

# Essentials of Good Pain Care: A Team-Based Approach

Organize your practice to safely manage acute and chronic pain



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How will this module help you and your practice develop a safe approach to treating adults with pain outside of active cancer treatment, palliative care and end-of-life care?

- 1 Six STEPS to improve the safety of acute and chronic pain treatment
- 2 Answers to common questions about treating patients with pain
- 3 Downloadable tools you can use in your office



## Introduction

Pain-related concerns account for up to 20 percent of all outpatient visits in the United States.<sup>1</sup> In 2016, an estimated 6.3 percent of the population was receiving treatment with long-acting opioids, 27 percent of people received at least a one-month supply of opioids. Overall, 66.5 opioid prescriptions were written for every 100 persons.<sup>2</sup> There is no single underlying cause for the current “opioid epidemic”, however driving factors include the illicit activity of pill mills, misuse of opioid analgesics, and a chronic lack of treatment for opioid use disorder (OUD). Drug overdose (particularly from illicit fentanyl and heroin) is now the leading cause of death in people under 50 years of age in the United States.<sup>3</sup> Improving access to overall pain management, access to comprehensive pain care, and judicious prescribing are a few of the solutions to this public health emergency.

### Q&A

#### What is chronic pain?

Chronic pain is defined by the Centers for Disease Control and Prevention (CDC) as pain that lasts for greater than three months or beyond the time of normal tissue healing.<sup>4</sup> Estimates of the overall prevalence of chronic pain vary, but recent data suggest that more than 10 percent of adults in the United States report having daily pain, with higher rates among the elderly.<sup>5</sup>

#### What are the risks of long-term opioid use?

Opioids can have serious adverse effects, including overdose and death. Long-term use of opioids can result in tolerance, dependence, addiction, and OUD. Opioid use during pregnancy can result in poor pregnancy outcomes including fetal anomalies, premature labor, and neonatal opioid withdrawal syndrome. Opioids may reduce the probability of chronic pain resolution.<sup>6</sup>

#### Is there evidence for the benefits of long-term opioid use?

Although more studies are needed, recent evidence suggests that for some patients, discontinuing long-term opioid therapy may actually improve pain, function, and quality of life.<sup>10</sup> Multiple meta-analyses have demonstrated that chronic opioid therapy provides little benefit to patients.<sup>7-9</sup>

#### What is opioid use disorder (OUD)?

OUD is a problematic pattern of opioid use leading to clinically significant impairment or distress. Specific criteria for OUD include two or more of the following over a 12-month period, as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM-5):

- Using larger amounts of opioids or over a longer period than was intended
- Persistent desire to cut down or unsuccessful efforts to control use
- Great deal of time spent obtaining, using, or recovering from use
- Craving, or a strong desire or urge to use substance
- Failure to fulfill major role obligations at work, school, or home due to recurrent opioid use
- Continued use despite recurrent or persistent social or interpersonal problems caused or exacerbated by opioid use
- Giving up or reducing social, occupational, or recreational activities due to opioid use
- Recurrent opioid use in physically hazardous situations

- Continued opioid use despite physical or psychological problems caused or exacerbated by its use
- Tolerance (marked increase in amount, marked decrease in effect)
- Withdrawal syndrome as manifested by cessation of opioids or use of opioids (or a closely related substance) to relieve or avoid withdrawal symptoms

What about using opioids to treat acute pain?

Many acute pain conditions can be treated with non-opioid therapy. Limiting exposure to opioids for acute pain is considered an important strategy to minimize the development of OUD in those who are susceptible (see Step 4). If opioids are required, many conditions do not require more than a few days of opioid therapy.<sup>1</sup> A recent systematic review showed that more than half of opioids prescribed for acute pain go untaken, and the unused pills are rarely stored safely.<sup>11</sup> These unused pills can be potentially diverted to inappropriate use. Over half of those who misuse opioids get them from a family or friend for free.<sup>12</sup>

A patient's risk for long-term use of opioids has been correlated with the characteristics of initial prescriptions.<sup>13,14</sup> For example, in one study, the CDC reported that the rate of long-term opioid use one year after therapy was 6.0 percent for persons with at least one day of opioid therapy, but increased to 13.5 percent when the first episode of use was >8 days and 29.9 percent when the first episode of use was >31 days.<sup>13</sup>

