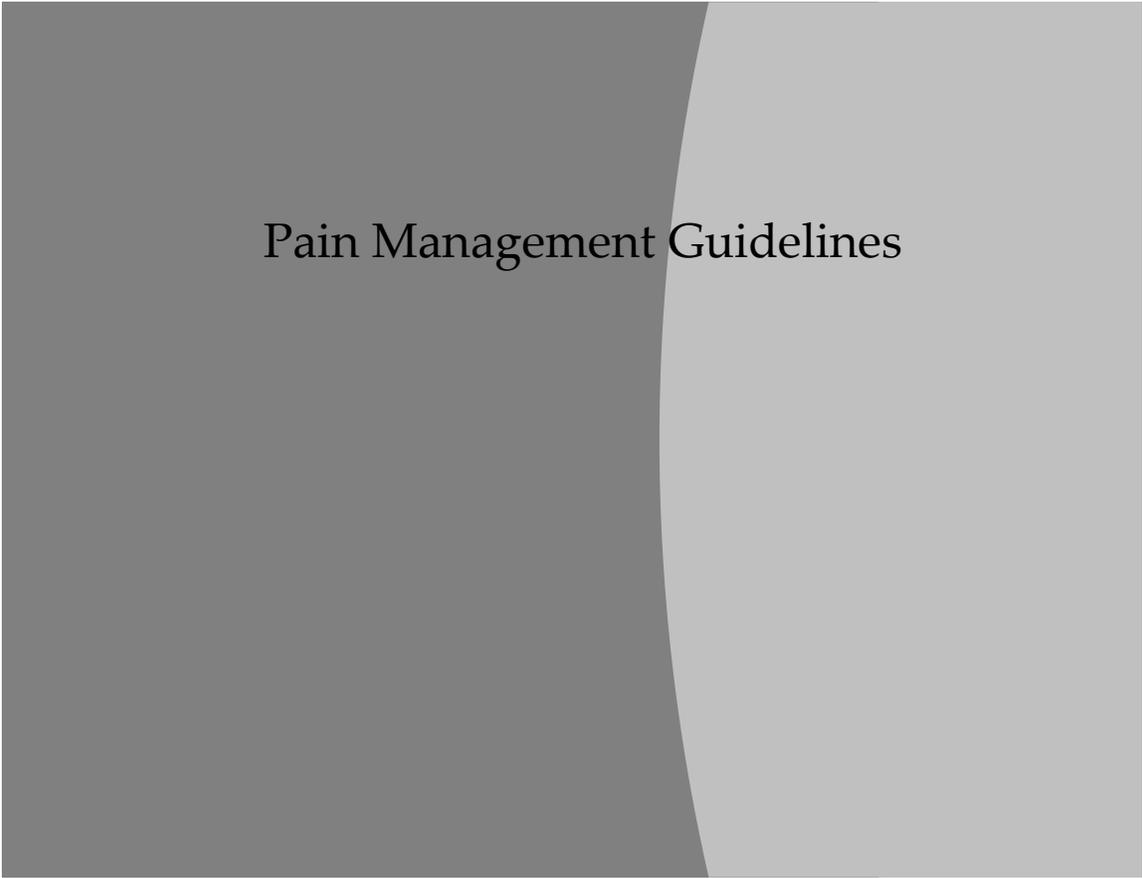




State of California Prison Health Care Services



Pain Management Guidelines

The following California Prison Health Care Services (CPHCS) Pain Guidelines were developed by the CPHCS Pain Committee whose members are listed below. These Guidelines represent a compilation of previously published guidelines by the Institute for Clinical Systems Improvement ⁽¹⁾, the Veterans Administration ⁽²⁾, the American Pain Society and the American Academy of Pain Medicine ⁽¹⁾. The framework of these guidelines and the selection of formulary medications are based on the work of the Correctional Medicine Consultation Network Pain Management Group who began this process in 2008. Several additional sources were utilized and are referenced.

CPHCS Pain Committee Members

John Zweifler-Chair
Bonnie Gieschen
Caroline Capitano
Louis DeBarraicua
Gabriel Williams
Melanie Roberts
Lucy Michael
Katrina Ball
Janet Lewis
Alan Frueh
Jack Martin
Jane Robinson
Larry Schmidt
Paul Carlisle
Bruce Barnett
Catherine Portman
Karen Higgins

Thanks to the following for indispensable formatting and administrative support:

Allie Baker, Christine Coustaut and Amanda Johnson

Table of Contents

I.	Executive Summary	1
II.	CPHCS Pain Management: Guideline Summary	1
A.	General Principles.....	1
B.	Acute Pain.....	2
C.	Chronic Pain.....	3
D.	Pain Management Review/Support	4
III.	Policy Statement.....	5
IV.	Purpose.....	5
V.	Background.....	6
A.	The Many Layers of Pain	6
B.	Definitions of Commonly Used Pain Terms.....	6
1.	Pain: Temporal Definition.....	6
2.	Pain: Neurophysiologic Definitions	7
C.	Definitions Associated with Opioid Therapy ^{(6) (1)}	8
1.	Physical Dependence:.....	8
2.	Misuse:	8
3.	Abuse:.....	8
4.	Addiction:	8
5.	Pseudoaddiction:.....	9
6.	Tolerance:.....	9
7.	Diversion:.....	9
8.	<i>Opioid Induced Hyperalgesia</i> :.....	9
D.	Definitions Associated with Pain and Disability	9
1.	Symptom magnification for secondary gain.....	9
2.	Pain behavior.....	10
3.	Malingering.....	10
4.	Somatoform Disorders	10
5.	Overwhelming Chronic Pain Syndrome.....	10
E.	Factors Increasing/Decreasing Pain Threshold ⁽⁸⁾	13

F.	Cultural Considerations in Pain Management.....	12
1.	Cultural Aspects of Pain Management	12
G.	Pharmacologic Treatment Principles	12
1.	General Principles ⁽⁸⁾ ⁽⁷⁾	12
2.	Analgesic Ladder ⁽¹²⁾ ⁽⁷⁾	13
3.	Nonopioid Analgesics	14
4.	Opioid Analgesics.....	16
5.	Pharmacologic Adjuvants for Pain Management ⁽¹⁷⁾	25
VI.	Acute Pain: Description of Program	31
A.	Assessment.....	31
1.	General History.....	31
2.	Pain History.....	32
3.	Clinical Exam.....	32
4.	Further Diagnostic Work-Up	32
5.	Specialty Consult	32
6.	Goals and Expectations	32
7.	Follow-up.....	32
B.	Pain Scales	32
C.	Diagnosis/ Mechanism of Pain	33
D.	Treatment.....	33
1.	General principles:.....	33
2.	Non-Pharmacologic Approaches	33
3.	Pharmacologic	34
4.	Opioid Medication:.....	35
5.	The WHO Pain Ladder offers a step wise approach:.....	36
VII.	Chronic Pain: Description of Program	38
A.	Evaluation/Assessment	38
1.	History/Physical.....	38
2.	Psychosocial Evaluation.....	39
3.	Functional Evaluation	40

4.	Goals and Expectations	40
B.	Diagnosis	41
1.	Establish Diagnosis/Medical Co- Morbidities	41
2.	Identify Psychosocial Complications	41
3.	Identify Baseline Functional Status	42
4.	Setting Goals and Expectations of Chronic Pain Treatment.....	42
5.	Patient Education and Anticipatory Guidance	42
C.	Treatment.....	43
1.	Multidisciplinary Care/ Biopsychosocial Model	43
2.	Primary Care Team:	43
3.	Other Multidisciplinary Team Members:	44
4.	Non-Pharmacologic Pain Adjuvants ⁽¹²⁾	46
5.	Pharmacologic Treatment	50
6.	Opioid Medication:.....	51
7.	Putting it all together-WHO Pain Ladder offers step wise approach to meds:.....	55
D.	Monitoring During Treatment.....	56
1.	Periodic Review/Documentation	56
2.	Assess 4 A's at each visit.....	56
3.	Adherence-Urine Drug testing	57
E.	Specialty Referral ⁽¹⁾⁽¹⁸⁾	59
F.	Implementation ⁽⁷⁾	60
G.	Special Clinical Situations	62
1.	Opioid Use in setting of history of substance abuse	62
VIII.	Works Cited	64

