplished and also should schedule regular assessments of whether continued treatment is needed.

Reasons to stop opioid therapy include:

- It no longer is necessary
  - A lack of progress toward therapeutic goals
  - Pain is no longer being generated
- It no longer is tolerated, having unmanageable physical/social side effects
- It no longer is safe for the patient in other ways, e.g. addiction
- Aberrant behavior cannot be otherwise managed
- It is being diverted or there is strong evidence that the medication is not being taken [negative drug screens]
Providers should share the exit plan with the patient when starting opioids. Patients should be strongly advised against stopping chronic opioid therapy suddenly due to the likelihood of withdrawal. They should also be warned against tapering on their own as this may also lead to withdrawal. If not done carefully, withdrawal can be severe.

An alternative pain treatment should always be offered if needed when weaning a patient off opioids.

**MRS. THOMAS: EXIT PLAN**

**Patient:** Mrs. Louise Thomas, 58 y/o

**Scenario:** Mrs. Thomas is being prescribed an immediate release opioid for severe, constant chronic neck pain. It will be titrated to an effective dose, stabilized on that dose, and then re-evaluated. If her pain continues to be a problem when the IR opioids wear off, an extended release formulation of the same opioid may be considered.

**Learning Task:** Briefly describe an exit plan from opioid treatment for Mrs. Thomas.

- An exit plan, in case she can no longer take the opioid for whatever reason, should include a humane tapering off of the prescribed opioid, with detoxification if needed, and offering her an alternative pain treatment.

### MANAGING ADVERSE EVENTS

**Preventing and Managing and Side Effects**

Adverse events are most common during initial dosing and also at dose change and opioid rotation/conversion.

<table>
<thead>
<tr>
<th>Side Effect</th>
<th>Prevent</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Confusion</td>
<td>If a risk, e.g. with dementia, use non-opioids as much as possible</td>
<td>Dose reduction, opioid rotation, low dose neuroleptics</td>
</tr>
<tr>
<td>Constipation</td>
<td>Stool softeners, bowel stimulants, non-pharm treatments</td>
<td>Treat constipation, opioid rotation</td>
</tr>
<tr>
<td>Dizziness</td>
<td>--</td>
<td>Treat vertigo, dose reduction + co-analgesics</td>
</tr>
<tr>
<td>Edema, sweating</td>
<td>--</td>
<td>Opioid rotation</td>
</tr>
<tr>
<td>Endocrine dysfunction/reduced libido/hypogonadism</td>
<td>Baseline endocrine status + annual reassessment</td>
<td>Opioid rotation, dose reduction, endocrine treatments/consultation</td>
</tr>
<tr>
<td>Hives</td>
<td>Use different chemical class with a history</td>
<td>Opioid rotation</td>
</tr>
</tbody>
</table>
**Risk Reduction Strategies for Opioids**

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Strategy and Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Myoclonus</td>
<td>--</td>
</tr>
<tr>
<td>Nausea/vomiting</td>
<td>Use antiemetic with a history</td>
</tr>
<tr>
<td>Pruritis</td>
<td>Opioid rotation, antihistamines</td>
</tr>
<tr>
<td>Rash</td>
<td>Use different chemical class with a history</td>
</tr>
<tr>
<td>Respiratory depression</td>
<td>Start with low dose and titrate, monitor</td>
</tr>
<tr>
<td>Sedation</td>
<td>Start with low dose and titrate, monitor</td>
</tr>
<tr>
<td>Urinary retention</td>
<td>Start with low dose and titrate, monitor</td>
</tr>
</tbody>
</table>

(Adapted from Zacharoff et al., 2010)

**Note:** Use a diagnostic evaluation to assure that these symptoms are not coming from other causes.

**Special Precautions for Patients with Depression**

Higher-dose opioid regimens have been associated with increased symptoms of depression; however, it is unclear whether the increased symptoms of depression are due to the high-dose opioids\(^{37}\).

Patients with depression or anxiety disorders require additional interventions; for example, cognitive behavioral therapy (CBT), which often focuses on coping strategies. Affect and mood may also benefit from relaxation strategies and biofeedback. All patients with chronic pain may benefit from learning better coping skills. Pain patients have also been shown to benefit from traditional antidepressant therapy\(^{38}\).

Unmanaged mental health disorders are an indication for referral for psychiatric/psychological evaluation and possibly to pain and addiction specialists. Dual disorders (substance use problems plus mental health problems) provide a strong indication for management by specialists.

