INFORMED CONSENT:
• Set goals and expectations (see UMMHC/DFMCH Patient Baseline Chronic Pain Evaluation Questionnaire & Opioid Pain Medication Agreement)
• (one prescriber, one pharmacy, random drug screens, expected intervals between visits, use of pill counts, limits on number of pills dispensed, storage of medication)
• Review potential risks
  • Common side effects (constipation, nausea, sedation)
  • Risk of abuse, addiction, overdose
  • Risk of long term use (hyperalgesia, endocrinologic/sexual dysfunction)
• Review alternative therapies
• Specify in writing both patient and clinician responsibilities (see UMMHC/DFMCH Opioid Pain Medication Agreement)

BE CAUTIOUS IF:
• High risk is identified by risk assessment screens or history
• Presence of constipation, nausea, pulmonary disease, cognitive impairment
• Family or personal history of alcohol or drug abuse
• Younger age (<45)
• Current psychiatric condition

CONSIDER OPIOIDS IF:
• Pain is moderate to severe
• Pain is well defined
• Pain has adverse effect on functioning and/or quality of life
• Not responded to other therapies
• Potential benefits are likely to outweigh risks based on thorough assessment

MANAGEMENT PLAN SHOULD INCLUDE:
• Pain and functional status goals
• Schedule for medication
• Expectations for monitoring and follow up
• Expectations for concomitant therapies
• Indications for tapering or discontinuing (failure to benefit, difficult side effects, serious aberrant drug-related behavior)
• Expectations for modest improvements in pain
• Documentation (see UMMHC/DFMCH Opioid Pain Medication Agreement)
• Guidance to patients to keep medication safe (locking medication safe)
• Guidance to patients on how to dispose of unused opioids
• Periodically update and re-evaluate

PATIENTS DO BETTER WHEN:
• Comprehensive approach used
• Consider functional impairment
• Psychosocial factors considered

ASSESS PATIENT
(see UMMHC/DFMCH Patient Baseline Packet & Clinician Intake forms)

History
• Treatment history
• Psychosocial history
• Family history
• Current legal or worker compensation issues

Physical Exam
• Pain level
• Impact on functioning
• Type of pain-neuropathic, myofascial, nocioceptive

Testing
• Appropriate imaging, nerve conduction and lab tests
• Assess for risk of abuse, misuse, addiction or diversion of opioids (see UMMHC/DFMCH Patient Baseline Chronic Pain Evaluation Questionnaire & Pain Management Intake Forms)
• Screening tools for drug abuse are useful although not definitive

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INITIATING OPIOIDS:
- Consider it a trial to see if use of opioids is appropriate
- Select medication, dose, titration based on patient medical condition and history
- May want to start with short-acting for opioid naïve patients
- Transition to long-acting opioid with around the clock dosing can provide
  - More consistent pain control
  - More adherence
  - Lower risk of abuse/addiction

MONITORING:
- Risk stratify patients for regular appointments and re-evaluation
  - Low risk, 1-2x per year
  - Minimal risk, 4x per year (every 3 months)
  - Higher risk, daily, weekly, monthly as called for
- Closer monitoring required WHEN:
  - History of addiction
  - Occupation requiring mental acuity
  - Older adult
  - Unstable or dysfunctional social environment
  - Comorbid psychiatric or medical conditions

ROUTinely CONSIDER ADDITIONAL INTERVENTIONS
- (see Chronic Pain Resource Sheets for your site)
- Cognitive behavioral therapy, relaxation, biofeedback-refer to UMMHC Dept. Psychiatry pain groups, therapy or patient’s insurance for Behavioral Medicine
- Functional restoration (PT/OT) &/or simulated physical tasks in supervised setting
- Pain education
- Cardiovascular fitness
- Pain clinics or UMMHC Spine Clinic
- Chiropractors, acupuncture
- Osteopathic manipulation therapy

MONITORING REQUIRES:
- Regular, repeat evaluation of pain severity, functioning, review of adverse effects, progress toward therapeutic goals, and review of comorbidity conditions, psychological status etc. (see UMMHC /DFMCH Patient Follow Up Questionnaire & Pain Progress Note)
- Specific monitoring for aberrant drug use highly recommended: urine screens, pill counts, family interviews, prescription monitoring (see UMMHC/DFMCH Pain Progress Note)
- Patient self-report plus careful provider review of issues important
- Abnormal urine screen should take into account range of possible explanations including abuse as well as self-medication for poorly controlled pain, psychological issues, diversion [absence of medication]
- Consider rotating medications to address adverse side effects or inadequate response
- Carefully and independently evaluate breakthrough pain for those on 24-hour medication; consider options other than adding short acting or rapid-release opioids

HIGH RISK PATIENTS:
- Usually have history of drug abuse, psychiatric disorder, or serious aberrant drug-related behaviors
- Can be safely treated only with intensive supervision
- If patient is not high risk, don’t consider all aberrant medication issues as serious, but any presence should institute re-evaluation and closer monitoring
- Continually re-evaluate risk/benefit of treatment refractory patient on high doses of opioids (200 mg daily morphine or equivalent)
- Taper or wean off patients with repeated serious aberrant behaviors.

ANTICIPATE, IDENTIFY, TREAT SIDE EFFECTS:
(see UMMHC/DFMCH Pain Progress Note)
- Constipation: fluid & fiber intake, stool softeners, laxatives
- Nausea or vomiting: antiemetic therapy oral or rectal
- Sedation: counsel patients to avoid driving, working with equipment, and identify interactions with other medications
- Slower reflexes/cognitive impairment: legal proscription for public transportation employees
- Hypogonadism/dehydroepiandroster one sulfate decreases: fatigue, decreases libido, sexual dysfunction
- Pruritus/ myoclonus
- Respiratory depression: with rapid increases in dosage