How Will This Toolkit Help Me?

Learning Objectives:

1. Assess a patient’s need for pain control
2. Apply team-based care and a patient-centered approach when treating acute and chronic pain
3. Review patients on long-term opioid therapy and implement strategies to mitigate risk
Introduction

Pain-related concerns account for up to 20% of all outpatient visits in the United States. From 1999 to 2019, nearly 247,000 people died in the United States from overdoses involving prescription opioids. In 2017, there were still 58 opioid prescriptions written for every 100 persons. Drug overdose (particularly from illicit fentanyl and heroin) is the leading cause of death in people under 50 years of age in the United States. Improving access to evidence-based treatment for substance use disorders and comprehensive pain care are key to curbing this public health epidemic. Furthermore, compassionate, empathetic care centered on a patient–clinician relationship is necessary to counter the stigma of living with chronic pain.

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 3 months or beyond the time of normal tissue healing. Estimates of the overall prevalence of chronic pain vary, but recent data estimate that chronic pain affects 50 million US adults.

What are the risks of long-term opioid use?

Opioids, similar to other controlled substances, can have serious adverse effects that are dose-dependent, including overdose and death. Long-term use of opioids can result in tolerance, dependence, addiction, and opioid use disorder. 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.

It is important to note that long-term opioid use does not necessarily equate with the development of an opioid use disorder or addiction. Some patients benefit from long-term opioid therapy, and all decisions about the use of opioids as part of the pain care management for a patient should be made on an individual basis using a patient-centered approach.

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

There is an absence of high-quality data on opioid effectiveness for chronic pain. Although more studies are needed, there is evidence that suggests that discontinuing long-term opioid therapy may actually improve pain, function, and quality of life for some patients. Multiple meta-analyses have demonstrated that long-term opioid therapy provides little benefit to patients.

What is opioid use disorder (OUD)?

OUD is a problematic pattern of opioid use leading to clinically significant impairment or distress. According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) individuals with OUD meet 2 or more of the following specific criteria over a 12-month period:

- Using larger amounts of opioids or over a longer period than was intended
- Persistent desire to cut down or unsuccessful efforts to control use
- Spending a great deal of time 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 with 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 at risk (see STEP 4). If opioids are required, many conditions do not require more than a few days of opioid therapy. 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. 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.

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

Six STEPS to Promote Safe and Effective Pain Treatment in Your Practice

1. Engage the Team
2. Engage the Patient
3. Assess the Patient
4. Use Non-Pharmacologic and Non-Opioid Therapies First
5. Prescribe Opioids Safely and Have a Discontinuation Plan
6. Monitor the Patient

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 for pain treatment, particularly with opioids. Examples of practice-based policies include the use of prescription drug monitoring program (PDMP) data, if available, maintaining a registry of all patients on long-term opioids within the practice, and instituting an opioid refill policy. More information on each of these components is provided below.

Resources to Educate the Team on Evidence-based Pain Care and the Use of Opioids

- AMA end the epidemic initiative
Q&A

What is a prescription drug monitoring program (PDMP)?

A PDMP is a database of controlled substances 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 (eg, 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 3 to 6 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 regularly checking the PDMP is mandatory to do 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 long-term 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 judgment and their patients’ best interests. Patient–physician 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.

**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, stigmatizing, or dismissive. Pain care should be individualized for each patient in a patient-centered manner.

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 cure your pain completely, 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 2 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.
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 the reduction of pain to zero.

Current assessment tools can obtain a more complete picture of patient pain by assessing the patient's functional status and emotional well-being. A scale developed by the Department of Defense and Department of Veterans Affairs, 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.

Opioid Management Note
This note offers considerations to ask yourself before prescribing opioids.

Pearls for a Pain Visit
A checklist for assessing risk, counseling, treatment, 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 efficiently perform pain assessments when necessary.