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**ONGOING URINE DRUG TESTING (UDT)**

Ongoing urine drug testing (UDT) is recommended for **all** patients on chronic opioid therapy\(^{14,39,40}\).

- Test all patients to prevent missing potential problems and avoid stigmatizing certain patients.
- Tests should always be scheduled randomly, so patient is not forewarned.
  - Low risk patients: At baseline, and at least every 6 months
  - Moderate risk patients: At baseline, and every 3 months
  - High risk patients: At baseline, and more often than every 3 months
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 collection.

**Uses of Ongoing UDTs:**
- To increase patient safety
- To decrease diversion
- To identify cases of drug misuse or abuse

**UDT Interpretation**
Concerning results of urine drug tests (UDTs) fall in the following categories:
1. Prescribed drug is not detected
2. An illicit drug is detected
3. A nonprescribed scheduled drug or drug of concern (such as the muscle relaxant carisoprodol) is detected

Record the UDT results and interpretation in the patient's chart and discuss with the patient. Positive screening tests should be followed by asking the patient if they used the substance detected. Take into consideration all possibilities when interpreting urine drug test results. Consider prescribed and OTC medications, including herbals, which could cause false positive results, as well as conditions which could alter metabolism or excretion of medications.

Before action is taken, there should be confirmatory testing and consultation with a toxicologist regarding possible continued false positives.

**Possible Causes of Unexpected Urine Test Results**

**Unexpected Positive Results**
- Misuse, addiction, or undertreated pain
- Lab error, test overly sensitive
- Cross-reactivity with the patient's medications
- Metabolite of a prescribed drug

**Unexpected Negative Results**
- Patient is not taking the drug, whether for innocent reasons or because of diversion.
- Test is not sensitive enough.
- Urine belonging to someone else was diluted or adulterated to avoid an illicit drug being detected.

**PRACTICE TIP**
Interpretation of UDTs is complex and a consultation with the laboratory toxicologist is often indicated. Interpreting incorrectly in either direction could have significant harmful consequences for the patient.
Limitations of UDT
While UDTs can quantify the amount of a drug in the urine, at this time, it is not possible to affirm that a patient is taking the prescribed dose. Algorithms are in development that could lead to making conclusive relationships between urine concentrations and dosage, but at this time, the technology and interpretation of findings are not sufficiently evolved to recommend their use.\(^{43}\)

OTHER ELEMENTS OF ONGOING MONITORING

When to Monitor
Monitor patients on chronic opioid therapy regularly:

- All patients: Monitor carefully and communicate with them and their caregivers or family during dose initiation or change.\(^{44}\)
- Low risk, stable patients: Provide quick monthly check-in + in-detail check-in at least every 6 months.
- Higher risk patients: Provide weekly or more frequent monitoring.

What to Monitor
Just as for initial assessment, a systematic approach should be used to monitor the patient once treatment has been initiated. Because chronic pain can persist indefinitely, the treatment plan should include a plan for long-term monitoring of:

MEDICATION RESPONSE

- Analgesia: Treatment objectives need to be clear and realistic. It rarely possible to eliminate pain. The best improvement achievable may be a reduction of several points on a 1 to 10 pain scale. Patients may be asked to record pain over time in a pain diary or in their own electronic health record.
- Functioning:
  - Physical function: activities of daily living, e.g., walking, working, attending to personal hygiene, child care
  - Psychosocial function: participation in relationships and general effect on mood, the ability to enjoy life

Re-assess pain and functioning using objective evidence and any available relevant information such as caregiver's reports. Tolerance, a decrease in one or more of the opioid's effects over time, may develop, though tolerance to side effects [e.g., respiratory depression, nausea, sedation] presents earlier than tolerance to analgesia.\(^{45}\) Medication should be adjusted if pain is under-treated.

Note that:

- Opioid-induced hyperalgesia (increasing pain or pain sensitivity) is a possibility if pain worsens without an identifiable cause in a patient receiving high doses of opioids.\(^{45}\)
• Improvement in pain may not correspond directly to improvement in functioning and vice versa.

CONTINUED NEED

• Evaluate the underlying condition if one has been identified.

COMPLIANCE

• Patients should be asked about proper use of medication at each appointment. Is there compliance with the treatment plan and appropriate use as spelled out in the Provider/Patient Treatment Agreement?