IX.	Attachments .....	.....
A.	Pain Management Formulary – Abbreviated (1 Page) .....	.....
B.	Pain Management – Acute Pain Algorithm (1 Page) .....	.....
C.	(Page 1) Pain Management – Chronic Pain Evaluation & Assessment.....	.....
C.	(Page 2) Pain Management – Chronic Pain Treatment Algorithm .....	.....
C.	(Page 3) Pain Management – Chronic Pain Opioid Therapy .....	.....
C.	(Page 4) Pain Management – Chronic Pain Opioid Therapy .....	.....
C.	(Page 5) Pain Management – Chronic Pain Opioid Therapy .....	.....
C.	(Page 6) Pain Management – Chronic Pain – Opioid Therapy Side Effects .....	.....
C.	(Page 7) Pain Management – Chronic Pain – NonSteroidal Anti Inflammatories .....	.....
C.	(Page 8) Pain Management – Chronic Pain Adjuvant Medication .....	.....
D.	CPHCS Chronic Pain Intake Sheet (2 Pages) .....	.....
E.	Initial Pain Assessment – Patient Completion (5 Pages) .....	.....
F.	CPHCS Opioid Agreement & Informed Consent – English (1 Page).....	.....
G.	CPHCS Opioid Agreement & Informed Consent – Spanish (1 Page) .....	.....
H.	Chronic Pain Follow-Up Form (1 Page).....	.....
I.	Diagnostic & Therapeutic Procedures (2 Pages) .....	.....
J.	Dealing With Depressive Thinking (2 Pages) .....	.....
K.	Dealing With Anxious Thinking (2 Pages).....	.....
L.	Relaxation Techniques (1 Page) .....	.....
M.	Anger Management (2 Pages).....	.....
N.	Cervical and Lumbosacral Dermatomes (1 Page).....	.....

I. Executive Summary

Across our 33 adult institutions, there is a wide disparity in the amount and type of pain treatment provided. The nature of incarceration makes some nonpharmacologic therapies difficult to support, and pharmacologic treatments can be challenging. Many of the adjuvant medications used for pain treatment in the community, such as the tricyclic antidepressants, pose additional risks to our patients. The use of opioids for chronic pain varies widely and reliable data does not exist. Anecdotal reports and clinician opinion suggest that both the under treatment and over treatment of chronic pain are problems within CPHCS.

The appeal process at the local, director, and Habeas Corpus levels demonstrate that some of our patients are frustrated with the pain management they receive; believing it to be spurious and fragmented. It has been observed that the treatment of pain, especially chronic pain, may vary widely from provider to provider, and institution to institution. These Guidelines seek to standardize the evaluation and treatment of pain within the CPHCS system by adapting existing community and VA Guidelines for Acute and Chronic Pain.

The Guidelines are organized into the following sections:

- CPHCS Pain Management Guideline Summary
- Policy
- Purpose
- Background: Pain definitions, pharmacology
- Acute Pain Guidelines
- Chronic Pain Guidelines
- References
- Attachments

II. CPHCS Pain Management: Guideline Summary

A. General Principles

A diagnosis should be obtained and documented.

A rational step-wise approach to treatment should be used.

- First, nonpharmacologic therapies should be employed; including education, exercise, physical therapy and coping skills.
- Then, if necessary, medications can be used in a step-wise approach.
 - A good model for this is the WHO Analgesic Ladder
 - Step One: Non-opioid analgesics +/- adjuvants
 - Step Two: Weak opioid +/- adjuvants
 - Step Three: Strong opioid +/- adjuvants

Both anticonvulsants and anti-depressants are effective adjuvants for neuropathic pain. There has been some concern regarding primary care providers using these medications. Mental Health has agreed that these medications can be used by primary care to treat neuropathic pain with the following conditions:

Anticonvulsants may be prescribed by PCPs without guidance from Mental Health if treatment is solely for the purpose of pain management and if the screen for depression contained in the intake tool is negative. If already within the Mental Health delivery system, review the medication profile to avoid potential drug-drug interactions with prescribed psychotropic medications.

Anti-depressants may be prescribed by PCPs without guidance from Mental Health if treatment is solely for the purpose of pain management and if the screen for depression contained in the Intake tool is negative. Document consultation from Mental Health if screen is positive for depression, or the patient is currently in EOP or CCCMS program prior to prescribing antidepressants for pain management. Document the review of medication profile to avoid potential drug-drug interactions with prescribed psychotropic medications.

B. Acute Pain

(Pain generally lasting <30 days)

- **Nonpharmacologic therapies** including,
 - Education: local pain control, immobilization, warm/cool
 - Physical: PT screening, exercises and stretches
 - Psychologic: coping skills, relaxation
- **Non-opioid analgesics**
 - Tylenol or ASA
 - NSAID-Ibuprofen, Naprosyn, Disalcid and Sulindac
- **Adjuvant medication**
 - **Antispasmodics** – if pain is due to muscle spasm
 - Methocarbamol – NA/DOT only – restricted to 10 day supply
 - Baclofen – NA/DOT only – restricted to 10 day supply (generally use is limited to spinal cord injuries)
 - **Anticonvulsants** - indicated for neuropathic pain, to be administered DOT and crushed/floated (or liquid)
 - Oxcarbazepine (Trileptal) – NA/DOT only
 - Gabapentin (Neurontin) – NA/DOT – must be crushed/floated
 - Carbamazepine (Tegretol) – NA/DOT only - alternate (preferred first line for Trigeminal Neuralgia)
 - **Anti-depressants** - indicated for neuropathic pain, to be administered DOT and crushed/floated (or liquid)
 - Venlafaxine (Effexor)-SNRI – NA/DOT only
 - Nortriptyline (Pamelor) – NA/DOT only - must be crushed/floated
 - Duloxetine (Cymbalta)- SNRI alternate agent if failed above – NA/DOT only (nonformulary)
- **Opioids** (Short-acting)
 - Consider opioid use if severe pain with objective evidence of injury including; laceration, fracture, ecchymosis, or evidence of inflammation or illnesses associated with pain syndromes on lab studies.
 - Acetaminophen and Codeine (Tylenol #3)- NA/DOT only – must be crushed/floated.
 - Tramadol (Ultram) - Nonformulary, chronic use not recommended. Because 10% of patients cannot metabolize codeine, short-term use of Tramadol may be considered in patients nonresponsive to Tylenol #3. NA/DOT only.
 - Morphine IR- if pain control cannot be achieved with the above meds then immediate release morphine can be used. The short half-life requires frequent dosing that may not be available outside of a CTC setting. NA/DOT only – must be crushed/floated.

- Morphine SR- in rare instances, sustained release morphine may be used in treatment of acute pain, especially if frequent dosing of Morphine IR is unavailable. NA/DOT only – Do Not Crush.
- If pain persists more than 30 days, evaluate as Chronic Pain patient (see below).

C. Chronic Pain

(Pain lasting > 30 days)

Definition: Pain that is present >30 days, that may have been elicited by an injury or illness, but now may be perpetuated by factors that are remote and unrelated to the original source of pain.

