ASSESSMENT

> Evaluate the original tissue injury and determine nociceptive, neuropathic, or central characteristics of the pain perception, document baseline pain and function¹.

> Assess the risk of prescribing opioids to a patient through your clinic’s chosen assessment tool².

> Were prior attempts made to treat this pain with non-opioid modalities?

> Query CURES prior to assuming prescribing and periodically thereafter, but no less than twice a year.

NON-OPIOID OPTIONS

Create a plan of treatment with the patient that incorporates non-opioid interventions:

> Patient lifestyle plan: Nutrition, exercise, restorative sleep, supplements

> Behavioral therapies: cognitive behavioral therapy, peer support, mindfulness training, psychotherapy, biofeedback, and case management

> Physiotherapy modalities: OT, PT, passive modalities, walking, acupuncture, chiropractic manipulation

> Medical interventions: Pharmacological, procedural, surgical

OPIOID TREATMENT

Is the diagnosis appropriate for opioid treatment? (There is minimal evidence of benefit in chronic lower back pain, headaches, or fibromyalgia):

> Discuss the risk³ vs. benefit of opioids and document that discussion occurred.

> Create a care plan that includes functional goals and criteria for stopping opioids.

> Perform urine drug screen prior to prescribing.

> Avoid prescribing at initial visit. If presenting on opioid therapy (legacy patient), consider prescribing only enough to last until the next visit (Ideally < 7 Days) while assessing for opioid failure.

> Ensure patients have a Naloxone rescue kit.

REASSESS FOR OPIOID FAILURE

AT EACH Rx REFILL:

Do the risks outweigh the benefits of opioid use?

> Are there life-threatening or unmanageable adverse effects?²

> Is there evidence of diversion or inappropriate use?

> Has general function failed to improve?

> Has therapy failed to meet pain goals?

> Has an adequate dose and length of opioid therapy been attempted? (50 mg ME (medical equivalence)/day for more than 45 days)

OPIOID FAILURE MANAGEMENT

> Transition to Medication-Assisted Treatment (MAT) such as methadone clinic or suboxone.

> Encourage Behavioral Health support.

> Offer resources for alternative therapies for pain (see non-opioid options).

> Seek consultation, pain management, or addiction services as needed.

AT EVERY VISIT

Evaluate progress toward functional goals. Strongly consider tapering in the absence of functional improvement on opioids.

> Screen for appropriate medication use

> Assess for negative health consequences of chronic opioid therapy³

> Periodic assessment (no less than twice a year):

  o Urine drug screen (UDS)

  o CURES (www.cures.doj.ca.gov)

CARE

> Initiate opioid tapering⁴.

Footnotes:

¹ For ex: PEG scale—see tools column on reverse

² Personal or family history of SUD or OD, mental health conditions, respiratory conditions or sleep-disordered breathing, concurrent benzodiazepine use, pregnancy, >65 years of age, renal/hepatic insufficiency

³ Addiction, overdose, sleep apnea, benzodiazepine use, depression, decreased bone density, low testosterone, hyperalgesia, tolerance

⁴ See tapering flowchart on reverse

Adapted with permission from Oregon Pain Guidance
Acute Pain Management

Patient presents after an acute injury (trauma, surgical procedure):

> Determine your expected recovery time based on clinical evaluation, literature, your experience, and the patient’s general condition.
> Educate the patient regarding expectations for healing, duration and intensity of pain.

CAUTION

Basic principle: For longer-acting drugs, less stable patient, use a faster taper.

1. Frame the conversation around tapering as a safety issue.
2. Determine the rate of taper based on the degree of risk.
3. If multiple drugs are involved, taper one at a time (e.g., start with opioids, follow with short-acting drugs).
4. Set a date to begin and set a reasonable time for completion. Provide information to the patient and document in the chart note.

NON-OPIOID OPTIONS

Create a plan that incorporates non-opioid interventions:

> Initial rest followed by graded exercise of the affected body area
> Include pain-reducing modalities such as immobilization, heat/cold, and elevation
> OTC medications including doses and duration

OSTHOPID TREATMENT

> If considering opioids, first ask about risks for opioid misuse: previous history of substance use disorder (SUD), overdose history, suicidality, alcohol use, and benzodiazepine use.
> Perform CURES query. (www.cures.doj.ca.gov)
> If opioids are contraindicated, clearly state to the patient and document in the chart note that the risks of treatment overshadow the benefits. Stress other modalities of pain modification.
> If prescribing opioids, use the lowest possible dose for the shortest amount of time (no more than 3-7 days). Most acute painful situations will resolve in 3-7 days.

STOP AND REASSESS

Should the patient request additional opioids, consider having the patient return for a re-evaluation. At follow-up, you or your staff should:

> Be sure there are no unforeseen complications requiring further testing or treatment. Evaluate for worsening injury.
> Be sure there is no evidence of substance use complicating treatment. Consider a urine drug screen (UDS)
> Only prescribe additional opioids if you feel it is clinically appropriate. Otherwise, continue to reinforce non-opioid modalities of pain control

Chronic Opioid Use: Tapering

START HERE

Consider opioid taper for patients with opioid MED >90 mg/d or methadone > 30 mg/d, serious opioid adverse effects, not taking medications as prescribed, and lack of improvement in pain and function. MED >120 STRONGLY recommend taper.

1. Frame the conversation around tapering as a safety issue.
2. Determine the rate of taper based on the degree of risk.
3. If multiple drugs are involved, taper one at a time (e.g., start with opioids, follow with short-acting drugs).
4. Set a date to begin and set a reasonable time for completion. Provide information to the patient and document in the chart note.

OPIOID TAPER

Basic principle: For longer-acting drugs and a more stable patient, use a slower taper. For shorter-acting drugs, less stable patient, use a faster taper.

1. Use an MED calculator to help plan your tapering strategy. Methadone MED calculations increase exponentially as the dose increases, so methadone tapering is generally a slow process.
2. Long-acting opioids: Decrease the total daily dose by 5-10% of initial dose per week.
   Short-acting opioids: Decrease the total daily dose by 5-15% per week.
3. See the patient frequently during the process and stress behavioral supports. Consider a Urine Drug Screen and CURES query to help determine adherence.
4. After 1/4 to 1/2 of the dose has been reached, consider slowing taper.
5. Consider adjuvant medications: antidepressants, gabapentin, NSAIDs, clonidine, anti-nausea, anti-diarrhea agents (see tool column for dosage).

Tools

Assessing Pain & Function Using PEG Scale

PEG score = average 3 individual question scores

Q1: What number from 0-10 best describes your pain in the past week?
0 = “no pain”, 10 = “worst you can imagine”
Q2: What number from 0-10 describes how, during the past week, pain has interfered with your enjoyment of life?
0 = “not at all”, 10 = “complete interference”
Q3: What number from 0-10 describes how, during the past week, pain has interfered with your general activity?
0 = “not at all”, 10 = “complete interference”

Morphine Equivalent Per Day (MED) for Selected Opioids

<table>
<thead>
<tr>
<th>Opioid</th>
<th>Approx. Equianalgesic Dose (oral and transdermal)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morphine</td>
<td>30mg</td>
</tr>
<tr>
<td>Codeine</td>
<td>200mg</td>
</tr>
<tr>
<td>Fentanyl transdermal</td>
<td>12.5mcg/hr</td>
</tr>
<tr>
<td>Hydrocodone</td>
<td>30mg</td>
</tr>
<tr>
<td>Hydromorphone</td>
<td>7.5mg</td>
</tr>
<tr>
<td>Methadone Chronic</td>
<td>4mg</td>
</tr>
<tr>
<td>Oxycodone</td>
<td>20mg</td>
</tr>
<tr>
<td>Tramadol</td>
<td>300mg</td>
</tr>
</tbody>
</table>

MED Calculator: www.agencymeddirectors.wa.gov/Calculator/DoseCalculator.htm

Acute Withdrawal or Anticipated Withdrawal as Part of a Planned Taper

Clonidine 0.1mg QID x anticipated length of withdrawal. (Check BP and watch for hypotension.)

Diarrhea: Loperamide 4mg then 2mg QID. May have opioid effects at high doses. Alternatively, consider Hyoscyamine 0.125mg q 4-6 hrs PRN

Myalgias: Ibuprofen 400mg po QID or Acetaminophen 325mg po q6hrs

Anxiety: Gabapentin Escalating Dose to 1200mg/day. Start loading one month prior to planned taper. Clonidine 0.1mg QID x anticipated length of withdrawal. (Check BP and watch for hypotension.) Hydroxyzine 25mg po TID

Insomnia: Trazodone 50-100mg po QHS

Nausea: Ondansetron 8mg po BID x anticipated length of withdrawal.

Additional Resources

Health Improvement Partnership: hipscc.org
Central California Alliance for Health: ccah-alliance.org

SafeRx Santa Cruz County

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