Check compliance using the following:

• Checking the Prescription Drug Monitoring Program at least every 3 months. Consider checking at each prescription.
• Medication reconciliation, for example random call back for pill counts
• Urine drug testing
• Observing for aberrant drug-related behavior.
• Checking on safe (Locked) storage

SIDE EFFECTS

Side effects of pain medication may contribute to poor quality of life despite improved pain. Some side effects may develop later in treatment, such as endocrinopathies, tolerance, sleep disorders, and opioid use disorder, and so patients should be evaluated periodically.

Regarding endocrinopathies, monitor men for hypogonadism; ask about libido, erectile dysfunction. Depression and lethargy may also be related to low testosterone. Note, testosterone levels return to normal as soon as 24 hours after stopping opioids. Testosterone replacement helps with many of the symptoms of endocrinopathy. In women, endocrinopathy may manifest as dysmenorrhea, sexual dysfunction, depression, and decreased bone mineral density (and increased fractures).

ADDICTION/MISUSE RISK

Current addiction or risk of addiction or misuse, just as when initially prescribing the opioid.

ONGOING COMMUNICATION: PAIN DIARY

Pain Diary for Provider-Patient Communication

Having the patient keep a pain and activity diary may help assess pain over time, get better answers to pain history questions, improve your diagnostic abilities, and streamline efforts to relieve suffering. Typical diaries have patients record:

• Pain levels (scale of 1 to 10)
  • Monitored retrospectively to avoid bringing attention to the pain throughout the day, but monitored throughout the day when appropriate, for example, when changing medications
Risk Reduction Strategies for Opioids

- Individual recordings can be connected to show a graph of pain throughout the day (see below)
- Many apps for cell phones or other mobile devices are available now for tracking pain and can be found with an Internet search of "pain diary app" or "pain tracking app"
  - Medications and other treatment modalities
  - Functioning
    - The impact of pain and treatment on the patient's ability to engage in his/her activities of daily living
  - Mood

The Target Chronic Pain Notebook (see Related Resources on this page) is an example of a pain diary that can be used.

Example Pain Chart and Pain Log

PATIENT RECORD DURING MONITORING

What to Record During Ongoing Monitoring
In addition to a written treatment plan, thorough records should be kept of each visit. Keeping complete records of the following elements is important for tracking treatment progress, being
prepared in the event of a government audit, and assuring continuity of care if a referral becomes necessary.

1. Medication Response – analgesia and functioning. Document tolerance if present and reasons for dose change or switching medications
2. Continued Need
3. Compliance/Treatment adherence
4. Side effects and adverse events
5. Addiction/Misuse and Risk

Additionally, there should be periodic case reviews that evaluate and update treatment goals and outcomes.

**Document Assessments and Monitor Results At Each Appointment**

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 their lives and that you will do everything you can to help them.

It is important to note that while prior substance abuse might require additional monitoring and expert consultation, it does not rule out the possibility of treatment with ER/LA opioids.

**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 review.
3. Use records to spot trends over time.

**THE VALUE OF ONGOING ASSESSMENT TOOLS**

Ongoing assessment tools are used throughout opioid treatment for chronic pain to monitor the patient's progress and identify abuse of medication. They identify current misuse in patients already on opioids. Frequent use of the tool as a monitoring system should alert the clinician to early aberrant change in the patient's behavior, and minimize the damaging effects of addiction in the patient's life.

Since physical dependence and tolerance occur in most patients on long-term opioid therapies these factors, commonly used in other settings, will not be helpful in identifying patients with addiction to opioids. It can thus be a challenging task for clinicians to determine whether a chronic pain patient, who is physically dependent upon prescription opioids for pain management, is in fact addicted to opioids. Ongoing assessments tools can thus be an essential tool to identify addiction.
Examples of Ongoing Assessment Tools
The tools below help providers identify current misuse in patients already on opioids in order to monitor progress and prevent medication misuse. Each assessment tool varies in terms of criteria, length, target population and context. The clinician should take steps to address any addiction issues that arise, whether through treatment changes, referrals or increased monitoring.

COMM - Current Opioid Misuse Measure
Purpose: The Current Opioid Misuse Measure (COMM) tool assesses aberrant medication-related behaviors of patients with chronic pain.

ABC - Addiction Behaviors Checklist
Purpose: The Addiction Behaviors Checklist (ABC) screens for characteristic addictive behaviors in chronic pain patients that are prescribed opioid medications. It tracks past and present behaviors to assess inappropriate opioid use.

