

PAIN MANAGEMENT GUIDELINES

REV. 6/2014

PREAMBLE

Protection of the public shall be the highest priority for the Medical Board of California (Board) in exercising its licensing, regulatory, and disciplinary functions. The Board recognizes that principles of high-quality medical practice dictate that the people of California have access to appropriate, safe and effective pain management. The application of up-to-date knowledge and treatment modalities can help to restore function and thus improve the quality of life of patients who suffer from pain, particularly chronic pain.

In 1994, the Medical Board of California formally adopted a policy statement titled, "Prescribing Controlled Substances for Pain." This policy statement was used to provide guidance to physicians prescribing controlled substances. There have been several statute changes since 1994 that resulted in revising these guidelines, most recently, in 2007.

The Center for Disease Control and Prevention has declared prescription drug abuse to be a nationwide epidemic. The number of deaths by drug overdose is now the leading cause of non-natural deaths, exceeding deaths due to motor vehicle accidents. Even more disturbing is that a majority of those overdose deaths are due to prescription drugs. As a result of the increase in addiction and overdose deaths, the Board called for revision of the guidelines to provide additional direction to physicians who prescribe controlled substances for pain. These guidelines are intended to promote improved pain management for all forms of pain and for all patients in pain.

The Board understands that each patient needs to be evaluated based upon his/her particular presenting issues. This document is intended to be used to provide guidance to physicians in treating patients with pain and the Board encourages physicians to utilize these guidelines as appropriate to the treatment of each individual patient.

UNDERSTANDING PAIN

The diagnosis and treatment of pain is integral to the practice of medicine. In order to cautiously prescribe opioids, physicians must understand the relevant pharmacologic and clinical issues in the use of such analgesics, and carefully structure a treatment plan that reflects the particular benefits and risks of opioid use for each individual patient. Such an approach should be employed in the care of every patient who receives chronic opioid therapy.

The California Medical Association¹ has defined and clarified key concepts relating to pain excerpted below:

Pain: The definition of pain proposed by the International Association for the Study of Pain is “an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage.” It has also been said that “Pain is what the patient says it is.” Both definitions acknowledge the subjective nature of pain and are reminders that, with the rare exception of patients who intentionally deceive, a patient’s self-report and pain behavior are likely the most reliable indicators of pain and pain severity. As a guide for clinical decision-making, however, both of these definitions are inadequate. In addition, it is important to remember that the subjectivity of pain, particularly when the cause is not apparent, can lead to the stigmatization of those with pain.

Acute and Chronic Pain: Traditionally, pain has been classified by its duration. In this perspective, “acute” pain is relatively short-duration, arises from obvious tissue injury, and usually fades with healing. “Chronic” pain, in contrast, has been variously defined as lasting longer than would be anticipated for the usual course of a given condition, or pain that last longer than arbitrary cut-off times such as 3 or 6 months. Temporal pain labels, however, provide no information about the biological nature of the pain itself, which is often of critical importance.

Nociceptive and Neuropathic Pain: A more useful nomenclature classifies pain on the basis of its patho-physiological process. Nociceptive pain is cause by the activation of nociceptors, and is generally, though not always, short-lived and is associated with the presence of an underlying medical condition. It is a “normal” process; a physiological response to an injurious stimulus. Nociceptive pain is a symptom. Neuropathic pain, on the other hand, results either from an injury to the nervous system or from inadequately-treated nociceptive pain. It is an abnormal response to a stimulus; a pathological process. It is a neuro-biological disease. Neuropathic pain is caused by abnormal neuronal firing in the absence of active tissue damage. It may be continuous or episodic and varies widely in how it is perceived. Neuropathic pain is complex and can be difficult to diagnose and to manage because available treatment options are limited.

A key aspect of both nociceptive and neuropathic pain is the phenomenon or sensitization, which is a state of hyper excitability in either peripheral nociceptors or neurons in the central nervous system. Sensitization may lead to either hyperalgia or allodynia. Sensitization may arise from intense, repeated or prolonged stimulation of nociceptors, or from the influence of compounds released by the body in response to tissue damage or inflammation. Importantly, many patients – particularly those with persistent pain --- present with “compound” pain that has both nociceptive and neuropathic components, a situation which complicates assessment and treatment.

¹ California Medical Association (Prescribing Opioids: Care amid Controversy March 2014)

Differentiating between nociceptive and neuropathic pain is critical because the two respond differently to pain treatments. Neuropathic pain, for example, typically responds poorly to both opioid analgesics and non-steroidal anti-inflammatory (NSAID) agents. Other classes of medications, such as anti-epileptics, antidepressants or local anesthetics, may provide more effective relief for neuropathic pain.

Cancer and Non-Cancer Pain: Pain associated with cancer is sometimes given a separate classification, although it is not distinct from a patho-physiological perspective. Cancer-related pain includes pain caused by the disease itself and/or painful diagnostic or therapeutic procedures. The treatment of cancer-related pain may be influenced by the life expectancy of the patient, by co-morbidities and by the fact that such pain may be of exceptional severity and duration.

A focus of recent attention by the public, regulators, legislators, and physicians has been chronic pain that is not associated with cancer. A key feature of such pain, which may be caused by conditions such as musculoskeletal injury, lower back trauma and dysfunctional wound healing, is that the severity of pain may not correspond well to identifiable levels of tissue damage.

Tolerance, Dependence and Addiction: Related to the nomenclature of pain itself is continuing confusion not only among the public, but also in the medical community, about terms used to describe the effects of drugs on the brain and on behavior. To help clarify and standardize understanding, the American Society of Addiction Medicine (ASAM), the American Academy of Pain Medicine (AAPM) and the American Pain Society (APS) have recommended the following definitions:

Tolerance: A State of adaptation in which exposure to a drug induces changes that result in a diminution of one or more of the drugs' effects over time.

Physical Dependence: A state of adaptation that often includes tolerance and is manifested by a drug class-specific withdrawal syndrome that can be produced by abrupt cessation, rapid dose, reduction, decreasing blood level of the drug and/or administration of an antagonist.

Addiction: A primary, chronic, neurobiological disease, with genetic, psychosocial and environmental factors influencing its development and manifestations. It is characterized by behaviors that include one or more of the following: impaired control over drug use, compulsive use, continued use despite harm and craving.

Pain as an Illness: Finally, it may be helpful to point out that pain can be regarded as an illness as well as a symptom or a disease. "Illness" defines the impact a disease has on an organism and is characterized by epiphenomena or co-morbidities with bio-psycho-social dimensions. Effective care of any illness, therefore, requires attention to all of these dimensions. Neuropathic pain, end-of-life pain and chronic pain should all be viewed as illnesses.

PATIENT EVALUATION AND RISK STRATIFICATION

Given the potential risks of opioid analgesics, careful and thorough patient assessment is essential. The nature and extent of the evaluation depends on the type of pain and the context in which it occurs. This includes but is not limited to:

- Completing a [medical history and physical examination](#) (Appendix 1).
- Establishing a diagnosis and medical necessity (review past medical records, review laboratory studies e.g., x-rays, MRI, and order new ones if necessary).
 - [pain inventories quality of life scales](#) (Appendix 2)
 - [Neuropathic Pain Scale](#)
- [Exploring therapeutic options](#) (Appendix 3)
- Performing a psychological evaluation.
 - Psychological assessment should include risk of addictive disorders and screening tools:
 - [Opioid Risk Tool \(ORT\)](#) (Appendix 4);
 - [CAGE-AID](#) (Appendix 5,
 - [PHQ-9](#) (Appendix 6),
- Establishing a benefit/risk ratio ([ASIPP Guidelines](#))
- Reviewing the prescription drug monitoring program, [Controlled Substance Utilization Review and Evaluation System \(CURES\)](#), report for the patient.
- Being cognizant of aberrant or drug seeking behaviors:
 - Patient requesting specific controlled substances.
 - Repeatedly running out of medication early.
 - Unscheduled refills requested.
 - Unwillingness to try non-opioid treatments.
 - Engaging in doctor shopping activities.

SPECIAL PATIENT POPULATIONS

All patients may experience pain. Below are treatment considerations for differing patient populations or scenarios.

