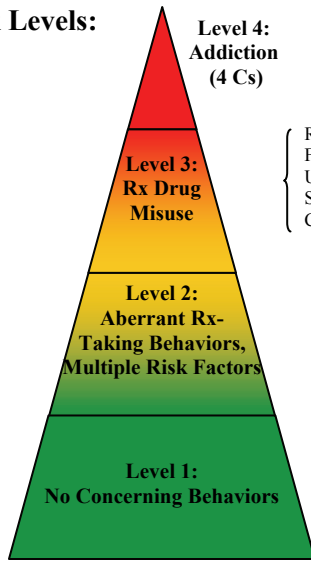


Risk Levels:



**Level 4:
Addiction
(4 Cs)**

- Loss of **C**ontrol
- C**ompulsive use
- C**ontinued use despite harm
- C**raving

**Level 3:
Rx Drug
Misuse**

- Recurrent problems:
- Failure to fulfill major obligations
- Use in hazardous situations
- Substance-related legal problems
- Continued use despite social/interpersonal problems

**Level 2:
Aberrant Rx-
Taking Behaviors,
Multiple Risk Factors**

- Illegal activities
- Missing/lost prescriptions
- Non-adherent with monitoring
- Deterioration in function
- Resistance to change therapy
- Runs out of Rx early
- Requests specific brand
- Requests increased dose
- Non-adherence with other therapies

**Level 1:
No Concerning Behaviors**

- No concerning behaviors (no early refill requests or dose escalation; keeps appts, brings pill bottle; Rx count correct, UDS OK)

Risk Factors for Addiction or Abuse:

- Tobacco dependence
- History of alcohol, cannabis, or cocaine use
- Family history of substance abuse
- Lifetime history of substance use disorder
- History of severe depression or anxiety
- Legal problems

Pre-visit Assessment:

- Obtain records from previous providers
- Check state Prescription Monitoring Program
- Scan available hospital/clinic records

Assessment: 6 As:

Analgesia (P)	What number (0-10) best describes your Pain level on average last week?
Affect (E)	What number (0-10) best describes how, during the past week, pain has interfered with your Enjoyment of life?
Activities (G)	What number (0-10) best describes how, during the past week, pain has interfered with your General activity?
Measure PEG score every visit. Taper meds at 3-6 months if PEG score does not improve.	
Adjuncts	What else have you done to try to reduce/manage your pain (non-opioid meds, exercise, physical therapy, guided imagery, yoga, cognitive behavioral therapy, injections, pumps)?
Adverse Effects	Constipation, nausea, sedation, decreased cognition, loss of control
Aberrant Behaviors	(See Level 2 above)

Not at all 0 1 2 3 4 5 6 7 8 9 10 Extremely

cm



Prescription Opioid Monitoring Framework:

Risk/benefit discussion	Potential benefits: Analgesia, function, quality of life Potential risks: Toxicity/side effects (sedation, constipation), functional impairment (driving, heavy machinery), interactions (alcohol, sedatives), physical dependence, increased pain sensitivity, <u>loss of control/addiction (3-19%), overdose/death</u>	
Explore non-opioid treatment options	Non-opioid analgesics (oral, topical), injections, pumps Exercise/flexibility training Physical therapy	Yoga/meditation/guided imagery Cognitive behavioral therapy Add gabapentin to opioids
Opioid “test/trial”	If appropriate, talk about opioid “test/trial” of 3-6 months.	
Define treatment goals	Work with patient to identify specific, measurable, realistic, functional goals & measure using the PEG. Use these goals jointly to measure benefit. Remind patient that pain is unlikely to go away completely.	
Encourage patient responsibility	Explain legal responsibilities (safeguarding, lockbox, disposing, not sharing or selling). Encourage patient to look out for early signs of harm. (Safe to drive or operate heavy machinery? Trouble controlling the use of meds?)	
Explain opioid monitoring measures including agreement/contract	Why? Patient safety, standard policy with all patients. Universal Precautions are used to protect patient safety: Agreements (1 provider, no early refills) Urine Drug Testing for evidence of: Therapeutic adherence Non-use of illicit drugs Pill Counts Prescription Monitoring Programs Phone Follow-up Agreement/contract is scanned into chart.	Caution with higher opioid doses (OD risk lowest at 1-20 mg/d morphine equivalent, 3.7x higher with 50-99 mg/d, 8.9x higher with >100mg/d). Set level of monitoring to match risk (more visits/monitoring in high-risk patients or those with aberrant behaviors). Consider tapering or switching to buprenorphine or methadone if: PEG shows no benefit at 3-6 months & /or repeated aberrant behaviors Taper Guidelines: emphasize risk/benefit & safety issues, show empathy, taper meds by 10-20% per week, use comfort meds for withdrawal symptoms, continue non-opioid Rx

Guidelines for Discontinuing Opioids:

Differential Diagnoses:	Inadequate analgesia (pseudoaddiction); Addiction; Opioid analgesic tolerance; Self-medication of psychiatric or other physical symptoms (not pain); Criminal intent (diversion).	
Assessment	Assess PEG ; Assess for aberrant behaviors; Check state prescription monitoring program. Discussion with patient: Nonjudgmental, open-ended questions, express concerns, examine for patient flexibility (is the patient focused more on the opioid or pain relief?).	
Balance Risk vs. Benefits	Assess & document benefits and harms. Benefits must outweigh observed or potential harms to continue opioids. Not necessary to prove addiction or diversion to stop opioids.	
Brief Intervention	When pain not responsive to opioids: Treat underlying disease, comorbidities, offer adjuncts. If benefit lacking, STOP opioids (or taper and reassess). When concerned about abuse or addiction: Increase monitoring; switch to buprenorphine/methadone, stop opioids or refer to Tx	
Talking Points	Empathize with patient remaining collaborative and respectful Reiterate lack of benefit with no good fix Focus on patient strengths Encourage other therapies for coping with pain	Commit to continue care without opioids Stress some patient’s pain improves when opioids are stopped Clarify not discharging patient, discontinuing ineffective Tx Taper slowly to prevent withdrawal
Tapering	Decrease by 10-20% per week Allow supply of short-acting meds for “breakthrough” symptoms Schedule close follow-ups	Medications: Treatment—clonidine Comfort—ibuprofen, dicyclomine, antiemetics, muscle relaxants, antidiarrheals, sleep aids
Discontinuation Strategy	Discuss possible addiction: specific feedback on concerns, agree to disagree, risks outweigh benefits, menu of options (detox & opioid-free treatment, buprenorphine, or methadone)	



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