Chabal 5-Point Prescription Opiate Abuse Checklist
Purpose: The Chabal 5-Point Opiate Abuse Checklist assesses criteria that suggest prescription opioid misuse in chronic pain patients.

PMQ - Pain Medication Questionnaire
Purpose: The Pain Medication Questionnaire (PMQ) is an assessment tool for ongoing monitoring of aberrant behaviors. It helps clinicians to identify whether a long-term chronic pain patient is exhibiting aberrant behaviors associated with opioid medication misuse.

PDUQ - Prescription Drug Use Questionnaire
Purpose: The Prescription Drug Use Questionnaire (PDUQ) assesses opioid misuse and dependence in chronic pain patients.

PADT - Pain Assessment and Documentation Tool
Purpose: The Pain Assessment and Documentation Tool (PADT) assesses patient progress on long-term opioid treatment for chronic pain, and is used throughout opioid treatment. It addresses the patient's pain in various dimensions, including level of physical pain, how pain affects the patient's everyday living, adverse effects of pain, and noticeable drug-seeking behaviors. It is not intended to be predictive of drug-seeking behavior, a quantitative approach to pain management or predict positive and negative outcomes of opioid therapy.

MEDICATION RECONCILIATION AND PRESCRIPTION DRUG MONITORING

Medication Reconciliation
Purpose: Medication reconciliation tests are used to:
  • determine if the patient is using the medication as directed
  • detect substance abuse or diversion

Methods: Medication reconciliation is achieved through:
  1. Prescription Drug Monitoring Programs (Discussed below)
  2. Call backs Unscheduled requests to come to the clinic for the following:
a) **Urine Drug Tests:** Look for results that would be expected if the patient is taking the medication as directed

b) **Pill Counts:** With little advance warning, ask the patient to bring their pills in the container and verify the correct number are present. Look for too few or too many and inquire about reasons for a discrepancy.

**Prescription Drug Monitoring Programs**

Prescription drug monitoring programs (PDMPs) are databases that prescribers should check regularly to learn:

- when a patient has received a controlled substance prescription
- what prescriber wrote the prescription
- what prescriptions have been written with your name as the provider (check for forgeries)
- to identify behaviors that may represent abuse

PDMPs detect when patients have prescriptions from multiple prescribers ("doctor-shopping"). You can also check on your own name to make sure that you actually wrote every prescription that is in the data base and have not had forged or altered prescriptions under your name. Check adjacent states, too, if possible. For more information on how to use your state’s PDMP please see "A Closer Look at State Prescription Drug Monitoring Programs" in Related Resources.

**RECONCILING MEDICATION THROUGH PILL COUNTS AND CALL BACKS**

**Call Backs**

Patients with higher risk and those on high-potency opioids, such as extended-release or long-acting opioids, will need to be randomly "called back" for unscheduled visits, with less than 24 hours of advance warning for urine drug tests and pill counts. Making this unscheduled helps decrease their ability to plan to alter urine drug tests or find a way provide the expected number of pills if they have already been diverted. Unscheduled callbacks should be documented in the Patient/Provider Treatment Agreement as a condition of continued treatment.

**How to Conduct Pill Counts**

1. Request the patient bring all unused pills to an appointment in the original container.
2. The number of pills in the container should match the number expected if the prescribed dosage was followed.

**Interpreting Pill Counts**

Possible reasons for fewer pills than expected include:

- diversion
- use beyond the prescribed amount due to abuse, to get "high"
- use beyond the prescribed amount due to undertreated pain
• use beyond the prescribed amount to cope with life problems ("chemical coping")
• use beyond the prescribed amount in an attempt to self-medicate for mental health problems, especially depression or anxiety ("self-medicating")
• misunderstood directions

Possible reasons for more pills than expected include:

• low intake to avoid side effects
• low intake due to oversedation
• the prescribed dose was higher than needed
• misplaced medication found again
• misunderstood directions

MR. WONG — MEDICATION RECONCILIATION

Patient: Mr. Brian Wong, 47 y/o male

Scenario: Mr. Wong has moderate to severe left shoulder pain, resulting from chronic overuse. First-line therapies, including discontinuing tennis and golf, which caused the problem, have already been tried and were unsuccessful. After monitoring him for three years while on chronic LA opioid therapy to help manage his pain, he begins to show aberrant behaviors that suggest he may be selling his medication rather than taking it himself.

Question: Which of the following are an appropriate response to this concern?

1. Increase urine drug testing to every appointment
   • Feedback: This is not as effective an approach as he could be sure to take the opioid the required amount just for a few days before the appointment and then cut back again so that he can sell his supply of medication.