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## Six STEPS to improve the safety of pain treatment in your practice

1. Engage the team  
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2. Engage the patient  
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3. Assess the patient  
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4. Use non-pharmacologic and non-opioid therapies first  
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5. Initiate opioids safely  
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6. Monitor the patient



### 1 Engage the team

It is important to make sure that everyone in the practice is committed to safety as a primary concern when treating acute or chronic pain. This will involve developing practice-based policies that allow for some standardization of procedures when it comes to pain treatment, particularly with opioids. Examples of practice-based policies include use of prescription drug monitoring program (PDMP) data, if available, maintaining a registry of all patients on chronic opioids within the practice, and instituting an opioid refill policy. More information on each of these components is provided below.

**Use available resources to educate the team on opioids**

The following resources are highlighted within this module:

- AMA [end the opioid epidemic](#) initiative

- AMA e-learning module [A Primer on the Opioid Morbidity and Mortality Crisis: What Every Prescriber Should Know](#)
- A glossary of common terms used in relation to opioids
- Essentials of good pain care [video](#) by the Department of Defense/Department of Veterans Affairs
- American Academy of Family Physicians chronic pain management [toolkit](#)
- The [Prescription Drug Monitoring Program](#)

Q&A

[What is a prescription drug monitoring program \(PDMP\)?](#)

A PDMP is a database of controlled substances that are dispensed by pharmacies in each state (with a few exceptions, including Veterans Administration prescriptions). A list of state PDMP websites can be found [here](#). Reviewing the PDMP allows physicians to identify the controlled substances that have been dispensed to a patient, or if potentially hazardous drug interactions may exist (e.g., between opioids and benzodiazepines).

[How should the PDMP be used?](#)

Physicians can use their state PDMP to make more informed treatment decisions. For some patients, it may make sense to check the PDMP every three to six months, for others, it may be appropriate to check with each prescription renewal. Physicians should also become familiar with their state laws about checking the PDMP, as this is mandatory in certain states and the mandated frequencies may differ. Some electronic health records (EHR) have PDMP data integrated into them.

In certain states, physicians can delegate PDMP access to nurses or medical assistants; those team members can access patient PDMP reports as a part of [pre-visit planning](#). However, some states require prescribers to access the PDMP report themselves.

[What is an opioid registry?](#)

Some practices build and maintain a registry of all patients in the practice who are on chronic opioid therapy. Such a registry can be employed to track the use of alternative therapies, referrals to physical therapy, imaging studies done, use of urine drug tests, use of PDMP data, and follow-up visits.

[What should an opioid reauthorization policy include?](#)

An opioid reauthorization policy should be established by the practice to maintain consistent risk and safety messages for patients. Your practice can agree on answers to some common questions:

- Will patients need office visits for opioid reauthorizations?
- If a visit is required for opioid reauthorization, can that visit be with a nurse?
- Can a patient pick up an opioid prescription at the front desk?
- How will reauthorization requests after office hours or on weekends be handled?

It is important that your practice's policies are consistent with state law and specialty guidelines or recommendations, which in some cases may be contradictory. Your state medical society may be a resource for the latest information.

[What if I am concerned about patient satisfaction scores for the practice?](#)

Physicians should make treatment decisions based on their own professional judgement and their patients' best interests. Physician-patient communication is the most important factor related to patient

satisfaction with treatment recommendations. Listen and respond with empathy when discussing patient preferences and values. In many instances, communication, not prescribing, is the key to patient satisfaction.

## 2

## Engage the patient

When it comes to pain management, patients need to feel heard. **Communicating** with patients includes listening to their stories and acknowledging their pain, while also educating them about the nature of chronic pain in a way that is not patronizing or dismissive.

Useful phrases can include:

- Tell me more about how this pain impacts your life.
- What are your goals for therapy?
- What would you like to be able to do that you are not doing now because of pain?
- You may always have some pain. One of our goals is to help you manage it safely and maximize your function.
- Gentle daily exercise may help to decrease your pain.
- While we may not be able to completely cure your pain, our goal is to make it so the pain doesn't keep you from achieving some of your goals in life.

### Q&A

#### [How can I encourage realistic expectations and goals?](#)

Physicians can help patients understand that complete resolution of chronic pain may not be possible and that the main goal is improvement in function. Some functional goals defined by patients might include being able to walk the dog, play with grandkids, clean the house, or climb two flights of stairs.

#### [Where can I access patient engagement resources?](#)

There are a number of patient resources on chronic pain available online. The Department of Defense and the Department of Veterans Affairs have collaborated to produce the following patient education videos: [Understanding Pain \(6 minutes\)](#) and [Chronification of Pain \(7.5 minutes\)](#)

These short, animated videos can be shown to patients during a clinic visit.



3

## Assess the patient

Many physicians have been taught to assess patients' pain using the numeric pain intensity scale ranging from 0 to 10, and some may have understood the goal of treatment to be reduction of pain to zero.

Current assessment tools can obtain a more complete picture of patient pain by assessing functional status and emotional well-being. A scale developed by the Department of Defense and Department of Veterans Affairs called the [Defense and Veterans Pain Rating Scale \(DVPRS\)](#) is an enhanced version of the original 0 to 10 pain scale that includes components of functional status, mood, stress, sleep, and activity level. A provider-focused video further explaining this pain scale can be found [here](#). Another tool is the [PEG scale](#) for pain assessment and follow-up.

Q&A

[Using a pain assessment tool at every visit will take time. How can I include this in each visit?](#)

Several systematic approaches can help the team routinely identify patients in need of pain assessment.

- Banners in the EHR can be used to highlight to physicians and staff that a patient is receiving an opioid analgesic, and signal to rooming staff to provide a pain assessment questionnaire.
- Rooming staff can be empowered to identify chronic opioid prescriptions during medication reconciliation, triggering an automatic pain assessment questionnaire.
- List “Chronic Pain Disorder” on the problem list. This, too, can be a flag for the rooming staff to provide the pain assessment questionnaire.
- A separate visit type can be created for patients with chronic pain who are being treated with opioids, and pain assessment can be included as a routine part of the rooming protocol. During pre-visit planning, these patients can be identified and asked to complete a pain assessment questionnaire upon check-in.

[For patients on chronic opioid therapy, how can I assess their risk of opioid use disorder \(OUD\)?](#)

Every patient prescribed opioids should be assessed for risk of opioid misuse before initiating treatment. The [Opioid Risk Tool \(ORT\)](#) takes less than one minute to administer and can be helpful in identifying patients with higher risk for developing OUD.

The level and frequency of opioid monitoring depends on the patient's initial risk evaluation. Ongoing evaluation also helps determine whether the benefits of treatment outweigh the risks.

**Note:** While outside the scope of this module, naloxone co-prescribing should be considered for patients who are at an increased risk of respiratory depression. Further information can be found [here](#).

[What factors are associated with patients at high-risk of opioid use disorder \(OUD\)?](#)

Although no one is immune to developing OUD, factors more predictive of developing opioid dependence or OUD include a personal history of substance use disorder (with either illicit or prescription drugs), alcohol or nicotine use, a family history of substance use disorder, legal history such as a DUI citation or incarceration, higher daily dose and longer duration of opioid therapy, presence of a mental health disorder, higher rate of utilization of medical and psychiatric services, and history of preadolescent sexual abuse.<sup>19</sup> Findings on the relationship between age and risk of OUD vary.

[Should I screen for depression in patients with chronic pain?](#)

Yes. Available evidence suggests that 50 to 80 percent of patients with chronic pain also suffer from depression.<sup>15,16</sup> Depression can exacerbate pain, which is why antidepressants are often effective for

chronic pain treatment. Compared with patients without depression, patients with pain and depression have significantly poorer quality of life, greater somatic symptom severity, a higher prevalence of panic disorder, and a six-fold higher prevalence of anxiety disorders. These patients also have a poorer adherence to treatment, worse satisfaction with treatment, higher likelihood of relapse and less chance for functional improvement.

For these reasons, it is important that any patient on long-term opioid therapy be screened regularly for depression and, if present, treated appropriately. The [PHQ-2](#), followed by a [PHQ-9](#) if positive, is a good instrument to use for depression screening. The [GAD-2](#) or [GAD-7](#) are good screening instruments for anxiety.