- Banners in the EHR can be used to highlight to physicians and other team members that a patient is receiving an opioid analgesic, and signal to rooming staff to provide a pain assessment questionnaire.
- The rooming team can be empowered to identify long-term opioid prescriptions during medication reconciliation, triggering an automatic pain assessment questionnaire.
- List “chronic pain” or “chronic pain disorder” on the problem list. If present, this, too, can be a flag for the rooming team 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. These patients can be identified during pre-visit planning and asked to complete a pain assessment questionnaire upon check-in.
For patients on long-term 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 help identify patients at higher risk for developing OUD.

The level and frequency of opioid monitoring depend 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 toolkit, naloxone coprescribing should be considered for patients 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
- A history of adverse childhood experiences

Should I screen for depression in patients with chronic pain?

Yes. Available evidence suggests that 50% to 80% of patients with chronic pain also suffer from depression. 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 6-fold higher prevalence of anxiety disorders. These patients also have poorer adherence to treatment, worse satisfaction with treatment, higher likelihood of relapse, and less chance for functional improvement.

For these reasons, any patient on long-term opioid therapy should be screened regularly for depression and, if present, treated appropriately. The PHQ-2, followed by a PHQ-9 if positive, are good instruments 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
Clinicians should not rely on these as the sole determinant of risk; these tools 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. Risk profiles 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% of overdoses involving opioids also involve benzodiazepines. Both types of drugs cause sedation, impair cognition, and suppress breathing, which can be fatal.

Although the risk of overdose by benzodiazepine co-prescription with opioids is well established, this combination may still have clinical value in select cases, for example in patients who have chronic pain and spasticity. Initiating regular long-term use of benzodiazepines with opioids should be done with caution. Co-prescription should be managed and coordinated by physicians and clinician specialists who have knowledge, training, and experience in co-prescribing benzodiazepines with opioids. For patients with anxiety disorders, SSRIs, SNRIS, and psychotherapies are preferred treatments for anxiety disorders.

**Are there additional tools available?**

- Defense and Veterans Pain Rating Scale (DVPRS)
- Providers’ Clinical Support System—Opioid Therapies (PCSS-O) Curriculum
- American College of Physicians “ACP Quality Connect: Chronic Pain and Mental Health Assessments” video by Matthew J. Bair
- Three-question PEG scale

**Consider Non-Pharmacologic and Non-Opioid Treatment Options**

When weighing risks against 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. For neuropathic pain, front-line therapies include topical lidocaine patches, duloxetine, venlafaxine, tricyclic antidepressants, gabapentin, and pregabalin. Patients with fibromyalgia may experience fewer symptoms with selective serotonin reuptake inhibitors (SSRIs), selective serotonin-norepinephrine reuptake inhibitors (SNRIs), strength training, aquatic exercise therapy, aerobic exercise, and cognitive behavioral therapy (CBT). 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.

Some patients may face considerable challenges in accessing non-opioid pain care. This includes cost-prohibitive co-pays or co-insurance, and lack of access to transportation to go to physical therapy 3 times per week. Just
because a non-opioid alternative may be the first choice, the fact of it being inaccessible raises significant challenges that may factor into the decision-making process.

Prescribe Opioids Safely and Have a Discontinuation Plan

The decision to use opioids to treat pain requires careful deliberation and detailed conversations between the patient and the physician. 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, 3 days is sufficient.¹

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, such as these sample forms from the National Institute on Drug Abuse (NIDA), 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. For 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?

Physicians can consider an alternative therapy to opioids for patients at high risk. 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 whose case the patient and the physician jointly decide the benefit of opioids outweighs the risk, the care team should employ extra monitoring and risk mitigation
strategies, including more frequent toxicology testing, naloxone prescription, consideration of pill counts, shorter duration of prescriptions, and more frequent follow-up visits. Care must be taken to avoid stigmatizing the patients who may benefit from long-term opioid therapy; for example, this “extra care” should be communicated with patients from the beginning so they do not feel like they are being singled out because of their chronic pain condition.