2. Urine drug testing at just some appointments
   • Feedback: Random urine drug testing is more likely to detect a patient who skips opioids in order to divert them. The chances of this being effective are greatly increased if he is called back for a drug test within 24 hours, without any advance warning. Agreeing to this call back could be added to the signed patient-provider treatment agreement of a high risk patient.

3. Call the patient back for an unscheduled pill count
   • Feedback: Unscheduled call backs for pill counts are one way of detecting if he is diverting his medication; the number of pills in the bottle would be too low. This is not foolproof, however, as some diverters might borrow medication.

4. Calling patients back for unscheduled medication reconciliation without proof that they are diverting is not acceptable medical practice.
   • Feedback: Callbacks for medication reconciliation are an acceptable part of providing adequate treatment structure to high-risk patients.
MONITOR ABERRANT DRUG-RELATED BEHAVIORS REGULARLY

Definition
Aberrant drug-related behavior refers to behavior outside of the societal norm and clinical expectations that may indicate substance misuse, abuse, or addiction, but may also indicate undertreated pain, misunderstandings, and a number of other problems.

Some level of monitoring aberrant behaviors should happen at each appointment. More formal monitoring with urine drug testing and assessment questionnaires can be used as needed according to risk level.

Three Levels of Aberrant Drug-Related Behavior
Level I: Relatively minor deviations that do not place the immediate health or safety of anyone in danger but can degrade the efficacy or treatment or the patient-provider interaction. Examples include:
  • non-adherence to medication dosing
  • non-adherence to other elements of the treatment plan
  • attempts at early refills
  • misplacing medications
  • obtaining and distributing medications
  • more than 3 Level I violations in a year are considered Level II

Level II: Continued violations of the treatment agreement that stem from severe psychological comorbidities. Patients who engage in Level II behaviors should be referred to a specialist in pain management, mental health, or addictions.

Level III: These are behaviors that are illegal, criminal, or dangerous. Cases of criminal diversion merit discontinuation of opioid therapy and referrals to regulatory authorities.

More on Aberrant Behavior
More examples and complete training on aberrant behavior detection and intervention are included in a different module dedicated to this important topic.
STRATEGIES TO TAPER OPIOIDS*

*UPDATE on Tapering Opioids: 10/2019.

Subsequent to the publishing of this module, the U.S. Department of Health and Human Services released a guideline: **HHS Guidelines for Clinicians on the Appropriate Dosage Reduction of Discontinuation of Long-Term Opioid Analgesics**. This guideline should be followed carefully when tapering patients’ opioid dosage as it is based on experience of some harmful misinterpretations of the CDC’s opioid prescribing guidelines.

Why Taper?
When therapy is no longer needed, is not tolerated, or is otherwise unsafe, tapering the opioid dose is necessary to safely end treatment with ER/LA opioid analgesics. Alternative pain treatments should be provided if there is still pain.

Variables such as female gender, older age, medical or psychiatric comorbidities, and abuse of multiple substances may prolong the duration of tapering.

When to Discontinue Immediately
This course of action may be taken

- due to threats made in the practice office. Communicate the likely need for medical management of withdrawal and alternative pain management to the patient, if safely possible, and to the law enforcement involved in apprehending the individual.
- when there is proof that opioids have not been taken recently and there is no risk of withdrawal.

Tapering Guidelines
Tapering must be customized to the individual patient and include proper patient education. Opioid therapy using multiple opioids should be combined into a single, long-acting medication before tapering.

Tapering is typically achieved slowly to avoid opioid withdrawal symptoms or worsening pain. One approach is

1. Reducing the total opioid dose by 10% of original dose every 1 to 4 weeks until dose is 20% of the original.
2. Then reducing by 5 percent of the original dose on the same schedule.

Note that there may be reasons to taper more rapidly, such as dangerous aberrant behaviors. If more rapid tapering is needed one more rapid method is to reduce the original dose by 25 percent every 3 to 7 days.

Patients being tapered will often need:

1. Temporary slight increases with flare up of pain
2. Adjunctive pain treatments such as gabapentin and pregabalin, SNRIs such as duloxetine or SSRIs, or non-benzodiazepine anti-anxiety drugs, such as buspirone. In some cases, non-sedating muscle relaxants may be beneficial when weighed against harms. Rehabilitative
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medicine and physical therapy can also support the process through strengthening muscles and various non-opioid treatments to relieve stress and decrease pain, such as massage.

