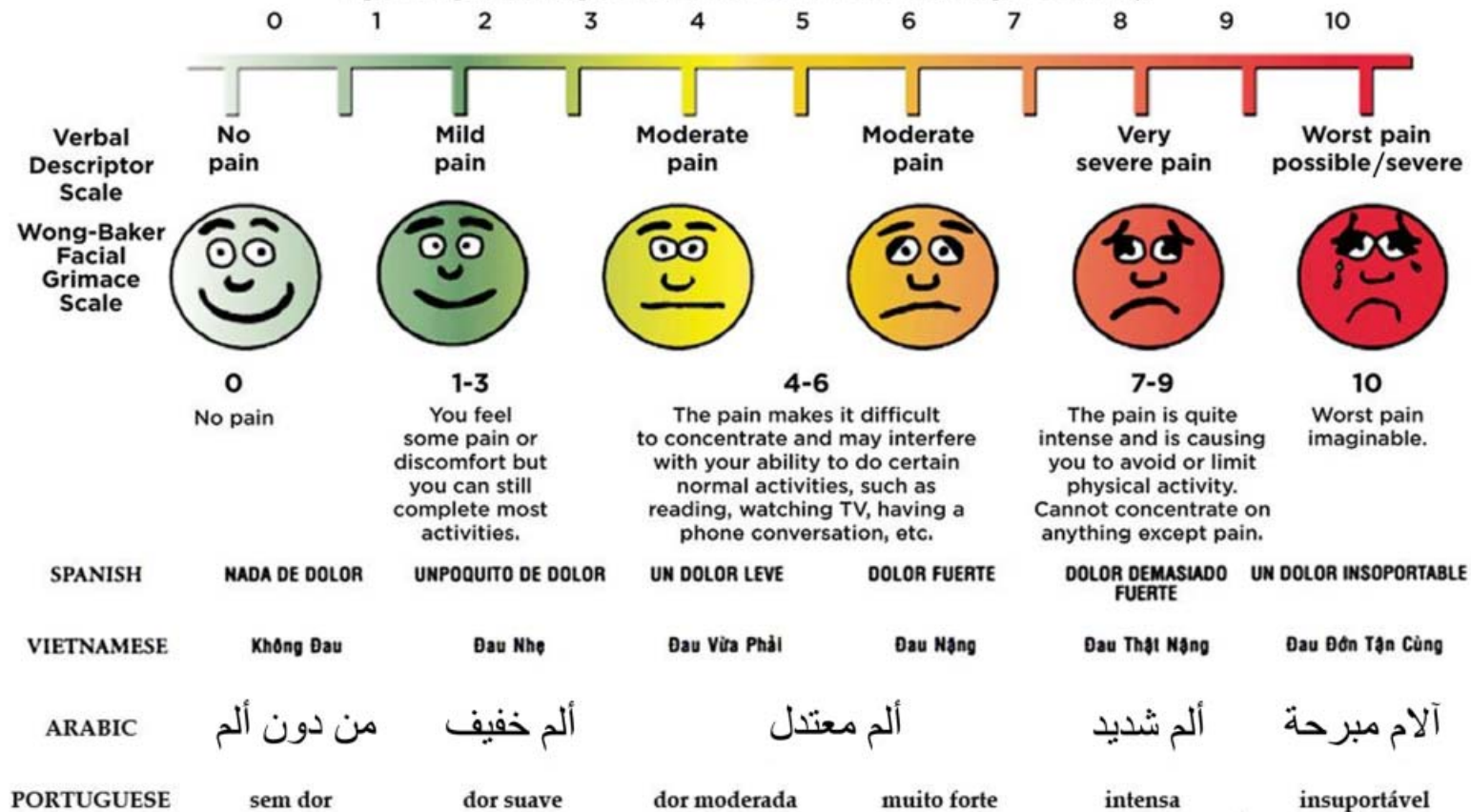


Pain Scale

- Patients with or at risk for substance use disorders, may have real pain that requires treatment
- Evaluation with a standardized tool can help convey a patient's experience of pain – such tools are subjective
- Pain derives from severity of pathology, emotional state and personal experience/ ability to cope with pain
- Additional questions should be asked to assess the impact of the pain and the effectiveness of the current pain management plan

UNIVERSAL PAIN ASSESSMENT TOOL

This pain assessment tool is intended to help patient care providers assess pain according to individual patient needs. Explain and use 0-10 Scale for patient self-assessment. Use the faces or behavioral observations to interpret expressed pain when patient cannot communicate his/her pain intensity.



Chronic Pain and MRI Findings

- Chronic pain refers to pain lasting more than 3 months
 - Does not include active cancer treatment, palliative care, or end-of-life care
- Disk protrusions and DJD changes are non-specific findings that are common in asymptomatic patients.
- Findings that would warrant more significant consideration include:
 - narrowing of foramina
 - thecal sac impingement
 - compromise of neural structures
- Look for well-documented objective evidence of disease prior to planning prescription treatment



2016 CDC Recommendations

- Use nonpharmacologic therapies (such as exercise and cognitive behavioral therapy) and nonopioid pharmacologic therapies (such as anti-inflammatories) for chronic pain
- Don't use opioids routinely for chronic pain
- When opioids are used, combine them with nonpharmacologic or nonopioid pharmacologic therapy, as appropriate, to provide greater benefits
- When opioids are used, prescribe the lowest possible effective dosage
 - Start with immediate-release opioids instead of extended-release/long-acting opioids
- Only provide the quantity needed for the expected duration of pain.