- **Emergency Departments**

Treating patients in an emergency department presents unique challenges in that, often times there is no ability to procure adequate patient history and the treating physician is not available. Drug seeking patients may take advantage of this in order to secure controlled substances. The American College of Emergency Physicians (ACEP) Clinical Policy: [Critical Issues in the Prescribing of Opioids for Adult Patients in the Emergency Department](#) makes the following recommendations:

 - ER/LA opioid medications should not be prescribed for acute pain conditions;
 - PDMPs should be used where available to help identify patients at high risk for opioid abuse or diversion;

- Opioids should be reserved for more severe pain or pain that doesn't respond to other analgesics; and
- If opioids are indicated, the prescription should be for the lowest effective dose and for a limited duration (e.g. < 1 week).

- **End-of-Life Pain²**

Pain management at the end of life seeks to improve or maintain a patient's overall quality of life. This focus is important because sometimes a patient may have priorities that compete with, or supersede, the relief of pain. For some patients, mental alertness sufficient to allow lucid interactions with loved ones may be more important than physical comfort. Optimal pain management, in such cases, may mean lower doses of an analgesic and the experience, by the patient, of higher levels of pain.

Fear of inducing severe or even fatal respiratory depression may lead to clinician under-prescribing and reluctance by patients to take an opioid medication. Despite this fear, studies have revealed no correlation between opioid dose, timing of opioid administration and time of death in patients using opioids in the context of terminal illness. A consult with a specialist in palliative medicine in these situations may be advisable.

- **Cancer Pain³**

Pain is one of the most common symptoms of cancer, as well as being one of the most-feared cancer symptoms. Opioid pain medications are the mainstay of cancer pain management and a trial of opioid therapy should be administered to all cancer patients with moderate or severe pain, regardless of the known or suspected pain mechanism.

Extended-release/long-acting opioid formulations may lessen the inconvenience associated with the use of short-acting opioids.

Patient-controlled analgesia with subcutaneous administration using an ambulatory infusion device may provide optimal patient control and effective analgesia. The full range of adjuvant medications should be considered for patients with cancer pain, with the caveat that such patients are often on already complicated pharmacological regimens, which raises the risk of adverse reactions associated with polypharmacy.

- **Older Adults**

With appropriate precautions opioid therapy for elderly patients can be efficacious. It is important to begin with lower starting doses, slower titration, longer dosing interval, and more frequent monitoring. Tapering of benzodiazepines is important to reduce the potential for respiratory depression.

² California Medical Association (Prescribing Opioids: Care amid Controversy March 2014)

³ California Medical Association (Prescribing Opioids: Care amid Controversy March 2014)

[Additional information](#) (Appendix 7)

- **Pediatric Patients**

Extreme caution should be used in prescribing opioids for adolescents. A trial of opioid therapy may be considered with supported somatic or neuropathic pain conditions when non-opioid alternatives have failed. Additionally, risk of opioid misuse should be low, and close monitoring and consultation should be undertaken.

[Additional information](#) (Appendix 8)

- **Pregnant Women**

Clinicians should encourage minimal or no use of opioids during pregnancy unless the potential benefits clearly outweigh risks. Pregnant patients taking long-term opioid therapy should be tapered to the lowest effective dose slowly enough to avoid withdrawal symptoms, and then therapy should be discontinued if possible.

Additional information on the appropriate use of opioids for pregnant patients is available: American Congress of Obstetricians and Gynecologists (ACOG) committee opinion titled "[Opioid Abuse, Dependence, and Addiction in Pregnancy](#)".

- **Patients Covered by Workers' Compensation⁴**

This population of patients presents its own unique circumstances. Injured workers are generally sent to an occupational medicine facility for treatment. Ideally, the injured worker recovers and returns to work in full capacity. If recovery or healing does not occur as expected, early triage and appropriate, timely treatment is essential to restore function and facilitate a return to work.

The use of opioids in this population of patients can be problematic. Some evidence suggests that early treatment with opioids may actually delay recovery and a return to work. Conflicts of motivation may also exist in patients on workers' compensation, such as when a person may not want to return to an unsatisfying, difficult or hazardous job. Clinicians are advised to apply the same careful methods of assessment, creation of treatment plans and monitoring used for other pain patients but with the added consideration of the psycho-social dynamics inherent in the workers' compensation system. Injured workers should be afforded the full range of treatment options that are appropriate for the given condition causing the disability and impairment.

- **Patients with History of Substance Use Disorder⁵**

⁴ California Medical Association (Prescribing Opioids: Care amid Controversy March 2014)

⁵ California Medical Association (Prescribing Opioids: Care amid Controversy March 2014)

Use of opioids for patients with a history of substance use disorder is challenging because such patients are more vulnerable to drug misuse, abuse and addiction. In patients who are actively using illicit drugs, the potential benefits of opioid therapy are likely to be outweighed by potential risks, and such therapy should not be prescribed outside of highly controlled settings (such as an opioid treatment program with directly observed therapy). In other patients, the potential benefits of opioid therapy may outweigh potential risks. Although evidence is lacking on best methods for managing such patients, potential risks may be minimized by more frequent and intense monitoring compared with lower risk patients, authorization of limited prescription quantities and consultation or co-management with a specialist in addiction medicine. Clinicians should use the CURES PDMP to identify patients who obtain drugs from multiple sources.

If either the patient's medical history, self-report or scores on screening assessment tools such as the Opioid Risk Tool suggest an above-average risk of substance abuse, clinicians should consider the following steps in proceeding with a pain management strategy:

- Exhaust all non-opioid pain management methodologies prior to considering opioid therapy;
- Consult with a specialist in addiction medicine;
- Create a written treatment plan and patient agreement and review carefully with the patient, obtaining their signed informed consent;
- Closely monitor and assess pain, functioning and aberrant behaviors;
- Regularly check with a PDMP for compliance with prescribed amounts of opioids (using cross-state PDMP systems whenever they are available);
- While the patient is on chronic opioid therapy, implement urine drug testing, if possible;
- If misuse or abuse of opioid analgesics is suspected or confirmed, initiate a non-confrontational in-person meeting, use a non-judgmental approach to asking questions, present options for referral, opioid taper/discontinuation or switching to non-opioid treatments, and avoid "abandoning" the patient or abruptly stopping opioid prescriptions.

- **Psychiatric Patients**

A higher risk for deleterious side effects exists for patients with psychiatric diagnoses who are receiving opioid treatment. Opioids should only be prescribed for well-defined somatic or neuropathic pain conditions. Clinicians should titrate slowly, closely monitor the patient and seek consultation.

- **Benzodiazepines**

Patients taking benzodiazepines and opioids are at an increased risk for respiratory depression, particularly elderly patients. Clinicians should consider a trial of tapering. If a trial of tapering is not indicated or is unsuccessful, opioids should be titrated more slowly and at lower doses.

TREATMENT PLAN AND OBJECTIVES

The clinician and the patient should develop treatment goals together. The goals of pain treatment include reasonably attainable improvement in pain and function; improvement in pain-associated symptoms such as sleep disturbance, depression, and anxiety; and avoidance of unnecessary or excessive use of medications. Pain relief is important, but it is difficult to objectively measure. Therefore, it cannot be the primary indicator to assess the success of the treatment. Effective pain relief improves functioning, whereas addiction decreases functionality. Effective means of achieving these goals vary widely, depending on the type and causes of the patient's pain, other concurrent issues, and the preferences of the physician and the patient.

The treatment plan and goals should be established as early as possible in the treatment process and revisited regularly, so as to provide clear-cut, individualized objectives to guide the choice of therapies. The treatment plan should contain information supporting the selection of therapies, both pharmacologic (including medications other than opioids) and non-pharmacologic. It also should specify the objectives that will be used to evaluate treatment progress, such as relief of pain and improved physical and psychosocial function.

The plan should document any further diagnostic evaluations, consultations or referrals, or additional therapies that have been considered.