**Alternative to Tapering**
Even with careful tapering, stopping chronic opioid therapy can be difficult once dependence is established and opioid replacement therapy may be needed (e.g., buprenorphine, methadone).

**RECOGNIZING WITHDRAWAL WHEN TAPERING OPIOIDS**

**Withdrawal Symptoms**
If opioids must be discontinued, whether due to severe aberrant behaviors or improved pain condition, tapering should be used to avoid a withdrawal syndrome. Withdrawal symptoms can occur when stopping opioids even after just a few days to a week of taking opioids. Plan to taper the patient off the opioid humanely to prevent withdrawal.

**Symptoms of withdrawal:**
- drug craving
- anxiety
- yawning
- sweating
- lacrimation
- rhinorrhea
- mydriasis
- gooseflesh
- spasms
- insomnia
- hypertension
- abdominal cramps
- vomiting
- diarrhea
- muscle and joint pain

**Detoxification**
If for the management of addiction, detoxification using may be performed in various providers with appropriate registrations or certifications or addiction treatment settings. For patients without severe medical or psychiatric comorbidities, an outpatient setting is appropriate. However, a rehabilitation setting may be necessary for patients with severe comorbidities.

**Suggested detoxification regimens:**
- **Outpatient detoxification:** Slow tapering performed by replacing short-acting opioids with medications that have long half-lives (such as methadone) or extended release medications or by using the prescribed short-acting opioid.
• **Inpatient detoxification:** This generally uses a rapid tapering strategy concomitantly with behavioral therapy. This may be appropriate for patients who are non-compliant, have comorbid psychiatric illness, and are medically unstable.

The AAPM/APS Clinical guidelines for the use of chronic opioid therapy for chronic noncancer pain provide more detailed recommendations and guidelines on how to wean or taper a patient off opioids.

**Offer alternative treatment**

Discontinuing opioid therapy does not mean that the patient should not receive treatment for their pain. Non-opioid medication treatment should be provided. Discharging the patient from pain treatment due to aberrant behaviors is never indicated, as neither pain nor the underlying cause of these behaviors is managed. This is particularly troublesome in the case of patients suffering addictive disease, whose condition will progress if untreated.

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**CASE VIGNETTE: MR. PARKER**

**Name:** Mr. Charles Parker  
**Age:** 68 years old  
**Reason for visit:** Follow-up visit for chronic lower back pain  
**Current Treatment:** Oxycodone (obtained from a friend), back exercises, acetaminophen as needed

**History:**

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

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

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.

At his intake, he had been managing severe pain with oxycodone, obtained from a friend.

<table>
<thead>
<tr>
<th><strong>Vital Signs</strong></th>
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<tbody>
<tr>
<td><strong>Height:</strong> 5'11&quot;</td>
<td><strong>Weight:</strong> 188 lbs</td>
</tr>
<tr>
<td><strong>Pulse:</strong> 80</td>
<td><strong>Blood Pressure:</strong> 120/70</td>
</tr>
<tr>
<td><strong>Respiration Rate:</strong> 14</td>
<td><strong>Temperature:</strong> 98.7° F</td>
</tr>
</tbody>
</table>

**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
**Significant Family/Social History**

**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**
- Extended release oxycodone 20 mg q 12 h
- Acetaminophen prn breakthrough pain
- Other treatments: Dry heat for occasional muscle spasms from overuse

**Past Medications**
- Celecoxib: 100 mg bid, discontinued for a year when he could not afford it.
  - Naproxen: 500 mg bid. Taken when he runs out of celecoxib
  - Acetaminophen: 500 mg bid ("2 extra strength Tylenol per day")
- Oxycodone: at the time of admission, 10 mg immediate release oxycodone. Not prescribed for him; obtained from a friend. 1 to 2 capsules taken intermittently prn pain. Two to three times per day
- Oxycodone: 20 mg immediate release taken for two months following surgery 2 years ago. Weaned through 6 month taper.

Lab values within normal limits
UDT - negative

1st visit: No tenderness to low back on palpation. Leg muscles appear symmetrical and well-developed. 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) also suggest some lumbosacral nerve-root compression that will require further evaluation with MRI. All other tests within normal limits.

Follow-up visit one: Physical exam unchanged from 1st visit

**MR. PARKER – WHAT TO MONITOR**

**Patient:** Mr. Charles Parker, 68 y/o

**Scenario:** Mr. Parker, who has severe back pain treated with extended release oxycodone, needs a plan for follow-up monitoring.