Prescription Monitoring Program (PMP)

- A PMP is a **statewide** electronic database which collects designated data on substances dispensed in the state.
 - Each state houses their own PMP with the goal of connecting all states
- Prescription monitoring programs collect data on the prescription and dispensation of potentially diverted drugs including opioids
- The PMP may also be accessed by law enforcement for investigative purposes.
- Differ by state, but generally includes:
 - Name
 - DOB
 - Summary of prescriptions (# prescriptions, providers and pharmacies)
 - Details of individual prescriptions

PMP Report

Patient Name: Case 2-Dana Johnson

DOB:

Prescriptions previous 12 months: 3

Prescribers previous 12 months: 1

Pharmacies previous 12 months: 1

Medication Generic [Brand]	Strength	Form	Fill date	Qty/Days supply	Prescriber	Pharmacy
Hydrocodone/acetaminophen (Vicodin)	10/325 mg	Tablet	1 month ago	80/28	YOU	CVS Lincoln St Worcester
Hydrocodone/acetaminophen (Vicodin)	5/325 mg	Tablet	2 months ago	80/28	YOU	CVS Lincoln St Worcester
Hydrocodone/acetaminophen (Vicodin)	5/325 mg	Tablet	9 weeks ago	42/7	YOU	CVS Lincoln St Worcester

The Opioid Risk Tool (ORT) can be administered and scored in less than 1 minute. The ORT helps predict that a patient being treated for chronic pain will exhibit aberrant behavior. The ORT is predictive at 0.82 males and 0.85 females (c.statistic)

Date today's visit

Patient Name Dana Johnson

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 [7]

Total Score Risk Category Low Risk 0 – 3 Moderate Risk 4 – 7 High Risk ≥ 8

Webster LR, Webster R. Predicting aberrant behaviors in Opioid-treated patients: preliminary validation of the Opioid risk tool. Pain Med.

University of Massachusetts Medical School

Communicating with Patients Regarding Planned Discontinuation of Opioids*

It can be difficult to tell a patient that you have decided to discontinue prescribing an opioid medication. It is important to emphasize that your decision is based on your medical opinion and not based on a feeling. Ex:

Good

"Based on my knowledge of your situation and my medical experience I am worried that the risks of these medications to you are greater than the benefits, and I have decided not to prescribe these any longer." (It is critical you be able to list the risks and benefits to support your judgment.)

"I am hearing that these medications help you feel better for the short term. However, I am very concerned these medications are not safe for you for the long term based on _____ (your history of substance misuse, etc) For this reason I am going to stop prescribing them for you."

Bad

"I do not feel comfortable prescribing this medication any longer."

Emotions

Many patients will have a significant emotional response to your decision. These reactions may include conflicting emotions such as: anger, fear, disappointment, betrayal, and/or sadness. It is critical to acknowledge, normalize, and communicate your understanding of these emotions, and convey your compassion and ongoing commitment to your patient. For example: "It is perfectly reasonable for you to be upset about this. Your pain is real and you are understandably afraid and angry. I want to be clear - I still intend to help you manage your pain, however we will need to work together to find treatments other than these medications."

Withdrawal

Any patient who is physiologically dependent on opioids will experience understandable apprehension about the prospect of having this medication discontinued. Patients who have experienced opioid withdrawal in the past may be especially nervous as they anticipate the physical distress of opioid withdrawal. It is important to communicate to these patients that you will provide them with a schedule for gradually tapering their medication. In many cases you will also prescribe other medications to help cope with the withdrawal symptoms or refer them to providers who have particular expertise in this area.

Pain

Patients who have acute or chronic pain will also be concerned about how they will cope with this pain without a prescription opioid. It is important to communicate a plan for managing this pain without opioids at the time opioids are discontinued. Do not be surprised if patients are initially skeptical of alternative treatments.

Diversion

Some patients divert or sell their prescription pain medication. When you stop prescribing opioids this can significantly change their financial circumstances. Patients may find it more difficult to secure safe housing, they may experience more food insecurity, or they may find it is more difficult to attend medical appointments because of unreliable transportation. Many patients will not share with you that they have been selling their medication. Nevertheless, it is important to provide them with an opportunity to share their financial difficulties with you, especially those that impact their health and safety. Whenever possible you should connect them with social services to address these issues.

Continuity

Some patients will decide that they no longer want to receive care from you after you discontinue prescribing an opioid medication. This should not influence your decision to continue or discontinue prescribing. You should emphasize your willingness to continue caring for them as a patient. Patients with chronic pain will need other treatments to manage their pain. Patients with substance use disorders also need ongoing healthcare, whether they chose to address their substance use disorder, or not.

*Reviewed/approved 1.29.2018 by Dan Mullin.

Key Concepts for OSTI

- Opioid use disorder is and should be treated as a chronic illness.
- The opiate epidemic has impacted communities of color for years. The current national focus suggests bias in the healthcare system, policy-makers and media.
- Safe-prescribing does not mean NO prescribing, even for patients in recovery.
- The prescription monitoring program (PMP or MassPAT) provides accurate, up-to-date prescribing information and must be accessed before prescribing
- Co-prescribing naloxone should be considered for any patient on chronic opiates.
- Best practices include risk assessment (including for diversion), informed consent, monitoring, safe storage and disposal counseling.
- Medication assisted treatment/Medications for opioid use disorder with agents such as methadone, buprenorphine or naltrexone can act as a bridge or long-term therapy to assist patients in overcoming opioid use disorders.