#### What tools are available to assess patient risk?

There is no single “gold standard” risk assessment tool; however, several tools have been used in practice:

- **ORT:** Opioid Risk Tool
- **SOAPP:** Screener and Opioid Assessment for Patients with Pain
- **STAR:** Screening Tool for Addiction Risk
- **SISAP:** Screening Instrument for Substance Abuse Potential
- **PDUQ:** Prescription Drug Use Questionnaire

Providers should not rely on these as the sole determinant of risk; they should be used in the context of overall risk based on individual patient interactions and medical history. It is also important to recognize that estimating a risk profile is a dynamic process, and can change when a patient misses an appointment, loses his/her medication, exhibits other aberrant behaviors, or has unexpected findings in a toxicology or urine drug test.

#### Why is it unsafe to prescribe opioids and benzodiazepines?

The risk of respiratory suppression increases when opioids and benzodiazepines are used together. Over 30 percent of overdoses involving opioids also involve benzodiazepines. Both types of drugs cause sedation, impair cognition and suppress breathing, which can be fatal.<sup>17</sup>

#### Are there additional tools available?

- Defense and Veterans Pain Rating Scale (DVPRS)
- [Providers' Clinical Support System—Opioid Therapies \(PCSS-O\) Curriculum](#)
- [ACP Quality Connect “Chronic Pain and Mental Health Assessments” video by Mathew Blair](#)
- [Three-question PEG scale](#)

## 4

### Consider non-pharmacologic and non-opioid treatment options

When weighing risks versus benefits, consider the use of non-pharmacologic and non-opioid treatments such as acetaminophen, nonsteroidal anti-inflammatory drugs (NSAIDs), physical therapy, various physical modalities, cognitive-behavioral therapy, meditation, mindfulness, movement-based therapies, and various forms of exercise therapy. In some cases, surgical or other interventions may be an appropriate consideration as well.

There is a limited but growing body of evidence for using non-opioid treatments for various types of pain.<sup>1</sup> For neuropathic pain, topical lidocaine patches, duloxetine, venlafaxine, tricyclic antidepressants, gabapentin, and pregabalin are front-line therapies. Patients with fibromyalgia may experience fewer symptoms with selective serotonin reuptake inhibitors (SSRIs), selective serotonin-norepinephrine reuptake inhibitors (SSNRIs), strength

training, aquatic exercise therapy, aerobic exercise, and cognitive behavioral therapy. Physical therapy, Tai Chi, acupuncture, and topical NSAIDs can reduce pain in those with osteoarthritis pain. NSAIDs, exercise therapy, massage, Pilates and yoga can reduce pain in those with low back pain. The CDC Fact Sheet provides further information on several non-opioid treatments for chronic pain.



## 5 Initiate opioids safely

The decision to use opioids to treat pain is one that requires careful deliberation and detailed conversations between the physician and patient. Long-term opioid therapy often begins with treatment of acute pain. If opioids are indicated, start low and go slow. The lowest effective dose of immediate-release opioids for the shortest therapeutic duration should be prescribed; often three days is sufficient.<sup>1</sup>

A checklist is helpful for the initial evaluation of patients with chronic pain.

Important components of a checklist include:

- Setting realistic goals for pain and function
- Discussing benefits and risks of long-term opioid use
- Evaluating the risk for opioid misuse
- Having an exit strategy in place for discontinuing opioid therapy

A patient agreement (example [here](#)) can be used to guide the conversation.

### Q&A

**Are there ways to use the EHR to assist physicians in changing their prescribing habits?**

Yes. As an example, some organizations have used the EHR to lower the default number of pills prescribed in the emergency room for a new opioid prescription.

**What can I do for a patient at high risk of OUD with chronic pain?**

Providers can consider finding an alternative therapy to opioids in high-risk patients. Explain to patients who are high-risk that their safety is always the number one concern. Offer alternatives to opioid therapy as described in Step 4. For high-risk patients in whom the physician and the patient decide the benefit of

opioids outweighs the risk, extra monitoring and risk mitigation strategies should be utilized, including more frequent toxicology testing, naloxone co-prescription, consideration of pill counts, shorter duration of prescriptions, and more frequent follow-up visits.

Providers can watch for unexpected changes in the patient's risk profile and consider discontinuing opioid therapy when a patient's risk/benefit ratio increases. Conversations regarding changes in the risk profile of patients on chronic opioids are usually best done in person rather than by EHR messaging or telephone. If there are any other acute or chronic medical conditions—such as hypertension, diabetes or heart disease—that need to be addressed at the visit, these medical conditions should be addressed first. Changes in the risk profile should generally be discussed last.