Because he has some risk for opioid misuse, related to a history of self-medicating unmanaged pain and taking opioids not prescribed for him, follow-up appointments will be more frequent at first. But if he is compliant with treatment, there will be only quick monthly check-in/prescription visits eventually, plus an in-detail visit every 6 months.

**Question:** What will you monitor during these appointments? (Check all that apply to Mr. Parker specifically.)

1. Medication response
   - Feedback: Monitor analgesia and functioning (physical and psychosocial) response along with continued need. This may include a pain diary or communications from the patient via electronic health record.
2. Prescription drug monitoring data base
   • Feedback: Compliance with treatment should be verified through periodic checking of the prescription drug monitoring program, along with urine drug testing, and medication reconciliation via callbacks for pill counts, because problems related to substance misuse can arise at any point during chronic opioid therapy. Additionally, there should be a periodic review of the patient treatment agreement and revisions as needed.

3. Side effects
   • Feedback: Side effects should be evaluated and managed. Remaining side effects should be evaluated and balanced against pain control and improvement in functioning.

4. Current opioid risk
   • Feedback: Current opioid risk should be evaluated periodically as it can change over time.

MR. PARKER – URINE DRUG TEST
Patient: Mr. Charles Parker, 68 y/o

Reminder: Mr. Parker was assessed to have mild risk for opioid misuse due to his using oxycodone without a prescription, prior to his intake at this clinic.

Question: Which of the following is the best approach to urine drug testing for Mr. Parker? (Check all that apply)

1. Use a urine drug test at every appointment confirm that he is taking oxycodone at the prescribed dose.
   • Feedback: Testing should be random rather than at every appointment. Choose a screening point of care urine drug test that tests specifically for oxycodone, or choose a laboratory test to detect oxycodone. A random pattern of testing is recommended so that a patient who wants to take deceptive steps does know when to prepare for a test. Beyond a threshold amount, you will not be able to detect exactly how much he is taking, however.

2. Random urine drug testing
   • Feedback: Random, unscheduled urine drug testing is part of the evidence-based recommendations for chronic opioid therapy.

3. Use a point-of-care urine drug screening test
   • Feedback: Checking for the presence of non-medical use of prescription medication and presence of illicit drugs in his urine is indicated. It could identify use of drugs with potentially dangerous indications. Presence of these drugs would also indicate increased risk of opioid addiction. A routine, point-of-care urine drug screening test is likely to test for the following: narcotics/opioids, non-presence of alcohol, barbiturates, benzodiazepines, cocaine, methadone, PCP, MDMA, amphetamine, methamphetamine, marijuana). Make sure the one you select also detects oxycodone.

4. Confirmatory urine drug testing for oxycodone as needed
   • Feedback: If point-of-care urine drug testing gives unexpected results (absence of the medication detected by a kit that is supposed to detect oxycodone), confirmatory testing by a laboratory to confirm that he is actually taking the oxycodone himself is
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indicated. This test helps detect patients who obtain a drug supply for diversion and do not actually take the medication themselves.

MR. PARKER – (CONTINUED)

Patient: Mr. Charles Parker, 68 y/o

NURSE’S NOTE: Mr. Parker requested his oxycodone prescription 2 weeks early this month and 1 week early the past 2 months, despite a dose adjustment for unmanaged pain 2 months ago. The Prescription Drug Monitoring Program shows that 4 weeks ago, he obtained a prescription for immediate-release oxycodone from another provider.

Question: Before talking with him about it, Mr. Parker's provider considers the possible reasons for this behavior. Which of the following should the provider consider as possible explanations? (Check all that apply)

1. Misunderstanding
   • Feedback: Correct. Misunderstanding is a possibility with any patient and is, unfortunately, common. But it seems less likely in a practice in which the provider uses a checklist for patient education and uses a signed patient-provider treatment agreement and with a patient who has been taking opioids for several months with regular follow-up visits.

2. Tolerance
   • Feedback: Not as likely. It is possible to develop some tolerance to the pain-relieving effects of opioids, but not a major problem. However, after achieving an effective dose initially, Charles just had a dose adjustment two months ago.

3. Diversion
   • Feedback: Correct. This is a definite possibility since there have been multiple different attempts to acquire additional medication, from requesting an increased dose to asking for early prescriptions or obtaining opioids from another provider.