Physicians can watch for unexpected changes in the patient's risk profile and consider discontinuing opioid therapy when a patient's risk-to-benefit ratio increases. Conversations regarding changes in the risk profiles of patients on long-term 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 4 opioid prescriptions from 4 different prescribers. Can you help me understand this?”

Use information from the PDMP or urine drug test results as a way to start the conversation and as 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 long-term opioids exceed the benefits. We still want to help you with your chronic medical conditions, and we want to treat your pain. We recommend a more comprehensive approach that includes physical therapy, pain management, psychiatry, surgical consultation, and non-opioid medicines. Our team will work with you to control your pain and hope you will work with us.”

Why use a patient agreement for long-term opioid therapy?

Pain care agreements not only provide an opportunity for informed consent and articulating a plan of care; they can serve as a patient counseling document. Patient agreements can help start a conversation and ensure that the patient's 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. The pain care agreement is not a contract and should not be used to dictate patient behaviors. For example, if a patient does not have the correct number of pills, or the urine drug test has concerning results, this does not necessitate discontinuation of opioids. Rather, these are opportunities to understand why the patient may be using prescription opioids or other substances in a manner that is different from what the physician expected.

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 as approximations only, as they can be affected by interpatient variability, type of pain (ie, acute versus chronic), chronicity of treatment, tolerance, and incomplete cross-tolerance between various opioids. MME calculators are available online here.
The AMA opposes the use of arbitrary MME thresholds used by national pharmacy chains, health insurance companies, and pharmacy benefit managers as they do not account for individualized patient circumstances. The CDC has also advised against use of any certain MME as a hard threshold.

How should tapering be done?

If appropriate and in the patient's best interest, tapering of opioids should be done according to recently developed protocols (eg, from the National Academy of Medicine or Centers for Disease Control). Tapering should be done in a manner that shows care for the safety and comfort of the patient. Forced or too-abrupt tapering can have significant adverse effects on patients both physically and psychologically.

Monitor the Patient

Regular follow-up visits are appropriate for patients on long-term opioid therapy. Use follow-up visits to assess for adverse events, changes in risk of OUD, and progress towards treatment goals. Determine the structure of care and intensity of monitoring based on each patient's perceived risk.

Risk mitigation strategies can include:

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

A checklist is very helpful for navigating follow-up visits with a patient on long-term opioid therapy. The CDC also provides a comprehensive checklist. It is important that the team supports these visits through team-based pre-visit planning and registry maintenance (see STEP 1).

Data Registry for Patients on Chronic Opioids
This spreadsheet can help you keep track of patients who were prescribed chronic opioids. (XLSX, 27 KB)

Q&A

How often should I see a patient who is on long-term opioid therapy?

A regular follow-up visit is recommended approximately every 3 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 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 long-term opioid therapy raises concerns about possible drug diversion. Second, finding illicit substances or other controlled substances that were not prescribed changes the risk profile for the patient. Urine drug testing can help facilitate important conversations with the patient.

Drug testing does not provide any information about pattern of use of drugs, dose of drugs taken, physical dependence on drugs, the presence or absence of a substance use disorder, or about mental or physical impairments that may result from drug use.

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.
How can patients safely dispose of unused medicines?

Information from the FDA on how to safely dispose of unused medicines can be found here.

Conclusion

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

Further Reading

Journal Articles and Other Publications

Pain management and opioid policy or position papers


Chronic pain background and resources


Screening tools


Opioid prescribing


Other


Webinars and Videos

Websites


Article Information

AMA CME Accreditation Information

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About the AMA Professional Satisfaction and Practice Sustainability Group

The AMA Professional Satisfaction and Practice Sustainability group has been tasked with developing and promoting innovative strategies that create sustainable practices. Leveraging findings from the 2013 AMA/RAND Health study, “Factors affecting physician professional satisfaction and their implications for patient care, health systems and health policy,” and other research sources, the group developed a series of practice transformation strategies. Each has the potential to reduce or eliminate inefficiency in broader office-based physician practices and improve health outcomes, increase operational productivity, and reduce health care costs.

References:


