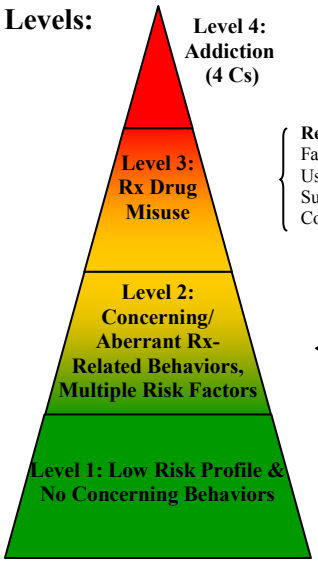
Risk Levels:



Loss of Control
Compulsive use
Continued use despite harm
Craving

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

Spectrum of severity

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

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
Genetic Predisposition

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 & document PEG score every visit. Taper meds at 3-6 months if PEG score does not improve >30%	
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
Concerning/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, **loss of control/ addiction (8-12% Vowles, et al: 2015), overdose/death**
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 NSAIDs/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, measureable, 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** **Personal contact** (friend, family member) **Agreement/contract** is scanned into chart.

Set level of monitoring to match risk (more visits/monitoring in high-risk patients or those with concerning/aberrant behaviors)

Keep opioid dose below 100 MME/day

Prescribe naloxone if opioid dose >50 MME/day

Consider tapering or switching to buprenorphine or methadone if:
Repeated concerning behaviors, <30% improvement in PEG scores at 3-6 months, patient also takes benzo's, signs of substance use disorder, patient experiences overdose or warning signs: confusion, sedation slurred speech

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 Diagnosis:	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 concerning/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: discontinuing ineffective Tx, not discharging the patient Taper slowly to prevent withdrawal
Tapering	Decrease by 10-20% per week Offer psychosocial support Encourage: "You can do this; I'll stick by you" Allow supply of short-acting meds for "breakthrough" symptoms Schedule close follow-ups **Medications:** Treatment-clonidine Comfort-ibuprofen, dicyclomine, antimetics, muscle relaxants, antidiarrheals, sleep aids
Addressing Possible Addiction	Give specific feedback on concerning behaviors, ask for patient feedback, agree to disagree if necessary, when risks outweigh potential benefits offer menu of options: detox & opioid-free treatment, buprenorphine, methadone, or injectable XR naltrexone

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Southeastern Consortium for Substance Abuse Training

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