4. Addiction
   • Feedback: Correct. This is a definite possibility, since it would explain a need for extra medication and there have been multiple different attempts to acquire additional medication, from requesting an increased dose, to asking for early prescriptions, to obtaining opioids from another provider. Other possible reasons besides the ones listed above include continued untreated pain, need for coping skills, and a psychiatric comorbidity.

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 prescribed and 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 oxycodone 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?

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

**Treatment Plan**  
Oxycodone titrated slowly to effect, establish a stable dose, co-analgesic to minimize opioid dose, physical therapy evaluation.

**Terms of Treatment:** Discuss why the use of his friend's oxycodone 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 to only 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?
SUMMARY AND KEY POINTS

- Monitor patients on chronic opioid therapy regularly.
- Urine drug testing (UDT) is recommended for all patients on chronic opioid therapy, typically at baseline and once or twice per year for low risk patients.
- PDMPs detect when patients have prescriptions from multiple prescribers ("doctor-shopping") in the same state.
- Withdrawal symptoms can occur when stopping opioids even after just a few days to a week of taking opioids.
- Recognize aberrant drug-related behavior, and that it may indicate substance misuse, abuse, or addiction, but may also indicate undertreated pain, misunderstandings, and a number of other problems.
- Know how to tailor opioid therapy depending on the patient being treated.
- Understand the appropriate method to stop opioid therapy via tapering to prevent withdrawal.

RESOURCES AVAILABLE THROUGH THIS MODULE:

- ABC: Addiction Behaviors Checklist
  An assessment checklist that screens for characteristic addictive behaviors in chronic pain patients prescribed opioid medications.
- A Closer Look at State Prescription Drug Monitoring Programs (DEA FAQ's)
  These FAQs address common questions regarding prescription drug monitoring programs.
- Patient Health Questionnaire 9 (PHQ-9) Quick Depression Screening
  Objectifies degree of depression severity
- 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.
- ER LA Opioid Analgesics REMS Safety Information
  Selected Important Safety Information. Abuse Potential and Risk of Life-Threatening Respiratory Depression for ER/LA Opioid Analgesics
- HHS Guide for Clinicians on the Appropriate Dosage Reduction for Discontinuation of Long-Term Opioid Analgesics.
  Guide for Clinicians on how to reduce or discontinue opioid dosage in chronic opioid therapy, considering risks vs benefits and steps to take to avoid harms from tapering.
- Oswestry Low Back Pain Disability Questionnaire
- PADT: Pain Assessment and Documentation Tool
The PADT is a clinician-directed interview; that is, the clinician asks the questions, and the clinician records the responses. The Analgesia, Activities of Daily Living, and Adverse Events sections may be completed by the physician, nurse practitioner, physician assistant, or nurse. The Potential Aberrant Drug-Related Behavior and Assessment sections must be completed by the physician. Ask the patient the questions below, except as noted.

- **PDUQ: Prescription Drug Use Questionnaire**
  An interview format yes or no questionnaire administered by the clinician and designed to detect prescription pain medication addiction in chronic pain patients. (Located at the end of article) Authors: Compton P, Darakjian J, Miotto Karen

- **Pharmacological Management of Persistent Pain in Older Persons**
  Guideline recommendations by the American Geriatric Society (AGS) for the pharmacological management of non-opioid, opioid, and other analgesic drugs. The recommendations focus on the prescription and any potential side effects of the medications.

- **PMQ: Pain Medication Questionnaire**
  Screening tool used to accurately identify chronic pain patients that are at risk for opioid dependency or abuse. This article examines the predictive validity of the PMQ in risk assessment. Authors: Dowling LS, Gatchel RJ, Adams LL, Stowell AW, Bernstein D Title: An evaluation of the predictive validity of the Pain Medication Questionnaire with a heterogeneous group of patients with chronic pain. Issue: 3(5): 257-66.

- **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

- **State List of HHS Certified Laboratories**
  This document lists the 40 laboratories which meet the Minimum Standards To Engage in Urine Drug Testing for Federal Agencies. Updated May 15, 2014

- **Target Chronic Pain Notebook**
  A notebook for tracking chronic pain.

**REFERENCES USED IN THIS MODULE:**


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29. FDA. FDA announces safety labeling changes and postmarket study requirements for extended-release and long-acting opioid analgesics. FDA Website. 2013.


42. Compton P. Urine Toxicology Screening: A Case Study. 2009.


50. VA/DoD. Tapering and Discontinuing Opioids. 2010.