PATIENT CONSENT

The decision to initiate opioid therapy should be a shared decision between the physician and the patient. The physician should discuss the risks and benefits of the treatment plan (including any proposed use of opioid analgesics) with the patient, with persons designated by the patient, or with the patient's conservator if the patient is without medical decision-making capacity. If opioids are prescribed, the patient (and possibly family members, if appropriate) should be counseled on safe ways to store and dispose of medications.

Patient consent typically addresses:

- The potential risks and anticipated benefits of chronic opioid therapy.
- Potential side effects (both short- and long-term) of the medication, such as constipation and cognitive impairment.
- The likelihood that tolerance to and physical dependence on the medication will develop.
- The risk of drug interactions and over-sedation.
- The risk of impaired motor skills (affecting driving and other tasks).
- The risk of opioid misuse, dependence, addiction, and overdose.
- The limited evidence as to the benefit of long-term opioid therapy.

For convenience, patient consent and a pain management contract can be combined into one document.

PAIN MANAGEMENT CONTRACT

Use of a pain management contract (also known as an “agreement”) is recommended for patients:

- On short-acting opioids at time of third visit;
- On long-acting opioids;
- Expected to require more than 3 months of opioids.

Pain management contracts typically outline the joint responsibilities of the physician and the patient and should include:

- The physician’s prescribing policies and expectations, including the number and frequency of prescription refills, as well as the physician’s policy on early refills and replacement of lost or stolen medications.
- Specific reasons for which drug therapy may be changed or discontinued (including violation of the policies and agreements spelled out in the treatment agreement).
- The patient’s responsibility for safe medication use (e.g., by not using more medication than prescribed or using the opioid in combination with alcohol or other substances; storing medications in a secure location; and safe disposal of any unused medication).
- The patient’s responsibility to obtain his or her prescribed opioids from only one physician or practice.
- The patient’s agreement to periodic drug testing (blood, urine, hair, or saliva).
- The physician’s responsibility to be available or to have a covering physician available to care for unforeseen problems and to prescribe scheduled refills.

[Sample of pain management contract](#)

INITIATING OPIOID TRIAL

In most cases, safer alternative treatment should be considered before initiating opioid therapy for chronic, non-malignant pain. Opioid therapy should be presented to the patient as a therapeutic trial or test for a defined period of time (usually no more than 45 days) and with specific evaluation points.

The physician should explain that progress will be carefully monitored for both benefit and harm in terms of the effects of opioids on the patient’s level of pain, function, and quality of life, as well as to identify any adverse events or risks to safety.

Continuation of opioid therapy after an appropriate trial should be based on outcomes such as: making progress toward functional goals; presence and nature of side effects; pain status; and a lack of evidence of medication misuse, abuse, or diversion. Patients with no, or modest, previous opioid exposure should be started at the lowest

appropriate initial dosage of a short-acting opioid and titrated upward to decrease the risk of adverse effects. The selection of a starting dose and manner of titration are clinical decisions made on a case-by-case basis because of the many variables involved. Some patients, such as frail older persons or those with comorbidities, may require an even more cautious therapy initiation. Short-acting opioids are usually safer for initial therapy since they have a shorter half-life and may be associated with a lower risk of overdose from drug accumulation. The general approach is to “start low and go slow.”

Since opioids are known in some circumstances to worsen pain (hyperalgesia), instances of ongoing pain may suggest opioid insensitivity (or an inadequate dose). Careful assessment must be undertaken. If hyperalgesia is suspected, a dose reduction, opioid rotation or tapering to cessation could be considered.⁶

Dosing For Opioid Naïve Patients⁷

- Start with a short acting opioid with a maximum dose of 4 times per day, not to exceed ____ total pills.
- Be careful not to exceed recommended maximum for acetaminophen of 3000mg per day.
- TYLENOL # 3 (30 mg codeine/ 300 mg acetaminophen)
 - 30 mg codeine = 3.6 mg hydrocodone = 3.6 mg oxycodone
- VICODIN (hydrocodone/ acetaminophen) - Use 5 mg
 - 5 mg hydrocodone = 27.5 mg codeine = 3.3 mg oxycodone
- NORCO (hydrocodone/ acetaminophen) - Use 5 mg
- LORTAB (hydrocodone/ acetaminophen) - Use 5 mg
- PERCOCET/ ENDOCET (oxycodone/ acetaminophen) - Use 5 mg
 - 5 mg oxycodone = 7.5 mg of hydrocodone = 41.3 mg codeine
 - Maximum of 8 tablets a day for 5 mg
- TRAMADOL/ ULTRAM
 - Start with IR 50mg mg q 4-6 hours (Maximum 400mg/ day)
 - Do not use if patient has liver disease, renal disease, is on a tricyclic antidepressant or SSRI medication.
 - This medication has a high abuse potential.
 - This medication does not show up on CURES reports and can be refilled, unlike the Vicodin or Percocet prescriptions.
 - This is available OTC in Mexico.
 - Deaths have been reported in patients with emotional disturbances and misuse of alcohol, tranquilizers, and other CNS active drugs.

[Information on administration and dosing](#) (Appendix 9)

We can be more vague per above (physician's should be cognizant of acetaminophen toxicity; drug interactions (e.g., tramadol/ultram); MEDs (if we use MED then we can link

⁶ California Medical Association (Prescribing Opioids: Care amid Controversy March 2014)

⁷ San Diego County Prescription Drug Abuse Medical Task Force - Safe Pain Medication Prescribing Guidelines

to a calculator) ... holy trinity. Most pain can be managed effectively in most patients with dosages at or below 200 mg/day of morphine or equivalent. Consideration of a higher dosage requires careful reassessment of the pain and of risk for misuse, and frequent monitoring with evidence of improved patient outcomes.

ONGOING PATIENT ASSESSMENT

When a trial of an opioid medication is successful and the physician and patient decide to continue opioid therapy, regular review and monitoring should be undertaken for the duration of treatment.

When possible, collateral information about the patient's response to opioid therapy should be obtained from family members or other close contacts, as well as the CURES database. The patient should be seen more frequently while the treatment plan is being initiated and the opioid dose adjusted. As the patient is stabilized in the treatment regimen, follow-up visits may be scheduled less frequently.

At each visit, the results of chronic opioid therapy should be monitored by assessing what have been called the "5-As" of chronic pain management:

- Analgesia: the patient is experiencing a reduction in pain
- Activity: the patient is demonstrating an improvement in level of function
- Adverse: the patient is not experiencing side effects
- Aberrance: the patient is complying with the pain management agreement and there are no signs of medication abuse or diversion
- Affect: the patient's behavior and mood are appropriate.

Validated brief assessment tools that measure pain and function, such as the three question "[Pain, Enjoyment and General Activity](#)" (PEG) scale or other validated assessment tools, may be helpful and time effective.

COMPLIANCE MONITORING

Physicians who prescribe opioids or other controlled substances for pain must ensure the provisions of a pain management contract are being heeded. Strategies for monitoring compliance include:

- CURES Report

A CURES report should be obtained for all new patients. The CURES report can be useful in establishing whether or not an individual is receiving controlled substances from multiple prescribers. The CURES report should be requested frequently for patients who are being treated for pain as well as addiction.

- Drug Testing

A patient's report of medication use is not always reliable; therefore, drug testing is an important monitoring tool.

The ease of collecting and storage, as well as cost-effectiveness, makes urine a preferred biologic specimen for testing. The physicians should keep in mind that forensic standards are not typically in place, so the collection is not observed nor are chain-of-custody protocols followed. Initial testing may be done using class-specific immunoassay drug panels (point-of-care or laboratory-based), which typically do not identify particular drugs within a class unless the immunoassay is specific for that drug. If necessary, this can be followed up with a more specific technique, such as gas chromatography/mass spectrometry (GC/MS) or other chromatographic tests to confirm the presence or absence of a specific drug or its metabolites. When drug testing in a pain practice, it is important to identify the specific drug not just the class of the drug.

Physicians need to be aware of the limitations of available tests (such as their limited sensitivity for many opioids) and take care to order tests appropriately. For example, when a drug test is ordered, it is important to specify that it include the opioid being prescribed. Because of the complexities involved in interpreting drug test results, it is advisable to confirm significant or unexpected results with the laboratory toxicologist or a clinical pathologist.