In broaching changes in risk profile with the patient, be direct, nonconfrontational and nonjudgmental. Use objective language such as “The PDMP shows you received” rather than “you received.” For example, you can say, “I ran your report in our state database. It shows that in the past month you received four opioid prescriptions from four different providers. Can you help me understand this?”

Use information from the PDMP or urine drug test results as a way to start the conversation and an opportunity to provide treatment for any potential OUD or other substance use disorder. The conversation should be framed in terms of risk versus benefit. For example, you can say, “Unfortunately, at this point, the risks of chronic opioids exceed the benefits. We still want to help you with your chronic medical conditions and we want to treat your pain. We would recommend a more comprehensive approach that includes physical therapy, pain management, psychiatry, surgical consultation, and non-opioid medicines. We will work with you to control your pain and hope you will work with us.”

#### Why use a patient agreement for chronic opioid therapy?

Pain care agreements provide an opportunity for informed consent and articulating a plan of care, and can serve as a patient counseling document. Patient agreements can help start a conversation and ensure that the patient and prescriber's expectations are clear. Patient agreements can be signed or just agreed upon verbally, depending on your practice's preference. It is useful to have an agreed upon set of guidelines to refer back to when you must address things such as missed appointments, lost medications, or unexpected urine drug test results. You and your practice can decide how to respond when expectations are not met and how often the agreement should be reviewed and/or signed.

#### When initiating opioids, should I use an immediate-release or extended-release/long-acting formulation?

There is increased potential for adverse effects from extended-release/long-acting opioids. It is better to initiate therapy with an immediate-release/short-acting agent that can be more easily titrated. In addition, most extended-release/long-acting opioids are only indicated in opioid-tolerant patients, and not for initial therapy.

#### What is an MME?

The potency of opioids is typically compared to a 10-mg parenteral dose of morphine. Morphine milligram equivalents (MME) are estimated equianalgesic doses of other opioid analgesics compared to morphine. Various equianalgesic conversion tables and calculators exist. Comparative values should be considered approximations only, as they can be affected by interpatient variability, type of pain (i.e., acute vs. chronic), chronicity of treatment, tolerance, and incomplete cross-tolerance between various opioids. MME calculators are available online, [here](#).

## 6

## Monitor the patient

Regular follow-up visits are appropriate for patients on chronic opioid therapy. These visits are used to assess for adverse events and changes in risk of OUD, as well as progress towards treatment goals. The structure of care and intensity of monitoring should be determined based on perceived risk.

Risk mitigation strategies can include:

- Regular clinic visits
- Toxicology testing (generally urine or oral fluid)
- Prescription drug monitoring program (PDMP) checks

A checklist is very helpful for navigating follow-up visits with a patient on chronic opioid therapy. The CDC also provides a [comprehensive checklist](#). Pre-visit planning and registry maintenance by the team in support of these visits is important (see Step 1).

### Q&A

#### How often should I see a patient who is on chronic opioid therapy?

A regular follow-up visit is recommended approximately every three months to discuss risks and benefits of opioids. Visits can be conducted more frequently in higher-risk patients.

#### What is the role of urine drug testing in monitoring of patients receiving opioid therapy?

Urine drug testing is a key monitoring component to ensure that the patient is taking the medication as prescribed. Urine drug tests can be helpful in two ways. First, a negative urine drug test in a patient who is supposed to be on chronic opioid therapy would raise concerns about possible drug diversion. Second, finding illicit substances or other controlled substances that were not prescribed would change the risk profile for the patient. Urine drug testing can help facilitate important conversations with the patient.

#### How accurate is toxicology testing?

Interpreting these tests requires an understanding of testing modalities, detection times for specific drugs and common explanations for false-positive, false-negative and unexpected results. Results should be interpreted in the context of the patient's entire history.<sup>20</sup>

Please see the [My Top Care tool](#) from the AMA Council on Science and Public Health for more information. This online tool can help you interpret the urine drug test.

#### How can patients safely dispose of unused medicines?

Information from the FDA on how to safely dispose of unused medicines can be found [here](#).



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## Conclusion

Addressing the opioid epidemic calls for physician leadership, creativity and initiative. Physicians and their practices should make this issue a top priority. Recognizing and treating OUD is a crucial component. With the materials provided in this module, physicians and their practices can work together to more safely manage chronic pain in partnership with their patients.

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## AMA Pearls

### Focus on the big picture

The treatment of chronic pain should not focus on reduction of the pain level to zero, but rather on maximizing overall quality of life and emotional and functional well-being for patients.

### Minimize risk

As with other medical interventions, the treatment of chronic pain, including the prescription of opioids, should be considered in terms of risk versus benefit.

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# STEPS in Practice

1

## Implementing Team-Based Pain Management in Philadelphia, PA: A Case Study

As associate medical director at Drexel University College of Medicine in Philadelphia, PA, Jason Fodeman, MD, spearheaded the development of an opioid prescribing program for the internal medicine resident clinic. When he started his position, he discovered a lack of protocols and policies regarding the treatment of chronic pain and prescription of opioid medications. As a result, physicians' prescribing methods were more likely to fall short of meeting the [CDC Guideline for Prescribing Opioids for Chronic Pain](#), while simultaneously sending mixed messages to patients about safe and effective chronic pain treatment.

After discussions with the medical director at Drexel, several policies for treatment of patients with chronic pain were developed, based on the CDC opioid guidelines. For example, patients on controlled substances could no longer pick up prescriptions for opioids at the front desk. Instead, patients needed to visit a physician every four weeks to discuss the management of their chronic pain and opioid usage. These visits provided additional opportunities to educate patients about the risks of opioids, to counsel them about behaviors to decrease their risk for abuse or addiction, and to discuss alternative treatments, such as physical therapy, pain management consultation, surgical consultation, psychiatry for cognitive-behavioral therapy and nonopioid-based medicines. Risk mitigation strategies were also implemented, including Urine Drug Screens (UDS) and the Prescription Drug Monitoring Program (PDMP). Importantly, prescribers were advised to have a high threshold to start new patients on opioids.

When these policies were implemented in the summer of 2016, they were presented to faculty and residents in formal presentations and via email correspondence, as well as through informal conversations with residents and faculty. Before implementation, Dr. Fodeman made efforts to listen to faculty and their thoughts on this issue. While there was broad consensus about the need to change the status quo, the main point of frustration regarding the new policies was that it was nearly impossible to do risk mitigation, patient education and counseling in a 20-minute patient visit. As a result, the visit length was increased from 20 to 40 minutes. By taking the time to gather feedback, residents and faculty were supportive of the policy changes at the time of implementation.

The new policies were also discussed with the clinic manager to make sure she understood the changes, the rationale for them, and the possible unintended consequences (e.g., decreased patient satisfaction). These conversations and the support of the administration were integral to the success of the changes once implemented.

Training was provided to faculty members and residents on how to deal with specific situations involving changes in a patient's risk profile (e.g., an unexpected UDS result or doctor shopping on the PDMP). This training helped increase their comfort and confidence in dealing with these challenging discussions. Although the impetus for the policy changes was to improve safety and minimize risk for patients, the process also provided an opportunity to improve the understanding and experience of residents regarding the treatment of chronic pain.

Given the demand for opioid medicines, there were some patient concerns about tighter monitoring. The physicians took time to address these concerns directly and explain the importance of this issue, the nature of the problem, the CDC opioid guidelines, and the efforts of federal and state governments on this front. Physicians wanted to make sure that patients understood the reason behind the changes and the risks of the medicines, and that the changes in policy were not personal. It was also important to ensure the clinic presented a unified voice on this front.

One year after implementing the chronic pain management initiative at the Drexel University internal medicine resident clinic, the effort has been largely successful. The clinic delivers more consistent messaging about risks of opioids and there is more widespread implementation of counseling, risk mitigation strategies, alternative therapies, and tapering.

**Learning Objectives:**

At the end of this activity, you will be able to:

1. Explain chronic pain and how pain-related issues have attributed to the opioid epidemic
2. Identify the importance of engaging those providing team-based care including the patient when treating acute or chronic pain
3. Describe how to assess a patient's need for pain control and safely initiate opioid treatment
4. Discuss the importance of monitoring patients on chronic opioid therapy and implementing strategies to mitigate risk.

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