- Pill Counting

Periodic (or more frequent, if necessary) pill counting can be a useful strategy to confirm medication adherence and to minimize diversion (selling, sharing or giving away medications).

The physician must decide whether or not to revise or augment a pain management contract and/or treatment plan if the patient's progress is unsatisfactory.

Evidence of misuse of prescribed opioids demands prompt intervention by the physician. Patient behaviors that require such intervention typically involve recurrent early requests for refills, multiple reports of lost or stolen prescriptions, obtaining controlled medications from multiple sources without the physician's knowledge, intoxication or impairment (either observed or reported), and pressuring or threatening behaviors. The presence of illicit or drugs not prescribed by a physician in drug tests similarly requires action on the part of the prescriber. Some aberrant behaviors are more closely associated with medication misuse than others. Most worrisome is a pattern of behavior that suggests recurring misuse, such as unsanctioned dose escalations, deteriorating function, and failure to comply with the treatment plan.

Documented drug diversion or prescription forgery, obvious impairment, and abusive or assaultive behaviors require a firm, immediate response. Indeed, failure to respond can place the patient and others at significant risk of adverse consequences, including

accidental overdose, suicide attempts, arrests and incarceration, or even death. For this reason, physicians who prescribe chronic opioid therapy should be knowledgeable in the diagnosis of substance use disorders and able to distinguish such disorders from physical dependence—which is expected in chronic therapy with opioids and many sedatives.

If it is suspected that a patient may be abusing or diverting prescribed medications, or using “street” drugs, a careful re-assessment of the treatment plan must be undertaken. A patient’s failure to adhere to a pain management contract by itself, is not necessarily proof of abuse or diversion. Failure to comply may be the consequence of inadequate pain relief, confusion regarding the prescription, a language barrier or economic concerns. A physician should arrange for an in-person meeting in order to have a non-judgmental conversation to clarify his or her concerns. If abuse is confirmed, consultation with an addiction medicine specialist or psychiatrist and/or referral to a substance use disorder treatment program should be immediately facilitated.

CONSULTATION

The treating physician should seek a consultation with, or refer the patient to, a pain, psychiatry, addiction or mental health specialist as needed. For example, a patient who has a history of substance use disorder or a co-occurring mental health disorder may require specialized assessment and treatment, if available.

Physicians who prescribe chronic opioid therapy should be familiar with treatment options for opioid addiction (including those available in licensed opioid treatment programs [OTPs]) and those offered by an appropriately credentialed and experienced physician through office-based opioid treatment [OBOT]), so as to make appropriate referrals when needed.

DISCONTINUING OPIOID THERAPY

Discontinuation or termination of opioid therapy may be required for many reasons:

- Resolution or healing of the painful condition
- Intolerable side effects
- Failure to achieve anticipated pain relief or functional improvement (although ensure that this failure is not the result of inadequate treatment)
- Evidence of non-medical or inappropriate use
- Failure to comply with monitoring, such as urine drug screening
- Failure to comply with pain management contract
- Patient exhibits drug-seeking behaviors or diversion such as:
 - Selling prescription drugs
 - Forging prescriptions
 - Stealing or borrowing drugs
 - Aggressive demand for opioids
 - Injecting oral/topical opioids

- Unsanctioned use of opioids
- Unsanctioned dose escalation
- Concurrent use of illicit drugs
- Getting opioids from multiple prescribers
- Recurring Emergency department visits for chronic pain management

If opioid therapy is discontinued, the patient who has become physically dependent should be provided with a safely structured tapering regimen. Opioid withdrawal symptoms are uncomfortable, but are not dangerous. Opioids can be stopped abruptly when the risks outweigh the benefits. This is not true for benzodiazepine withdrawals, which can be life threatening. Withdrawal can be managed either by the prescribing physician or by referring the patient to an addiction specialist. The termination of opioid therapy should not mark the end of treatment, which should continue with other modalities, either through direct care or referral to other health care specialists, as appropriate.

If complete termination of care is necessary (as opposed to termination of a specific treatment modality), clinicians should treat the patient until the patient has had a reasonable time to find an alternative source of care, and ensure that the patient has adequate medications, if appropriate, to avoid unnecessary risk from withdrawal symptoms. Practitioners can be held accountable for patient abandonment if medical care is discontinued without justification or adequate provision for subsequent care. If a patient is known to be abusing a medication, initiating a detoxification protocol may be appropriate. Consultation with an attorney and/or one's malpractice insurance carrier may be prudent in such cases. Physicians may want to also consult health plan contracts to ensure compliance.

Approaches to weaning range from a slow 10% reduction per week to a more aggressive 25 to 50% reduction every few days. In general, a slower taper will produce fewer unpleasant symptoms of withdrawal.

If a patient is dismissed for not honoring treatment agreements, consider referral to [addiction resources](#) (Appendix 10).

MEDICAL RECORDS

Every physician who treats patients for chronic pain must maintain accurate and complete medical records. Information that should appear in the medical record include copies of the signed informed consent and pain management contract; the patient's medical history; results of the physical examination and all laboratory tests; results of the risk assessment, including results of any screening instruments used; description of the treatments provided, including all medications prescribed or administered (including the date, type, dose and quantity); instructions to the patient, including discussions of risks and benefits with the patient and any significant others; results of ongoing monitoring of patient progress (or lack of progress) in terms of pain management and

functional improvement; notes on evaluations by and consultations with specialists; any other information used to support the initiation, continuation, revision, or termination of treatment and the steps taken in response to any aberrant medication use behaviors (these may include actual copies of, or references to, medical records of past hospitalizations or treatments by other providers); authorization for release of information to other treatment providers and results of CURES data searches.

The medical record must include all prescription orders for opioid analgesics and other controlled substances, whether written or telephoned. In addition, written instructions for the use of all medications should be given to the patient and documented in the record. The name, telephone number, and address of the patient's pharmacy also should be recorded to facilitate contact as needed. Records should be up-to-date and maintained in an accessible manner so as to be readily available for review.

Good records demonstrate that a service was provided to the patient and establish that the service provided was medically necessary. Even if the outcome is less than optimal, thorough records protect the physician as well as the patient.

COMPLIANCE WITH CONTROLLED SUBSTANCES LAWS

California laws:

- [California laws regarding controlled substances](#)
- [Guide to the Laws Governing the Practice of Medicine](#)

Federal laws:

- [Title 21 United States Code \(USC\) Controlled Substances Act](#)

Appendix 1⁸

Patient Evaluation and Risk Stratification:

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

The nature and extent of the evaluation depends on the type of pain and the context in which it occurs. For example, meaningful assessment of chronic pain, including pain related to cancer or non-cancer origins, usually demands a more detailed evaluation than an assessment of acute pain. Assessment of the patient's pain typically would include the nature and intensity of the pain, past and current treatments for the pain, any underlying or co-occurring disorders and conditions, and the effect of the pain on the patient's physical and psychological functioning.

For every patient, the initial work-up should include a systems review and relevant physical examination, as well as laboratory investigations as indicated. Such investigations help the physician address not only the nature and intensity of the pain, but also its secondary manifestations, such as its effects on the patient's sleep, mood, work, relationships, valued recreational activities, and alcohol and drug use.

Social and vocational assessment is useful in identifying supports and obstacles to treatment and rehabilitation; for example: Does the patient have good social supports, housing, and meaningful work? Is the home environment stressful or nurturing?.

Assessment of the patient's personal and family history of alcohol or drug abuse and relative risk for medication misuse or abuse also should be part of the initial evaluation, and ideally should be completed prior to a decision as to whether to prescribe opioid analgesics. This can be done through a careful clinical interview, which also should inquire into any history of physical, emotional or sexual abuse, because those are risk factors for substance misuse. Use of a validated screening tool (such as the Screener and Opioid Assessment for Patients with Pain [SOAPP-R] or the Opioid Risk Tool [ORT]), or other validated screening tools, can save time in collecting and evaluating the information and determining the patient's level of risk.

All patients should be screened for depression and other mental health disorders, as part of risk evaluation. Patients with untreated depression and other mental health problems are at increased risk for misuse or abuse of controlled medications, including addiction, as well as overdose.

Patients who have a history of substance use disorder (including alcohol) are at elevated risk for failure of opioid analgesic therapy to achieve the goals of improved

⁸ Federation of State Medical Boards - Model Policy on the Use of Opioid Analgesics in the Treatment of Chronic Pain July 2013

comfort and function, and also are at high risk for experiencing harm from this therapy, since exposure to addictive substances often is a powerful trigger of relapse. Therefore, treatment of a patient who has a history of substance use disorder should, if possible, involve consultation with an addiction specialist before opioid therapy is initiated (and follow-up as needed). Patients who have an active substance use disorder should not receive opioid therapy until they are established in a treatment/recovery program or alternatives are established such as co-management with an addiction professional. Physicians who treat patients with chronic pain should be encouraged to also be knowledgeable about the treatment of addiction, including the role of replacement agonists such as methadone and buprenorphine. For some physicians, there may be advantages to becoming eligible to treat addiction using office-based buprenorphine treatment.

Information provided by the patient is a necessary but insufficient part of the evaluation process. Reports of previous evaluations and treatments should be confirmed by obtaining records from other providers, if possible. Patients have occasionally provided fraudulent records, so if there is any reason to question the truthfulness of a patient's report, it is best to request records directly from the other providers.

If possible, the patient evaluation should include information from family members and/or significant others. Where available, the state prescription drug monitoring program (PDMP) should be consulted to determine whether the patient is receiving prescriptions from any other physicians, and the results obtained from the PDMP should be documented in the patient record.

In dealing with a patient who is taking opioids prescribed by another physician—particularly a patient on high doses—the evaluation and risk stratification assume even greater importance. With all patients, the physician's decision as to whether to prescribe opioid analgesics should reflect the totality of the information collected, as well as the physician's own knowledge and comfort level in prescribing such medications and the resources for patient support that are available in the community.

Appendix 2⁹

Pain Intensity and Interference (pain scale)

Pain intensity and interference										
<p>In the last month, on average, how would you rate your pain? Use a scale from 0 to 10, where 0 is "no pain" and 10 is "pain as bad as could be"? [That is, your usual pain at times you were in pain.]</p>										
No pain										Pain as bad as could be
0	1	2	3	4	5	6	7	8	9	10
<p>In the last month, how much has pain interfered with your daily activities? Use a scale from 0 to 10, where 0 is "no interference" and 10 is "unable to carry on any activities"?</p>										
No interference										Unable to carry on any activities
0	1	2	3	4	5	6	7	8	9	10

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

Pain Rating Item	Mild	Moderate	Severe
Average/Usual Pain Intensity	1–4	5–6	7–10
Pain-related interference with activities	1–3	4–6	7–10

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

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

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

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

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

⁹ Interagency Guideline on Opioid Dosing for Chronic Non-cancer Pain: An educational aid to improve care and safety with opioid therapy (Washington State Agency Medical Directors' Group)

Appendix 3

Therapeutic Options for Pain Management¹⁰

In treating pain, clinicians can avail themselves of five basic modalities of pain-management tools:

1. Cognitive-behavioral approaches
2. Rehabilitative approaches
3. Complementary and alternative therapies
4. Interventional approaches
5. Pharmacotherapy

Not all of these options are necessary or appropriate for every patient, but clinical guidelines suggest that all options should be considered every time a health care provider decides to treat a patient with chronic pain. These options can be used alone or in combinations to maximize pain control and functional gains. Only one of these options involves medications and opioids are only one of many types of medications with potential analgesic utility. Which options are used in a given patient depends on factors such as the type of pain, the duration and severity of pain, patient preferences, co-occurring disease states or illnesses, patient life expectancy, cost and the local availability of the treatment option.

Cognitive-behavioral Approaches

The brain plays a vitally important role in pain perception and in recovery from injury, illness or other conditions involving pain. Psychological therapies of all kinds, therefore, may be a key element in pain management. At the most basic level, such therapy involves patient education about disease states, treatment options or interventions, and methods of assessing and managing pain. Cognitive therapy techniques may help patients monitor and evaluate negative or inaccurate thoughts and beliefs about their pain. For example, some patients engage in an exaggeration of their condition called “catastrophizing” or they may have an overly passive attitude toward their recovery which leads them to inappropriately expect a physician to “fix” their pain with little or no work or responsibility on their part. Another way to frame this is to assess whether a patient has an internal or external “locus of control” relative to their pain. Someone with an external locus of control attributes the cause/relief of pain to external causes and they expect that the relief comes from someone else. Someone with an internal locus of control believes that they are responsible for their own well being; they own the experience of pain and recognize they have the ability and obligation to undertake remediation, with the help of others.

Some chronic pain patients have a strong external locus of control, and successful management of their pain hinges, in part, on the use of cognitive or other types of therapy to shift the locus from external to internal. Individual, group or family

¹⁰ California Medical Association (Prescribing Opioids: Care amid Controversy March 2014)

psychotherapy may be extremely helpful for addressing this and other psychological issues, depending on the specific needs of a patient.

In general, psychological interventions may be best suited for patients who express interest in such approaches, who feel anxious or fearful about their condition, or whose personal relationships are suffering as a result of chronic or recurrent pain. Unfortunately, the use of psychological approaches to pain management can be hampered by such barriers as provider time constraints, unsupportive provider reimbursement policies, lack of access to skilled and trained providers, or a lack of awareness on the part of patients and/or physicians about the utility of such approaches for improving pain relief and overall function.

Rehabilitative Approaches

In addition to relieving pain, a range of rehabilitative therapies can improve physical function, alter physiological responses to pain and help reduce fear and anxiety. Treatments used in physical rehabilitation include exercises to improve strength, endurance, and flexibility; gait and posture training; stretching; and education about ergonomics and body mechanics. Exercise programs that incorporate Tai Chi, swimming, yoga or core-training may also be useful. Other noninvasive physical treatments for pain include thermotherapy (application of heat), cryotherapy (application of cold), counter-irritation and electroanalgesia (e.g., transcutaneous electrical stimulation). Other types of rehabilitative therapies, such as occupational and social therapies, may be valuable for selected patients.

Complementary and Alternative Therapies

Complementary and alternative therapies (CAT) of various types are used by many patients in pain, both at home and in comprehensive pain clinics, hospitals or other facilities.²⁷ These therapies seek to reduce pain, induce relaxation and enhance a sense of control over the pain or the underlying disease. Meditation, acupuncture, relaxation, imagery, biofeedback and hypnosis are some of the therapies shown to be potentially helpful to some patients. CAT therapies can be combined with other pain treatment modalities and generally have few, if any, risks or attendant adverse effects. Such therapies can be an important and effective component of an integrated program of pain management.

Interventional Approaches

Although beyond the scope of this paper, a wide range of surgical and other interventional approaches to pain management exist, including trigger point injections, epidural injections, facet blocks, spinal cord stimulators, laminectomy, spinal fusion, deep brain implants and neuro-augmentative or neuroablative surgeries. Many of these approaches involve some significant risks, which must be weighed carefully against the potential benefits of the therapy.

Pharmacotherapy

Many types of medications can be used to alleviate pain, some that act directly on pain signals or receptors, and others that contribute indirectly to either reduce pain or improve function. For patients with persistent pain, medications may be used concurrently in an effort to target various aspects of the pain experience.

NSAIDs and Acetaminophen

Non-steroidal anti-inflammatory drugs (NSAIDs), which include aspirin and other salicylic acid derivatives, and acetaminophen, are categorized as non-opioid pain relievers. They are used in the management of both acute and chronic pain such as that arising from injury, arthritis, dental procedures, swelling or surgical procedures. Although they are weaker analgesics than opioids, acetaminophen and NSAIDs do not produce tolerance, physical dependence or addiction. Acetaminophen and NSAIDs are also frequently added to an opioid regimen for their opioid-sparing effect. Since non-opioids and opioids relieve pain via different mechanisms, combination therapy can provide improved relief with fewer side effects.

These agents are not without risk, however. Adverse effects of NSAIDs as a class include gastrointestinal problems (e.g., stomach upset, ulcers, perforation, bleeding, liver dysfunction), bleeding (i.e., antiplatelet effects), kidney dysfunction, hypersensitivity reactions and cardiovascular concerns, particularly in the elderly. The threshold dose for acetaminophen liver toxicity has not been established, although the FDA recommends that the total adult daily dose should not exceed 4,000 mg in patients without liver disease (although the ceiling may be lower for older adults).

In 2009, the FDA required manufacturers of products containing acetaminophen to revise their product labeling to include warnings of the risk of severe liver damage associated with its use. In 2014, new FDA rules went into effect that set a maximum limit of 325 mg of acetaminophen in prescription combination products (e.g. Vicodin and Percocet) in an attempt to limit liver damage and other ill effects from the use of these products. Of note, aspirin (> 325 mg/d), ibuprofen, ketoprofen, naproxen and other non-cyclooxygenase-selective NSAIDs, are listed as “potentially inappropriate medications” for use in older adults in the American Geriatrics Society 2012 Beers Criteria because of the range of adverse effects they can have at higher doses.

Nonetheless, with careful monitoring, and in selected patients, NSAIDs and acetaminophen can be safe and effective for long-term management of persistent pain.

Opioids

Opioids can be effective pain relievers because, at a molecular level, they resemble compounds, such as endorphins, which are produced naturally in the human central nervous system. Opioid analgesics work by binding to one or more of the three major types of opioid receptors in the brain and body: mu, kappa and delta receptors. The

most common opioid pain medications are called “mu agonists” because they bind to and activate mu opioid receptors. The binding of mu agonist opioids to receptors in various body regions results in both therapeutic effects (such as pain relief) and side effects (such as constipation).

Physical tolerance develops for some effects of opioids, but not others. For example, tolerance develops to respiratory suppressant effects within 5-7 days of continuous use, whereas tolerance to constipating effects is unlikely to occur. Tolerance to analgesia may develop early, requiring an escalation of dose, but tolerance may lessen once an effective dose is identified and administered regularly, as long as the associated pathology or condition remains stable.

Opioids, as a class, comprise many specific agents available in a wide range of formulations and routes of administration. Short-acting, orally-administered opioids typically have rapid onset of action (10-60 minutes) and a relatively short duration of action (2-4 hours). They are typically used for acute or intermittent pain, or breakthrough pain that occurs against a background of persistent low-level pain. Extended-release/long-acting (ER/LA) opioids have a relatively slow onset of action (typically between 30 and 90 minutes) and a relatively long duration of action (4 to 72 hours). The FDA states that such drugs are “indicated for the management of pain severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate.”

These agents achieve their extended activity in various ways. Some have intrinsic pharmacokinetic properties that make their effects more enduring than short-acting opioids, while others are modified to slow their absorption or to slow the release of the active ingredient. A given patient might be appropriate for ER/LA therapy only, short-acting only or a combination of an ER/LA opioid with a short-acting opioid. Note that patients may respond in very different ways to any given medication or combination of medications. One size does not fit all, and treatment is best optimized by titrating a given regimen on an individual basis. Combination products that join an opioid with a non-opioid analgesic entail the risk of increasing adverse effects from the non-opioid co-analgesic as doses are escalated, even if an increase of the opioid dose is appropriate.

In response to concerns about opioid misuse and abuse, abuse-deterrent and tamper-resistant opioid formulations have been developed. One class of deterrent formulation incorporates an opioid antagonist into a separate compartment within a capsule; crushing the capsule releases the antagonist and neutralizes the opioid effect. Another strategy is to modify the physical structure of tablets or incorporate compounds that make it difficult or impossible to liquefy, concentrate, or otherwise transform the tablets. Although abuse-deterrent opioid formulations do not prevent users from simply consuming too much of a medication, they may help reduce the public health burden of prescription opioid abuse.

Patients who receive opioids on a long-term basis to treat pain are considered to be receiving chronic opioid analgesic therapy, which is differentiated from opioid use by

patients who have an established opioid use disorder who use an opioid (e.g. methadone) as part of their treatment program.

Potential Adverse Effects of Opioids

Although opioid analgesics (of all formulations) may provide effective relief from moderate-to-severe pain, they also entail the following significant risks:

- Overdose
- Misuse and diversion
- Addiction
- Physical dependence and tolerance
- Potentially grave interactions with other medications or substances
- Death

At the heart of much of the current controversy over the use of opioid analgesics for chronic pain are beliefs about the degree to which these pain medications are potentially addicting. Unfortunately, it is difficult to quantify the degree of addictive risk associated with opioid analgesics, either for an individual patient or the population of pain patients in general.

In this context, it is critical to differentiate addiction from tolerance and physical dependence which are common physiological responses to a wide range of medications and even to widely-consumed non-prescription drugs (e.g. caffeine). Physical dependence and tolerance alone are not synonymous with addiction. Addiction is a complex disease state that severely impairs health and overall functioning. Opioid analgesics may, indeed, be addicting, but they share this potential with a wide range of other drugs such as sedatives, alcohol, tobacco, stimulants and anti-anxiety medications.

Rigorous, long-term studies of both the potential effectiveness and potential addictive risks of opioid analgesics for patients who do not have co-existing substance-use disorders have not been conducted. The few surveys conducted in community practice settings estimate rates of prescription opioid abuse of between 4% to 26%. A 2011 study of a random sample of 705 patients undergoing long-term opioid therapy for non-cancer pain found a lifetime prevalence rate of opioid-use disorder of 35%.⁴¹ The variability in results reflect differences in opioid treatment duration, the short-term nature of most studies and disparate study populations and measures used to assess abuse or addiction. Although precise quantification of the risks of abuse and addiction among patients prescribed opioids is not currently possible, the risks are large enough to underscore the importance of stratifying patients by risk and providing proper monitoring and screening when using opioid analgesic therapy.

Particular caution should be exercised when prescribing opioids to patients with conditions that may be complicated by adverse effects from opioids, including chronic obstructive pulmonary disease (COPD), congestive heart failure, sleep apnea, current

or past alcohol or substance misuse, mental illness, advanced age or patients with a history of kidney or liver dysfunction.

In addition, opioids generally should not be combined with other respiratory depressants, such as alcohol or sedative-hypnotics (benzodiazepines or barbiturates) unless these agents have been demonstrated to provide important clinical benefits, since unexpected opioid fatalities can occur in these combination situations at relatively low opioid doses.

In addition to the potential risks just described, opioids may induce a wide range of side effects including respiratory depression, sedation, mental clouding or confusion, hypogonadism, nausea, vomiting, constipation, itching and urinary retention. With the exception of constipation and hypogonadism, many of these side effects tend to diminish with time. Constipation requires prophylaxis that is prescribed at the time of treatment initiation and modified as needed in response to frequent monitoring. With the exception of constipation, uncomfortable or unpleasant side effects may potentially be reduced by switching to another opioid or route of administration (such side effects may also be alleviated with adjunctive medications). Although constipation is rarely a limiting side effect, other side effects may be intolerable. Because it is impossible to predict which side effects a patient may experience, it is appropriate to inquire about them on a regular basis.

Patients should be fully informed about the risk of respiratory depression with opioids, signs of respiratory depression and about steps to take in an emergency. Patients and their caregivers should be counseled to immediately call 911 or an emergency service if they observe any of these warning signs.

As of January 2014, a California physician may issue standing orders for the distribution of an opioid antagonist to a person at risk of an opioid-related overdose or to a family member, friend, or other person in a position to assist a person at risk of an opioid-related overdose. A physician may also issue a standing order for the administration of an opioid antagonist to a person at risk of an opioid-related overdose to a family member, friend, or other person in a position to assist a person experiencing or reasonably suspected of experiencing an opioid overdose.

The potential of adverse effects and the lack of data about the addictive risks posed by opioids do not mean these medications should not be used. Common clinical experience and extensive literature document that some patients benefit from the use of opioids on a short or long term basis. Existing guidelines from many sources, including physician specialty societies (American Academy of Pain Medicine, The American Pain Society), various states (Washington, Colorado, Utah), other countries (Canada) and federal agencies (Department of Defense, Veterans Administration), reflect this potential clinical utility.

Recommendations from authoritative consensus documents have been summarized in concise, user-friendly formats such as: Responsible Opiate Prescribing: A Clinician's

Guide for the Federation of State Medical Boards; the 2013 Washington State Labor and Industries Guideline for Prescribing Opioids to Treat Pain in Injured Workers; and the Agency Medical Directors' Group 2010 Opioid Dosing Guideline for Chronic Non-Cancer Pain.

Methadone

Particular care must be taken when prescribing methadone. Although known primarily as a drug used to help patients recovering from heroin addiction, methadone can be an effective opioid treatment for some pain conditions. Methadone is a focus of current debate because it is frequently involved in unintentional overdose deaths.⁴⁴ These deaths have escalated as methadone has increasingly been used to treat chronic pain.

Methadone must be prescribed even more cautiously than other opioids and with full knowledge of its highly variable pharmacokinetics and pharmacodynamics. Of critical importance is the fact that methadone's analgesic half-life is much shorter than its elimination half-life. This can lead to an accumulation of the drug in the body. In addition, methadone is metabolized by a different group of liver enzymes than most other opioids, which can lead to unexpected drug interactions.

When rotating from another opioid to methadone, extreme caution must be used when referring to equianalgesic conversion tables. Consensus recommendations suggest a 75 to 90% decrement in the equianalgesic dose from conventional conversion tables when a switch is made from another opioid to methadone.

Because the risk of overdose is particularly acute with methadone, patients should be educated about these risks and counseled to use methadone exactly as prescribed. They should also be warned about the dangers of mixing unauthorized substances, especially alcohol and other sedatives, with their medication. This should be explicitly stated in any controlled substance agreement that the patient receives, reads and signs before the initiation of treatment (such agreements are discussed in more depth on page 14).

Although uncommon, potentially lethal cardiac arrhythmias can be induced by methadone. The cardiac health of patients who are candidates for methadone should be assessed, with particular attention paid to a history of heart disease or arrhythmias. An initial ECG may be advisable prior to starting methadone, particularly if a patient has a specific cardiac disease or cardiac risk factors or is taking agents that may interact with methadone. In addition, it is important that an ECG be repeated periodically, because QT intervaliv prolongation has been demonstrated to be a function of methadone blood levels and/or in response to a variety of other medications.

Adjuvant Pain Medications

Although opioid medications are powerful pain relievers, in the treatment of neuropathic pain and some other centralized pain disorders such as fibromyalgia, they are of limited effectiveness and are not preferred. Other classes of medications, however, may provide relief for pain types or conditions that do not respond well to opioids. Some of these adjuvant medications exert a direct analgesic effect mediated by non-opioid receptors centrally or peripherally. Others have no direct analgesic qualities but may provide pain relief indirectly via central or peripheral affects.

Commonly-used non-opioid adjuvant analgesics include antiepileptic drugs (AEDs), tricyclic antidepressants (TCAs) and local anesthetics (LAs). AEDs, such as gabapentin and pregabalin, are used to treat neuropathic pain, especially shooting, stabbing or knife-like pain from peripheral nerve syndromes. TCAs and some newer types of antidepressants may be valuable in treating a variety of types of chronic and neuropathic pain, including post-herpetic neuralgia and diabetic neuropathy. LAs are used to manage both acute and chronic pain. Topical application provides localized analgesia for painful procedures or conditions with minimal systemic absorption or side effects. Topical LAs are also used to treat neuropathic pain. Epidural blocks with LAs, with or without opioids, play an important role in managing postoperative and obstetrical pain.

Appendix 4¹¹

Date _____

Patient Name _____

OPIOID RISK TOOL

		Mark each box that applies	Item Score If Female	Item Score If Male
1. Family History of Substance Abuse	Alcohol	[]	1	3
	Illegal Drugs	[]	2	3
	Prescription Drugs	[]	4	4
2. Personal History of Substance Abuse	Alcohol	[]	3	3
	Illegal Drugs	[]	4	4
	Prescription Drugs	[]	5	5
3. Age (Mark box if 16 –45)		[]	1	1
4. History of Preadolescent Sexual Abuse		[]	3	0
5. Psychological Disease	Attention Deficit Disorder	[]	2	2
	Obsessive Compulsive Disorder			
	Bipolar Schizophrenia			
	Depression	[]	1	1
TOTAL		[]		
Total Score Risk Category	Low Risk 0 – 3	Moderate Risk 4 – 7	High Risk \geq 8	

¹¹ Interagency Guideline on Opioid Dosing for Chronic Non-cancer Pain: An educational aid to improve care and safety with opioid therapy (Washington State Agency Medical Directors' Group)

Appendix 5¹²

CAGE-AID Questionnaire

Patient Name _____ Date of Visit _____

When thinking about drug use, include illegal drug use and the use of prescription drug other than prescribed.

Questions:	YES	NO
1. Have you ever felt that you ought to cut down on your drinking or drug use?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have people annoyed you by criticizing your drinking or drug use?	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever felt bad or guilty about your drinking or drug use?	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?	<input type="checkbox"/>	<input type="checkbox"/>

Scoring

Regard one or more positive responses to the CAGE-AID as a positive screen.

Psychometric Properties

The CAGE-AID exhibited:	Sensitivity	Specificity
One or more Yes responses	0.79	0.77
Two or more Yes responses	0.70	0.85

(Brown 1995)

¹² Interagency Guideline on Opioid Dosing for Chronic Non-cancer Pain: An educational aid to improve care and safety with opioid therapy (Washington State Agency Medical Directors' Group)

Appendix 6

PHQ-9 — Nine Symptom Checklist

Patient Name _____ Date _____

1. Over the last 2 weeks, how often have you been bothered by any of the following problems? Read each item carefully, and circle your response.
 - a. Little interest or pleasure in doing things
Not at all Several days More than half the days Nearly every day
 - b. Feeling down, depressed, or hopeless
Not at all Several days More than half the days Nearly every day
 - c. Trouble falling asleep, staying asleep, or sleeping too much
Not at all Several days More than half the days Nearly every day
 - d. Feeling tired or having little energy
Not at all Several days More than half the days Nearly every day
 - e. Poor appetite or overeating
Not at all Several days More than half the days Nearly every day
 - f. Feeling bad about yourself, feeling that you are a failure, or feeling that you have let yourself or your family down
Not at all Several days More than half the days Nearly every day
 - g. Trouble concentrating on things such as reading the newspaper or watching television
Not at all Several days More than half the days Nearly every day
 - h. Moving or speaking so slowly that other people could have noticed. Or being so fidgety or restless that you have been moving around a lot more than usual
Not at all Several days More than half the days Nearly every day
 - i. Thinking that you would be better off dead or that you want to hurt yourself in some way
Not at all Several days More than half the days Nearly every day

2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?
Not Difficult at All Somewhat Difficult Very Difficult Extremely Difficult

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PHQ-9 — Scoring Tally Sheet

Patient Name _____ Date _____

1. Over the last 2 weeks, how often have you been bothered by any of the following problems? Read each item carefully, and circle your response.

	Not at all 0	Several days 1	More than half the days 2	Nearly every day 3
a. Little interest or pleasure in doing things				
b. Feeling down, depressed, or hopeless				
c. Trouble falling asleep, staying asleep, or sleeping too much				
d. Feeling tired or having little energy				
e. Poor appetite or overeating				
f. Feeling bad about yourself, feeling that you are a failure, or feeling that you have let yourself or your family down				
g. Trouble concentrating on things such as reading the newspaper or watching television				
h. Moving or speaking so slowly that other people could have noticed. Or being so fidgety or restless that you have been moving around a lot more than usual				
i. Thinking that you would be better off dead or that you want to hurt yourself in some way				
Totals				

2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not Difficult At All 0	Somewhat Difficult 1	Very Difficult 2	Extremely Difficult 3

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How to Score PHQ-9

Scoring Method For Diagnosis

Major Depressive Syndrome is suggested if:

- Of the 9 items, 5 or more are circled as at least "More than half the days"
- Either item 1a or 1b is positive, that is, at least "More than half the days"

Minor Depressive Syndrome is suggested if:

- Of the 9 items, b, c, or d are circled as at least "More than half the days"
- Either item 1a or 1b is positive, that is, at least "More than half the days"

Scoring Method For Planning And Monitoring Treatment

Question One

- To score the first question, tally each response by the number value of each response:
Not at all = 0
Several days = 1
More than half the days = 2
Nearly every day = 3
- Add the numbers together to total the score.
- Interpret the score by using the guide listed below:

Score	Action
≤4	The score suggests the patient may not need depression treatment.
> 5-14	Physician uses clinical judgment about treatment, based on patient's duration of symptoms and functional impairment.
≥15	Warrants treatment for depression, using antidepressant, psychotherapy and/or a combination of treatment

Question Two

In question two the patient responses can be one of four: not difficult at all, somewhat difficult, very difficult, extremely difficult. The last two responses suggest that the patient's functionality is impaired. After treatment begins, the functional status is again measured to see if the patient is improving.

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How to Score PHQ-9

Appendix 7

Older Adults¹³

The prevalence of pain among older adults has been estimated between 25% and 50%. The prevalence of pain in nursing homes is even higher. Unfortunately, managing pain in older adults is challenging due to: underreporting of symptoms; presence of multiple medical conditions; polypharmacy; declines in liver and kidney function; problems with communication, mobility and safety; and cognitive and functional decline in general.

Acetaminophen is considered the drug of choice for mild-to-moderate pain in older adults because it lacks the gastrointestinal, bleeding, renal toxicities, and cognitive side-effects that have been observed with NSAIDs in older adults (although acetaminophen may pose a risk of liver damage). Opioids must be used with particular caution and clinicians should “start low, go slow” with initial doses and subsequent titration. Clinicians should consult the American Geriatrics Society Updated Beers Criteria for Potentially Inappropriate Medication Use in Older Adults for further information on the many medications that may not be recommended.

The various challenges of pain management in older adults, only sketched here, suggest that early referral and/or consultation with geriatric specialists or pain specialists may be advisable.

¹³ California Medical Association (Prescribing Opioids: Care amid Controversy March 2014)

Appendix 8

Pediatric Patients¹⁴

Children of all ages deserve compassionate and effective pain treatment. In fact, due to their more robust inflammatory response and immature central inhibitory influences, infants and young children actually may experience greater pain sensations and pain-related distress than adults. Effective pain management in the pediatric population is critical since children and adolescents experience a variety of acute and chronic pain conditions associated with common childhood illnesses and injuries, as well as some painful chronic diseases that typically emerge in childhood such as sickle cell anemia and cystic fibrosis.

The same basic principles of appropriate pain management for adults apply to children and teens, which means that opioids have a place in the treatment armamentarium. Developmental differences, however, can make opioid dosing challenging, especially in the first several months of life. In the first week of a newborn's life, for example, the elimination half-life of morphine is more than twice as long as that in older children and adults, as a result of delayed clearance. For older children, dosing must be adjusted for body weight.

Although a thorough discussion of this topic is not possible in this document, the following are summary recommendations for pain management in children and teens from the American Pain Society and the American Academy of Pediatrics:

- Provide a calm environment for procedures that reduce distress-producing stimulation;
- Use age-appropriate pain assessment tools and techniques;
- Anticipate predictable painful experiences, intervene and monitor accordingly;
- Use a multimodal approach (pharmacologic, cognitive, behavioral and physical) to pain management and use a multidisciplinary approach when possible;
- Involve families and tailor interventions to the individual child; and
- Advocate for the effective use of pain medication for children to ensure compassionate and competent management of their pain.

¹⁴ California Medical Association (Prescribing Opioids: Care amid Controversy March 2014)

Appendix 9¹⁵

Initiating Treatment with Opioids

Oral administration, especially for the treatment of chronic pain, is generally preferred because it is convenient, flexible and associated with stable drug levels. Intravenous administration provides rapid pain relief and, along with rectal, sublingual and subcutaneous administration, may be useful in patients who cannot take medications by mouth. Continuous infusions produce consistent drug blood levels but are expensive, require frequent professional monitoring and may limit patient mobility.

Transdermal administration is a convenient alternate means of continuous drug delivery that does not involve needles or pumps. Patient-controlled analgesia (PCA) allows patients to self-administer pain medications and may be useful if analgesia is required for 12 hours or more and mobility is not required. Intrathecal delivery of opioids is a viable option for patients with chronic pain who have not responded to other treatment options, or for whom the required doses result in unacceptable side-effects. Patients with intrathecal delivery systems typically require ongoing ambulatory monitoring and supportive care.

Patients on a steady dose of an opioid medication may experience pain that breaks through the analgesic effects of the steady-state drug. Paper or electronic pain diaries may help patients track these breakthrough episodes and spot correlations between the episodes and variables in their lives. A short-acting opioid is typically prescribed for treatment by patients with breakthrough pain.

Monitoring and Ongoing Assessment

“Opioid rotation,” the switching from one opioid to another in order to better balance analgesia and side effects, may be used if pain relief is inadequate, if side effects are bothersome or unacceptable, or if an alternative route of administration is suggested. Opioid rotation must be done with great care, particularly when converting from an immediate-release formulation to an ER/LA product. Equianalgesic charts, conversion tables and calculators must be used cautiously with titration and appropriate monitoring. Patients may exhibit incomplete cross-tolerance to different types of opioids because of differences in the receptors or receptor sub-types to which different opioids bind, hence clinicians may want to use initially lower-than-normal doses of the switched-to opioid.

Although there is no widely-agreed-upon dose of opioids that constitute an absolute “red flag” for prescriber concern that opioid therapy may not be working, doses above 100 mg daily of morphine or morphine equivalence have been suggested as worthy of clinician concern because the risk of overdose or adverse effects often rises with doses above this level. This suggestion is controversial, however. The FDA, in responding to a

¹⁵ California Medical Association (Prescribing Opioids: Care amid Controversy March 2014)

petition by Physicians for Responsible Opioid Prescribing, in 2012, rejected a request for a 100 mg morphine equivalent dose (MED) daily limit on opioids, citing weaknesses in the various studies offered in support of the proposal.

Referral to an appropriate specialist should be considered when higher doses are considered. There is no absolutely safe ceiling dose of opioids, however, and caution and monitoring are appropriate for applications of these medications. Opioid therapy must be re-evaluated whenever the risk of therapy is deemed to outweigh the benefits being provided.

Appendix 10

LINKS TO COUNTY ADDICTION REFERRAL RESOURCES (*under construction*)

Dial 2-1-1 to connect with community services near you - child care, senior services, counseling, food, shelter, job services, and much more. The service is available in most counties.

Counties With 211 Service are linked below.

1. [Alameda](#) - [Program information](#)
2. Alpine
3. Amador
4. Butte
5. Calaveras
6. Colusa
7. [Contra Costa](#)
8. Del Norte
9. El Dorado
10. [Fresno](#)
11. Glenn
12. Humboldt
13. Imperial
14. Inyo
15. [Kern](#)
16. [Kings](#)
17. Lake
18. Lassen
19. Madera
20. [Los Angeles](#)
21. [Marin](#)
22. Mariposa
23. [Mendocino](#)
24. Merced
25. Modoc
26. Mono
27. [Monterey](#)
28. [Napa](#)
29. [Nevada](#)
30. [Orange](#)
31. Placer
32. Plumas
33. [Riverside](#)
34. [Sacramento](#)
35. San Benito
36. [San Bernardino](#)
37. [San Diego](#)
38. [San Francisco](#)
39. San Joaquin
40. [San Luis Obispo](#)
41. [San Mateo](#)
42. [Santa Barbara](#)
43. [Santa Clara](#)
44. [Santa Cruz](#)
45. [Shasta](#)
46. Sierra
47. Siskiyou
48. [Solano](#)
49. [Sonoma](#)
50. [Stanislaus](#)
51. Sutter
52. Tehama
53. Trinity
54. [Tulare](#)
55. Tuolumne
56. [Ventura](#)
57. Yolo
58. Yuba