- Diagnose source of pain and classify pain type (neuropathic, somatic/visceral)
- Complete Pain Intake Form on initial chronic pain visit, and Follow-up Pain Form for subsequent visits when pain management is chief complaint
- Each pain visit should include functional status evaluation
- **Nonpharmacologic therapies:** including
 - Education: local pain control, immobilization, warm/cool
 - Physical: PT screening, exercises and stretches
 - Psychologic: coping skills, relaxation, cognitive behavioral skills
- **Non-opioid analgesics**
 - Tylenol or ASA
 - NSAID-Ibuprofen, Naprosyn, Disalcid and Sulindac
- **Adjuvant medication:** these are particularly helpful in chronic pain, especially neuropathic chronic pain.
 - **General use:**
 - Select from below adjuvant medications based on type of pain, medical and psychological comorbidities, and prior response
 - Titrate medication over 3-4 weeks, it takes time to reach peak effectiveness
 - If patient is not responding, re-screen for mental health and other comorbid conditions and reconsider mental health evaluation
 - If one medication/medication class does not work, try another
 - **Antispasmodics** – rarely indicated in chronic pain unless flare of pain due to muscle spasm
 - Methocarbamol up to 10 days
 - Baclofen-chronic use in spasticity due to spinal cord injury- to be administered DOT and crushed/floated (or liquid)
 - **Anticonvulsants:** indicated for neuropathic pain, to be administered DOT and crushed/floated (or liquid)
 - Oxcarbazepine (Trileptal)
 - Gabapentin (Neurontin) - to be administered bid unless documented neuropathic pain unresponsive to optimal bid dosing
 - Carbamazepine (Tegretol) -alternate (is preferred first line for Trigeminal Neuralgia)
 - **Anti-depressants:** indicated for neuropathic pain, to be administered DOT and crushed/floated (or liquid)
 - Venlafaxine (Effexor)-SNRI
 - Nortriptyline (Pamelor)
 - Duloxetine (Cymbalta)- SNRI alternate agent if failed above
- **Opioids:**
 - Consider opioid use if patient is unresponsive to non-opioid analgesics and adjuvant medications and has severe pain persisting for >30 days with:
 - Impaired function

- Ongoing objective evidence of severe disease (i.e. evidence of severe degenerative disease on imaging tests or exam, evidence of nonhealing fractures or tears, EMG evidence of neuropathy consistent with anatomic defects, non-healing wounds, or evidence of inflammation on lab studies with clinical findings consistent with inflammatory condition)
- If severe pain persists but above objective evidence for disease is not present, the patient should be referred to local Medical Leadership via the Pharmacy and Therapeutics (P & T), Medical Authorization (MAR) and any existing Narcotics Pain committee structure at the institution.
- Complete Consent and Treatment Agreement Form prior to initiation of opioid analgesics for chronic pain.
- If opioids are required for management of chronic pain, long-acting opioids should be used. Preferred agents are:
 - Methadone: dose carefully, refer to precautions, must monitor QT interval
 - Morphine SR: cannot crush or it becomes immediate release
- Breakthrough pain:
 - While patients may require 'breakthrough' doses of short-acting medications while titrating dose of long acting medication, ongoing "breakthrough" or "prn" medication is not indicated in stable chronic pain.
 - If patient has an occasional flare of his or her chronic pain, a short acting opioid such as Tylenol #3 or Morphine IR can be used for short periods, generally less than 14 days and not exceed 30 days.
 - If patient experiences flares with unexpected frequency or duration then further evaluation is warranted.
- If persistent pain despite the use of long acting opioids and treatment of breakthrough pain, consider evaluation for misuse of opioids including drug screening.
- Information received regarding misuse of pain medications, use or abuse of illegal substances, or misrepresentation of symptomatology can lead to discontinuation of chronic pain medications.

D. Pain Management Review/Support

In order to facilitate objective and consistent pain management throughout our 33 Prisons, each facility will be required to have a mechanism to review opioid use within the institution. Rather than establish a new committee for such review, the CPHCS Pain Committee recommends integrating these functions into the existing institution committee structure using the P & T Committee, MAR Committee, and any currently existing Narcotic/Pain Committee.

- The members of the existing committees should include:
 - CMO (+/- Chief P&S)
 - Physician and Surgeon representative(s)
 - Pharmacist
 - Nursing representative(s)
 - Mental Health Representative (strongly encouraged)
- The institution will be responsible for reviewing:
 - Continued opioid use for acute pain for longer than 30 days.
 - Cases where the patient reports ongoing severe pain with impaired function and does not have objective evidence of disease as outlined above.
 - Cases where the patient reports severe pain despite use of nonpharmacologic approaches, adjuvant therapy, long acting opioids and short acting opioids consistent with above guidelines.

- Prescribers who are ‘outliers’, either over or under prescribing opioids compared to their peers. (A Provider caring for more patients who have a special needs designation may indeed have a higher proportion of chronic pain patients and should not necessarily be considered an “over-prescriber”).
- Any inmate-patient suicides from the institution where pain management was part of the patient’s treatment.
- Cases where Pain Management specialty evaluation has been requested.

III. Policy Statement

The California Prison Health Care Services (CPHCS) shall operate a Pain Management Program that includes education, diagnosis, treatment and management of CDCR inmate-patients with acute or chronic pain.

This program shall be periodically reviewed and revised as needed to ensure that it reflects current scientific information and outcome data.

The CPHCS shall:

- Ensure that clinicians are familiar with the Pain Management Guidelines.
- Ensure that the Pain Management Guidelines are available to the CDCR patient population.

IV. Purpose

1. The purpose of these Guidelines is to provide the CPHCS clinician a standardized framework to address the problem of pain in their patients.
2. Within the CDCR Prison system, there has been a wide variation in the approach to pain treatment and this has resulted in frustration and confusion for both our providers and our patients.
3. The patient population that is served in the prison setting has a higher percentage than the general population of disorders such as:
 - History of substance abuse
 - Psychiatric and personality disorders
 - Impulsive disorders
4. Consensus decisions by many major medical pain organizations and pain psychologists agree that this population is at very high risk for abuse of opioid pain medications. Therefore, it is in the best interest of our patients to utilize all interdisciplinary evidence based guidelines for the treatment of their pain.
5. The goal of pain management in the prison system is aimed at:
 - Allowing function for activities of living and program participation.
 - General alleviation of the unnecessary physical and mental suffering associated with chronic pain.
6. We must recognize that the cognitive distress that occurs because of the social milieu in prison may result in patients who have a high level of baseline suffering, which can not be addressed by pain management.
7. The following sections will detail the CPHCS Guidelines for the management of both acute and chronic pain. These guidelines contain CDCR Pharmacy and Therapeutics algorithms for medication management, as well as other supporting clinical and decision support information.
8. The importance of thorough evaluation and diagnosis of patients before and during treatment will be addressed, as will the need for consistency amongst CPHCS providers.

9. Because it is a biopsychosocial problem, chronic pain management may include multidisciplinary involvement of medicine, psychiatry, nursing, physical therapy and custody.
10. While all chronic conditions benefit from strong physician/provider-patient relationships, such a relationship is required for successful management of the Chronic Pain patient.

V. Background

Section Outline

- A. The Many Layers of Pain
- B. Definitions of Commonly Used Pain Terms
- C. Definitions Associated with Opioid Therapy
- D. Definitions Associated with Pain and Disability
- E. Factors Increasing/Decreasing Pain Threshold
- F. Cultural Considerations in Pain Treatment
- G. Pharmacologic Treatment Principles

A. The Many Layers of Pain

Pain is an unpleasant *sensory* and emotional experience associated with actual or potential tissue damage or described in terms of such damage.

The *perception* of pain is influenced by physiological, psychological, and social factors.

The *human reaction to the sensory experience, suffering*, takes an added dimension in patients who have chronic, non-cancer pain. Some of these patients may have, in addition to the persistent pain:

- Overriding affective components
- Learned responses that can lead to severe psychological disability
- A pattern of repeated interaction with the health care system⁽¹⁾

B. Definitions of Commonly Used Pain Terms

1. Pain: Temporal Definition

a. *Acute Pain*⁽³⁾

1. Pain provoked by noxious stimulation produced by injury or disease of skin, deep somatic structures, or viscera or abnormal function of muscle or viscera.
2. This pain is biologically useful, warning of tissue damage.
3. Has well defined onset.
4. May be associated with objective physical signs of autonomic nervous system hyperactivity such as tachycardia, diaphoresis, elevated blood pressure, and pupillary dilatation.
5. It is almost always self-limited and with few exceptions, therapy is effective.
6. Acute pain can persist and progress to a chronic condition, even if properly treated.

b. *Chronic Pain*⁽⁴⁾⁽⁵⁾

1. Pain usually elicited by an injury but may be perpetuated by factors that are remote and unrelated to the origin of the original pain problem.

- Theories of pain centralization/ neural plasticity state continuous stimulation of the nerve (pain) fibers leads to actual structural and functional changes in both the peripheral and central nervous system.
 - These changes produce exaggerated responses, such as muscle spasm and increased sympathetic activity, which alter the patient's perception and contributes to pain chronicity.
2. Chronic pain extends for a long period of time, often associated with low levels of underlying pathology which does not explain the presence and extent of pain.
 3. Chronic pain serves no biological function, but imposes severe physical, emotional, and socioeconomical stresses on the patient, family, and society.
 4. May not have well-defined onset.
 5. Typically occurs without signs of autonomic nervous system hyperactivity.
 6. It is difficult to treat and prompts patients to frequently seek health care.

2. Pain: Neurophysiologic Definitions

c. *Nociceptive Pain*

1. An unpleasant sensation (nociception) produced by noxious stimuli.
2. In proportion with the degree of ongoing tissue damage.
3. There is protective benefit from this pain.
4. These sensory receptors are identified in all tissues and organs except the nervous system.
 - **Somatic pain:** carried along sensory fibers from muscle, skin, joints, connective tissue, or bone. (Examples: lacerations, fractures, dislocations)
 - **Description:** Often has an intense, achy, throbbing quality, and is easily localized.
 - **Visceral pain:** carried by autonomic (sympathetic) fibers from deep organs.
 - **Description:** The pain is diffuse and poorly localized (referred pain often causes difficulty in evaluation).

d. *Neuropathic Pain (aka non-nociceptive)*

1. Pain produced by an alteration of neurological structure and/or function, either central or peripheral.
2. It produces no protective benefit.
3. Neuropathic pain may or may not indicate well-defined neurological damage.
 - **Central Neuropathic Pain:** A lesion in the CNS (i.e. thalamic pain, post-stroke pain, post-paraplegia pain).
 - **Peripheral Neuropathic Pain:** lesions in the PNS causing persistent pain states (i.e. CRPS II, post-herpetic neuralgia, painful neuropathies).
 - **Descriptions** may vary but generally include:
 - Pain from a non-painful stimulus, i.e. pain on light touch (allodynia).
 - An exaggerated response to a normally painful stimulus (hyperpathia).
 - Dysesthesias: Burning, lancinating, shooting pain.
 - Symptoms are initially experienced distal to the site of injury.
 - Dermatome Map for usual nerve distribution. (See Attachment N).
 - Other examples: diabetic neuropathy, shingles, multiple sclerosis, herniated discs, and HIV associated neuropathy.

C. Definitions Associated with Opioid Therapy ⁽⁶⁾ ⁽¹⁾

1. Physical Dependence:

1. Manifests when, after a period of continuous use, a drug is stopped and physical symptoms occur (withdrawal or abstinence syndrome).
2. Physical dependence is a common feature of opioids, corticosteroids, barbiturates, benzodiazepines and anti-hypertensive's.
3. Physical dependence is easily managed by gradually tapering the drug if it is no longer needed.

2. Misuse:

1. Medical use of a medication for purposes other than directed or indicated.
2. A prospective cohort study of 196 opioid treated, chronic, non-cancer pain patients identified predictors of opioid misuse. Misuse was defined as having:
 - Negative urine toxicology screen (UTS) for prescribed opioids.
 - UTS positive for controlled substances not prescribed.
 - Procurement of opioids from multiple providers.
 - Diversion of opioids.
 - Prescription forgery.
 - UTS positive for stimulants.
3. The strongest predictors of misuse were:
 - The self-reported histories of previous alcohol or cocaine abuse (but history of substance abuse in any form does increase risk of misuse of opioids).
 - Previous criminal drug or alcohol-related convictions.
4. Demographics such as gender, race, literacy, disability, and socioeconomic status were not associated with misuse risk.

3. Abuse:

1. Use of any illegal drug.
2. Intentional, self-administration of a medication for a nonmedical purpose, such as altering consciousness.

4. Addiction:

1. Addiction is a primary chronic disease, and exposure to drugs is only one of the etiologic factors in its development.
2. Addiction, unlike tolerance and physical dependence, is not a predictable drug effect, but represents an idiosyncratic adverse reaction in biologically and psychosocially vulnerable individuals.
3. Addiction is recognized by the observation of one or more of its characteristic features:
 - Impaired control over drug use
 - Craving
 - Compulsive use
 - Continued use despite negative physical, mental and/or social consequences
4. It should be emphasized that no single event is diagnostic of addictive disorder. Rather, the diagnosis is made in response to a pattern of behavior that usually becomes obvious over time. ⁽¹⁾

5. Pseudoaddiction:

1. Behaviors in patients with under treated pain that can be mistaken for aberrant behavior associated with drug abuse or addiction, but that occur because of the need to obtain pain relief.
2. Pseudoaddictive behavior differs from addictive behavior in that when higher doses of opioid are provided, the level of function increases and medications are used as prescribed.
3. The iatrogenic syndrome known as “pseudoaddiction” is a direct consequence of inadequate pain relief. The patient’s demand for analgesics increases and the patient becomes intensely focused on finding relief when pain is unrelieved. These behavioral changes are driven by the severity of the pain and are resolved with provision of adequate pain relief.⁽¹⁾

Behaviors associated with Pseudoaddiction, Abuse, or Addiction:

- Failure to adhere to agreed-upon schedule
- Taking multiple doses together
- Use of nonprescribed psychoactive drugs
- Noncompliance with other medication regimens or evaluations
- Insistence on rapid-onset formulations
- Reports of no relief by any nonopioid agent
- Drug hoarding
- Unsanctioned dose escalation

6. Tolerance:

1. A physiologic state of adaptation in which a person requires an increased dosage of a psychoactive substance to sustain a desired effect.
2. Induction of biologic changes occur which diminish many adverse effects over time.
3. Increase dose overcomes decreased analgesic effect.
4. Age effects the speed to tolerance (greater the age, greater the time to tolerance).

7. Diversion:

1. Intentional removal of a medication from legitimate distribution and dispensing channels.

8. Opioid Induced Hyperalgesia:

1. This is characterized by increased sensitivity to pain, a paradoxical response to opioids in that the higher the opioid dose, the more intense the pain.
2. The increased pain is often poorly defined and can extend to areas beyond the site of the initial pain complaint.
3. Recent evidence has shown that opioids, in higher doses or over a prolonged period, can produce a state of hyperalgesia, i.e., amplified pain response. More and more clinicians, when faced with increasing pain in spite of increasing opioid doses, are recognizing this phenomenon as opioid-induced hyperalgesia and treating it with opioid reduction, rotation or discontinuation.⁽⁸⁾

D. Definitions Associated with Pain and Disability

1. Symptom magnification for secondary gain

1. A conscious and willful feigning or exaggeration of a disease or effect of an injury in order to obtain a specific external gain such as:

- Financial compensation
- Avoiding work
- Obtaining drugs
- Obtaining favorable living accommodation
- Avoiding responsibilities of self care
- Obtaining medical equipment with the goal of nonmedical use

2. Pain Behavior

1. Pain behavior is not necessarily associated with objective measures of disease or pathology and by itself is not an indication for opioids. These actions may include:
 - Audible complaints
 - Facial expressions
 - Abnormal postures or gait
 - Use of prosthetic devices
 - Avoidance of activities
 - Overt expressions of pain

3. Malingering

1. Malingering is a situation whereby a person has a clear secondary agenda to achieve external gain.
2. The presentation of numerous symptoms is stated to be the result of a given injury. However, when one investigates the causation there is no substantiation.
3. When you are alerted to any degree of symptom magnification, suspected malingering, or somatoform presentations, there are a number of objective tests that can be carried out for neuro-orthopedic evaluation. If performance on the tests is inconsistent, this can suggest nonorganic origin of the pain complaint.

4. Somatoform Disorders

1. Differs from malingering in that the patient has a psychiatric disorder, with psychiatric symptoms, and truly believes he was injured.
2. The differentiation between somatoform and malingering may involve a psychiatric evaluation and detailed documentation.

5. Overwhelming Chronic Pain Syndrome

1. This is an “enigmatic”, pain presentation, characterized by a patient presenting with no coherent or clearly defined constellation of symptoms and signs denoting a medical diagnosis. This then quickly results in conflict with the provider and mutual dissatisfaction.
2. With overwhelming chronic pain syndrome, the presence or absence of an identifiable abnormality has little bearing on how a patient experiences pain, suffering or disability. It is a psychosocial condition with medical aspects, rather than a medical condition with psychosocial aspect.
3. The distinguishing feature is that these patients repeatedly present to biomedical providers with pervasive disability and severe emotional distress attributed to pains that do not respond to conventional treatments.
4. Regardless of the etiology of the initiating painful condition or disease, these patients are universally both overwhelmed by pain and overwhelming to the medical system.

5. The patient presents with a lifestyle centered on seeking immediate relief from pain via repeated attempts to obtain medical or surgical treatment, as well as attempts to obtain pain-related compensation.
6. The patient has significant disease conviction.
7. The excessive focus on somatic functions allows development of symptoms of psychosocial dysfunction that the patient maintains are secondary to pain. These include:
 - Substance abuse
 - Depression
 - Sleep disruption
 - Disruption of vocational and societal roles
8. This syndrome represents the fundamental difference between disease and illness. It is the experience of illness, not the presence of disease that motivates the patient to seek repeated medical treatment.
9. Extrapolating management from other types of chronic pain, or advocating escalating opioid doses does not bridge this gap between the disease concept of the medical provider, and the illness experience by the patient.
10. The fundamental problem of these patients is not that they cannot cope with pain, but rather they cannot cope without it: pain becomes the solution, not the problem.
11. De-medicalization of this problem as the treatment plan emphasizes shift in focus from pain symptoms to strategies that increase functional activity and wellness despite the persistence of pain.

E. Factors Increasing/Decreasing Pain Threshold ⁽⁸⁾

1. Factors decreasing pain threshold:

Insomnia	Anxiety	Anger
Fatigue	Fear	Shame
Nausea	Misunderstanding	Sadness
Depression	Introversion	Any other
discomfort		
The memory of past pain and the expectation that the pain will recur.		

2. Factors increasing pain threshold:

Relief of other symptoms	Distraction
Adequate sleep/rest	Treatment of psychiatric disorders
Understanding	Around the clock pain medication

F. Cultural Considerations in Pain Management

1. Cultural Aspects of Pain Management

1. Pain is not just a response to tissue damage but also includes emotional and behavioral responses based on the individual's past education, experiences and perceptions of pain. Human responses to pain reflect cultural expectations and psychological predisposition.
2. Medical decisions regarding the treatment of pain require an understanding of the patient's ethnic and cultural background.
3. There are significant differences in the expression and tolerance of pain among diverse cultural groups. These differences need to be accounted for when evaluating the patient in pain.
4. Cultural responses to pain have been divided into two categories: stoic and emotive.
 - Stoic patients are less expressive of their pain and tend to "grin and bear it." They tend to withdraw socially.
 - Emotive patients are more likely to verbalize their expressions of pain.
5. Studies have shown that patients from ethnic minorities and cultures different from the health care professionals treating them and are more likely to receive inadequate pain management.⁽¹⁰⁾
6. When treating a patient whose cultural background is different from our own, it is important to try to understand their background. It is equally important to try and understand how our own upbringing affects our attitudes about pain.
7. A general framework for improving culturally/ethnic competent care is to incorporate the following information when cultural/ethnic barriers are thought to be the basis for ongoing pain issues:⁽¹⁰⁾
 - **Explanation:** What do you think may be the reason you have this problem? What do friends, family, and others say about your symptoms? Do you know anyone else who has had or who now has this kind of problem? Have you heard about/read about/seen it on TV/radio/newspaper? (If patients cannot offer an explanation, ask what most concerns them about their problems.)
 - **Treatments:** What kinds of medicines, home remedies, or other treatments have you tried for this illness? Is there anything you eat, drink, or do (or avoid) on a regular basis to stay healthy? Tell me about it. What kind of treatment are you seeking from me?
 - **Healers:** Have you sought any advice from alternate or folk healers, friends, or other people who are not doctors for help with your problems? Tell me about it.
 - **Negotiate:** Try to find options that will be mutually acceptable to you and your patient and that incorporate the patient's beliefs, rather than contradicting them.
 - **Intervention:** Determine an intervention with your patient that may incorporate alternate treatments, spirituality, and healers, as well as other cultural practices (e.g., foods eaten or avoided in general and/or when sick).
 - **Collaboration:** Collaborate with the patient, family members, other health care team members, healers, and community resources.

G. Pharmacologic Treatment Principles

1. General Principles⁽⁸⁾⁽⁷⁾

1. Prevention of pain is better than treatment; stay ahead of the pain if possible.
2. The biologic half-life of an agent must be considered when adjusting the dosage and interval. The maximum effect of a given dose may not be seen until the drug has been administered over 4 to 5 half-lives.

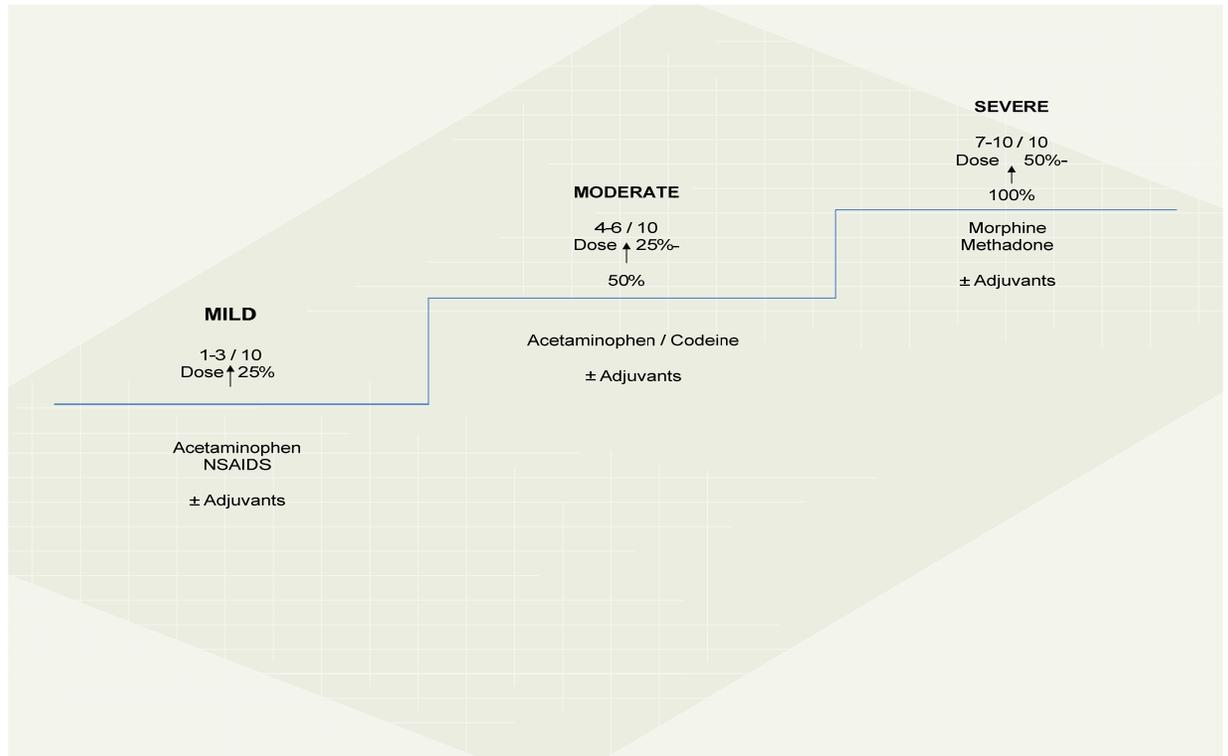
3. Once pain is controlled satisfactorily, the dose of analgesic usually remains fairly stable. If an increase in pain is seen, it often means progression of disease or new pathology rather than the development of tolerance.
4. Look for drug-related fears and misconceptions, as they may lead to poor compliance with a therapeutic regimen.
5. Define the goals of therapy before prescribing and tailor medications to meet the individual goals of each patient.
6. Give drugs an adequate therapeutic trial. When treating neuropathic pain, benefits may take weeks or longer to appear.
7. Rational poly-pharmacy may include the use of two or more drugs with complementary mechanisms of action that may provide greater pain relief with less toxicity and lower doses of each drug.
8. Avoid prescribing two drugs in the same class at the same time.
9. Be alert for possible interactions with other medication the patient is taking or additive side effects.
10. Titrate doses to achieve optimal balance between analgesic benefit, side effects and functional improvement.
11. Optimize administration of analgesics. Generally, better pain control is obtained with regularly scheduled doses and supplemented with as-needed doses for breakthrough pain.
12. Taper and discontinue drugs that don't meet treatment goals. If a drug does not produce the desired therapeutic outcome, there is no need to continue it. This practice helps to prevent expensive and potentially dangerous poly-pharmacy.

2. Analgesic Ladder ⁽¹²⁾ (7)

The World Health Organization (WHO) has published guidelines for the pharmacological treatment of cancer pain; many of these strategies also are used in nonmalignant pain. The following is a summary of the WHO recommendations:

1. Medications should be administered through the most effective and comfortable route, allowing patients the maximum control.
2. Analgesics given for moderate to severe pain are given on a fixed dose schedule around the clock and not on a PRN basis as is frequently (and incorrectly) done. This allows for more consistent pain relief since patients do not have to "play catch-up" with the previous dose that has largely worn off. Patients given analgesics this way are more comfortable and use less medication overall.
3. The ladder approach developed by the WHO provides for the administration of nonopioid medication (\pm adjuvants) first. This is followed by the use of mild opioids (e.g., codeine) for mild to moderate pain, \pm adjuvants, \pm nonopioids. For pain that persists, strong opioids (e.g., morphine) for moderate to severe pain are employed, \pm adjuvants, \pm nonopioids. This approach has been modified within CPHCS to reserve opioids for those with objective measures of severe disease or pathology.
4. There is a great deal of interpatient variability. The answer to the question, "How much opioid is enough?" is whatever it takes to relieve the pain without producing intolerable side effects for those with objective measures of severe disease or pathology.
5. Adjuvants are used for enhancing analgesics, controlling side effects, and managing other symptoms that are associated with chronic pain, such as nausea, depression, sedation, insomnia, and anxiety (see below). They also include medication for neuropathic pain, which is not well treated with opioids.

6. Follow-up closely with patients and look for changes in function and symptoms. Modify drug regimens as the symptoms dictate and continually educate the patient regarding the medication he or she is taking.



3. Nonopioid Analgesics

a. Acetaminophen

1. Analgesic that may be used initially for the treatment of mild chronic pain or to supplement other agents in treating mild to moderate pain.
2. Lacks anti-inflammatory effects but is generally well tolerated at therapeutic doses.
3. Does not damage the gastric mucosa but may have chronic renal or hepatic adverse effects.
4. Dosage should be restricted to a maximum of 4 grams per 24 hours, including acetaminophen contained in combination opioid products such as hydrocodone with acetaminophen.
5. Acetaminophen should be used cautiously or avoided in patients with liver impairment. For patients with liver disease, usual maximal daily dose is 2000 mg.

b. Aspirin

1. Aspirin salicylate

Dosing: Analgesic and antipyretic:

Oral: 325-650 mg every 4-6 hours up to 4 g/day

Rectal: 300-600 mg every 4-6 hours up to 4 g/day

Contraindications: CrCl <10 mL/minute:-Avoid use.

Avoid use in Severe Liver Disease

c. *Nonsteroidal Anti-inflammatory Drugs*

1. Until fairly recently, the analgesic effect of Nonsteroidal anti-inflammatory drugs (NSAIDs) was believed to arise exclusively from its peripheral action on the enzyme cyclooxygenase, which plays a central role in inflammatory conditions. It is now known that NSAIDs also act centrally, at least in certain pain states.
2. NSAIDs primarily are indicated for mild to moderate pain, particularly of somatic origin, although a number of newer compounds carry an indication for severe pain.
3. They are frequently used for soft tissue injury, strains, sprains, headaches, and arthritis.
4. They also exert synergy when paired with opioids, producing a dose-sparing effect, but they tend to be underutilized in this regard by many physicians.
5. There is little literature substantiating improved efficacy of one NSAID over another. Nevertheless, a patient who does not tolerate or respond to a particular NSAID may do well with another.
6. Compliance can be improved by switching to a twice a day or once daily preparation.
7. The reluctance of many patients and physicians to use NSAIDs to their full benefit stems in part from the many side effects associated with these drugs.

These side effects include:

- High-dose, long-term use of COX-2 agents has a higher rate of cardiovascular adverse effects. Recent reports indicate that cardiovascular adverse effects are not limited to the COX-2 agents alone (U.S. Food and Drug Administration, 2004).
- All NSAIDs have GI risks of gastritis and possible bleeding. Risks and benefits should be weighed, especially when treating elderly patients or those at higher risk for GI adverse effects. Consider using in combination with a proton pump inhibitor.
- Use with caution in patients with coagulopathies, thrombocytopenia, or other risk factors for bleeding.
- Chronic NSAID use increases the risk of renal insufficiency, especially those with diabetes, and patients should be monitored for signs of reduced renal function.
- Hepatic Toxicity can occur in patients with end-stage liver disease. However, patients with mild liver disease, for example, those who are Hepatitis C positive without evidence of elevated transaminases or cirrhosis may use NSAID's. A risk/benefit analysis should be made by the provider prior to deciding on whether to use Acetaminophen or NSAID's as a Step One analgesic.
- As a guideline you may start low-moderate dose NSAID's in patients with transaminase elevation of 3X or less. Once started, you should recheck transaminase levels in 2-3 weeks to be sure that further elevation has not occurred. Then recheck periodically while the patient is taking NSAID's.
- Do NOT use NSAID's in patients with severe or end-stage liver disease; for example those with lab abnormalities consistent with cirrhosis such as :
 - Serum albumin < 3 gm
 - INR >1.2
 - Platelets <100K,
 - Elevated LFT's>3X normal
 - Macrocytic anemia.

- Ketorolac should not be used for longer than five days and therefore is not an appropriate choice of NSAID in the treatment of chronic pain.
- Monitor all NSAID use including asking the patient about the use of non-prescription medication, to prevent duplication of therapy and adverse effects.
- Patients and clinicians should be vigilant for signs and symptoms of worsening liver disease when NSAIDs are prescribed.

4. Opioid Analgesics

a. General Principles

1. Opiates are naturally occurring alkaloids, such as morphine from the opium poppy seed.
2. Opioid is the term used broadly to describe all compounds that exert activity at the opioid receptor. The term narcotic derives from the Greek word for stupor.
3. Opioid Categories ⁽⁶⁾

The DEA classifies opioids into schedules related to potential abuse, and not potency (Table 1).

Table 1: DEA schedules of controlled drugs ⁽⁶⁾

I No medical use	high addiction potential	Heroin, marijuana, PCP
II Medical use	high addiction potential	Morphine, oxycodone, methadone, fentanyl, amphetamines
III Medical use	moderate addiction potential	Hydrocodone, codeine, anabolic steroids
IV Medical use	low abuse potential	Benzodiazepines, meprobamate, butorphanol, pentazocine, propoxyphene
V Medical use	low abuse potential	Buprenex, phenergan with codeine

4. Despite lack of pain control options in non-cancer patients with pain, some clinicians have been hesitant to prescribe opioids for several reasons:
 - The perceived and real legal ramifications of prescribing controlled substances
 - Known adverse-effects of opioid therapy
 - The need for increasing doses related to tolerance to therapy
 - The potential for addiction and abuse of opioids
 - The inability to predict when an opioid will be effective
 - Incomplete relief when chronic opioids are used to treat non-cancer pain
 - Lack of belief in patient's subjective reports of pain
 - Complexity of having to write monthly prescriptions for controlled substances
 - Difficulty dealing with co-morbidities in the chronic pain population

b. Is chronic opioid therapy effective in noncancer chronic pain? ⁽⁶⁾

1. The available evidence is highly variable.

2. A review of multiple systemic studies and the available literature in listed the following:
 - Transdermal fentanyl and sustained-release morphine: There is weak evidence to support long-term use of opioids in chronic non-cancer pain with improvement in function and reduction in pain for longer than 6 months.
 - Oxycodone, the evidence is limited.
 - Hydrocodone, the evidence is non-existent. There was no published evidence.
 - Evidence showing efficacy of Methadone and other drugs is non-existent.
3. The authors concluded that “This lack of evidence for the most commonly used opioids and weak evidence for morphine and transdermal fentanyl are insurmountable factors in the synthesis of evidence-based guidelines for opioid use for long-term management of chronic non-cancer pain.”
4. Therefore their recommendation:

Based on the review of multiple systematic reviews and the available literature, the recommendation is 2A — weak recommendation, high-quality evidence with benefits closely balanced with risks and burden; derived from RCTs without important limitations or overwhelming evidence from observational studies; with the implication that with a weak recommendation, best action may differ depending on circumstances or patients’ or societal values.

Consistent with this recommendation, CPHCS limits use of opioids to those with objective evidence of disease or pathology.

c. *Initiation and titration of Chronic Opioid Therapy* ⁽¹³⁾

1. Clinicians and patients should regard initial treatment with opioids as a therapeutic trial to determine whether chronic opioid therapy is appropriate with those with objective evidence of disease or pathology.
2. The decision to proceed with chronic opioid therapy should be intentional and based on careful consideration of outcomes during the trial. Outcomes to consider include:
 - Progress toward meeting therapeutic goals
 - Presence of opioid-related adverse effects
 - Changes in the underlying pain condition
 - Changes in psychiatric or medical co-morbidities
 - The identification of aberrant drug-related behaviors, addiction, or diversion.
3. Opioid selection, initial dosing, and titration should be individualized according to the patient’s health status, previous exposure to opioids, attainment of therapeutic goals, and predicted or observed harms.
4. In patients who are opioid-naive, or have modest previous opioid exposure, opioids should be started at a low dose and titrated slowly, to decrease risk of opioid related adverse effects. However, there is insufficient evidence to recommend specific optimal starting doses and methods of dose titration. In general, opioid doses should be individualized based on risk for adverse outcomes and responses to therapy.
5. Some patients, such as frail older persons or those with co-morbidities, may benefit from more cautious initiation and titration of therapy.
6. Short-acting opioids are probably safer for initial therapy since they have a shorter half-life and may be associated with a lower risk of inadvertent overdose.

7. However, there is no direct evidence from randomized trials that demonstrates that any one opioid is superior to any other for initial therapy.
8. For chronic opioid therapy, proposed benefits of transitioning to long-acting opioids with around-the-clock dosing include:
 - more consistent control of pain
 - improved adherence
 - lower risk of addiction or abuse (though well conducted studies have not examined these benefits)

d. Opioid Rotation/Equianalgesic Dosing⁽¹³⁾

1. Opioid rotation (switching from one opioid to another opioid) is a potential strategy for patients who experience intolerable adverse effects or inadequate benefit despite dose increases.
2. The theory behind opioid rotation is based on concepts of incomplete cross-tolerance to the analgesic and nonanalgesic effects across opioids and a high degree of individual variation in response to different opioids.
3. Well-designed studies that evaluate the benefits and harms of opioid rotation are lacking.
4. There is insufficient evidence to guide specific recommendations for performing opioid rotation. However, dose conversion tables are available (See Attachment C [Page 5]) and generally suggest that a switch to a new drug should be accompanied by a moderate (usually 25% to 50%) reduction in the calculated equianalgesic dose.
5. Methadone
 - The above method does not apply to cases in which patients are being rotated to methadone.
 - In opioid-tolerant patients, conversion to methadone should be performed cautiously.
 - Equianalgesic dose ratios for methadone relative to other opioids are variable and can range from 0.1% to 10% morphine equivalents (lower at higher doses).
 - In patients on lower doses of other opioids, safe starting doses of methadone may be similar to those used for opioid-naive patients.
 - Even in patients taking high doses of other opioids; when changing to Methadone the starting dose should generally not exceed 30 mg a day.
 - Several algorithms are available for converting from other opioids to methadone. (See Attachment C [Page 5])
 - Because of its long half-life and variable pharmacokinetics, it is recommended that methadone not be used to treat breakthrough pain or as an as-needed medication.

e. Methadone⁽¹³⁾

1. Use of methadone for chronic noncancer pain has increased dramatically.
2. In addition, a number of epidemiologic studies suggest an increased rate of methadone-associated deaths in the United States.
3. QT interval prolongation and cardiac arrhythmias may occur in patients on methadone, particularly at higher doses, or with concomitant use of drugs that interact with methadone or that themselves prolong the QT interval.
4. Clinicians who prescribe methadone should be familiar with its clinical pharmacology and associated risks.

5. Methadone has a very long and highly variable half-life, which necessitates careful titration to avoid delayed adverse events, such as overdose.
 - Although the half-life of methadone is usually estimated at 15 to 60 hours, in some reports the half-life is as high as 120 hours.
 - In a patient for whom the methadone half-life is 60 hours, it would take almost 12 days on a stable dose of methadone to approach a steady state (5 half-lives).
 - Methadone should therefore be started at low doses and titrated slowly.
 - The American Pain Society (APS) Guidelines suggest a safe starting dose in most opioid naive patients is 2.5 mg every 8 hours, with dose increases occurring no more frequently than weekly.
 - In older patients or those with renal or hepatic co-morbidities, less frequent dosing and more cautious dose titration are recommended.
 - In opioid-tolerant patients, conversion to methadone should be performed cautiously. Equianalgesic dose ratios for methadone relative to other opioids are variable (see above).
 - In patients on lower doses of other opioids, safe starting doses of methadone may be similar to those used for opioid-naive patients.
 - Starting methadone doses should generally not exceed 30 mg a day, even in patients on high doses of other opioids.(See Attachment C [Page 4])
 - As mentioned, because of its long half-life and variable pharmacokinetics, the APS recommends that methadone not be used to treat breakthrough pain or as an as-needed medication.

f. Adverse Effects

General Principles ^{(1) (14)}

1. Typical opioid adverse effects are common.
2. They include constipation, nausea, vomiting, somnolence, headache, dyspepsia, pruritus, dizziness, fatigue, dry mouth, sweating, and sedation.
3. Patient discontinuation due to adverse events is often reported.
4. In general, there are approaches to treating adverse effects from opioids:
 - Dose reduction
 - Changing to a different opioid or route of administration
 - Symptomatic management
 - Adjusting medication schedule
5. Titration of dosage needs to be in balance with a tolerable level of adverse effects.
6. Development of tolerance to adverse effects (with the exception of constipation) is commonly observed over time.

Nausea and Vomiting

1. Opioids affect the chemoreceptor trigger zone, the vestibular system and have a slowing effect on gastric emptying. All these can lead to nausea.
2. While nausea is common, tolerance usually occurs quickly, often within a week.
3. Treatment is given as needed.
 - When evaluating opioid-induced nausea, refractory constipation and impaction of stool must be considered and treated first.

- If nausea follows meals or is accompanied by postprandial vomiting, metoclopramide 10 mg t.i.d is an appropriate choice for short-term use.
- If it occurs with movement, meclizine 12.5-25 mg t.i.d may be more effective, but also should be considered for short-term use only.

Constipation

1. Multiple factors contribute to the development of constipation in patients receiving opioids. Opioids produce constipation by both direct and anticholinergic mechanisms. In addition, increased gastrointestinal transit time causes excessive water and electrolyte reabsorption from feces, and further dehydrates stool.
2. Elderly patients are particularly susceptible to constipation and stool impaction.
3. Focus should be on the prevention of constipation.
4. Cathartic and stool softening medications should be routinely initiated with around-the-clock opioid orders to prevent constipation, utilizing a stool softener such as docusate (colace) and a mild stimulant laxative such as senna (nonformulary).
5. Adequate hydration, physical activity, and regular toileting are also helpful.
6. Treatment
 - If constipation does develop despite a prophylactic regimen then treat with an osmotic laxative (as long as there is no evidence of obstruction), such as lactulose (10 to 20 gm) or magnesium citrate (200 mL).
 - A bisacodyl suppository or sodium phosphate enema (e.g., Fleet) is used for patients who are too nauseated to take oral cathartics.
 - Disimpaction may be facilitated with oral mineral oil, glycerin suppositories, or saline enemas.

Sedation and Cognitive Dysfunction

1. Somnolence and mental clouding are common when opioids are initiated or the dose is escalated.
2. Some patients continue to have these problems, especially when analgesic adjuvants (eg, antidepressants, anticonvulsants, benzodiazepines, antihistamines, phenothiazines) are being used.
3. Consider unrelated primary central nervous system pathology and metabolic abnormalities as potential causes of altered mental status when appropriate.
4. If symptoms persist, even if analgesia is not optimal, the opioid dose may be reduced.
5. Some patients, especially the elderly, may have cognitive impairment with opioids even at low doses and therefore may not tolerate their use.

Respiratory depression

1. All opioids affect the medullary respiratory center directly and can cause respiratory depression. No pure opioid agonist is less likely to cause respiratory depression than any other at an equianalgesic dose. Tolerance occurs quickly.

2. Respiratory depression may occur when initial opioid doses are too high, opioids are titrated too rapidly, or opioids are combined with other drugs that are associated with respiratory depression, or that may potentiate opioid-induced respiratory depression (such as benzodiazepines).
3. Patients with sleep apnea or other underlying pulmonary conditions may be at higher risk for respiratory depression and opioids should be initiated and titrated carefully.
4. If respiratory depression occurs, naloxone (narcan) 0.4 mg IV may be given and repeated as necessary. Since naloxone's half-life is shorter than that of most opioids, continued close monitoring for recurrence of respiratory depression is necessary.

Myoclonus

1. Myoclonus (uncontrollable spasms of certain muscle groups) is sometimes seen at very high doses of opioids.
2. There are no prospective studies on the treatment of opioid-induced myoclonus. However, clonazepam (0.5 to 2 mg PO three times daily) and perhaps other anticonvulsants also can be used to suppress myoclonus for patients, such as those at the end of life, who have no alternative but to continue the opioids.
3. If myoclonus occurs in a patient being treated for chronic pain, the opioid dose can be decreased.

Hyperalgesia

1. Excessive sensitivity to mildly noxious stimuli can be seen at very high doses of opioids. (See Section V – C.8 [Page 10])

Pruritus

1. Pruritus due to histamine release is observed in 2 to 10 percent of patients receiving chronic opioids.
2. Antihistamines are commonly recommended but there are no prospective studies on the treatment of opioid-induced pruritus. Anecdotal experience suggests benefit from short term use of Benadryl (25 mg with each opioid dose). If pruritus does not improve within a week, opioid dose may need to be decreased or discontinued.

Endocrine Effects

1. Chronic use of sustained-release oral opioids has been associated with hypogonadism and decreased levels of dehydroepiandrosterone sulfate in several cross-sectional studies.
2. The main effects of opioids on the hypothalamic-pituitary-gonadal axis involve the modulation of hormonal release, including:
 - Increase in prolactin
 - Decrease in LH, FSH, testosterone and estrogen
 - Studies have shown clinically relevant testosterone depletion develop in the majority of men receiving intrathecal opioid therapy for chronic pain⁽¹⁸⁾.
3. Consider testing for such hormonal deficiencies if patients report symptoms consistent with their presence, such as decreased libido, sexual dysfunction, or fatigue.

4. Insufficient evidence exists to recommend routine monitoring of asymptomatic patients on chronic opioid therapy for hormonal deficiencies, or to guide specific treatment approaches if a deficiency is identified.

g. Contraindications for Opioid Use

Background (1)

Although there are few absolute contraindications to the use of opioids in chronic pain, many factors must be considered prior to initiating therapy. The clinician must carefully weigh risks and benefits of chronic opioid therapy, and should discuss them with the patient. Patients with relative contraindications pose a higher risk of legal and clinical problems.

Absolute Contraindications:

Opioid therapy should *not* be used in the following situations:

- Allergy to opioid agents (may be resolved by switching agents).
- Co-administration of drug capable of inducing life-limiting drug-drug interaction.
- No objective evidence of severe disease or pathology (except when specifically approved by the institution's medical leadership via existing institution committee structure).
- Active diversion of controlled substances (providing the medication to someone for whom it was not intended).

Relative Contraindications:

Opioid therapy should only be used after careful consideration of the risks and benefits:

- Acute psychiatric instability or high suicide risk
- History of intolerance, serious adverse effects, or lack of efficacy of opioid therapy
- Meets DSM-IV criteria for current or past history of substance use disorder
- Inability to manage opioid therapy responsibly (e.g., cognitively impaired)
- Unwillingness or inability to comply with treatment plan
- Unwillingness to adjust at-risk activities resulting in serious re-injury
- Social instability
- Patient with sleep apnea not on CPAP
- Elderly patients
- COPD patients

If a relative contraindication exists, yet the patient has a diagnosed condition with objective evidence causing pain, a provider may wish to consult Mental Health or other specialist for assistance with the risk/benefit assessment and ongoing management.

h. Opioid Allergies (1)

1. Morphine causes the release of histamine, frequently resulting in itching, but this is not an allergic reaction.
2. True allergy to opioid agents (e.g. anaphylaxis) is not common but does occur.
3. Generally, allergy to one opioid agent does not mean the patient is allergic to other opioids; also switching to an agent in another opioid drug class may be effective.

4. For example, if a patient has a hypersensitivity to a phenanthrene, then a diphenylheptane drug may be tried (See table below).
5. When patients report an “allergy” to all but one agent (such as meperidine), the presence of a substance use disorder should be considered.

Table 2: Classes of Opioid Medications ⁽¹⁾

Phenanthrene	Diphenylheptanes	Phenylpiperidine
Codeine	Methadone	Fentanyl
Hydrocodone	Propoxyphene	Meperidine a
Hydromorphone		Other
Levorphanol		Tramadol
Morphine		
Oxycodone		

i. Indications to Stop Opioid Therapy

Are There Severe and Uncontrollable Adverse Effects?

1. Adverse effects associated with opioid therapy cannot always be resolved despite maximal attempts to mitigate them.
2. The determination of tolerability rests primarily with the patient and the care providers attempts to find solutions.
3. When the options have been exhausted and the therapy is a greater detriment than benefit, as determined in consultation with the patient, opioid therapy should be discontinued.

Serious Non-Adherence: Illegal, Criminal or Dangerous Behaviors

1. These behaviors are those that jeopardize the safety of the patient or society, or are illegal.
 - Active diversion (selling drugs)
 - Prescription forgery (common in the community)
 - Medication theft (less likely with DOT medication delivery)
 - Assault behaviors
2. Diversion, theft, or prescription forgery must be documented in the medical record to alert future providers of the behavior.
3. In most cases, Custody staff will be aware of the diversion or theft, often because they witnessed the behavior or discovered medications during a search of the patient’s cell. The Opioid Agreement specifically informs the patient that custody may be notified if diversion is suspected. Unless the patient or another person is in danger, the provider can use his or her own judgment about whether to inform custody of the patient’s actions.

4. Unless continued opioid prescription is specifically approved by the medical leadership via existing institution committee(s); diversion, theft, or prescription forgery will result in the immediate cessation (no taper needed with diversion, tapering doses needed in other cases) of the opioid with appropriate treatment of potential withdrawal symptoms.

Non-effective Therapy or Other Indications to Stop Therapy?

1. The efficacy of opioids is measured not just by impact on pain but also by impact on function (including sleep, eating, physical and social activities), interpersonal relationships and mood. Discussions with patients regarding the impact of opioids on all these aspects determine whether to continue or discontinue therapy.
2. If the patient has demonstrated substantial improvement both in function and reported pain levels, reasonable doses of opioids could continue.
3. Evaluation of the continued need for opioids every two months can be accomplished using techniques such as weaning and/or substitution of alternative treatments.
4. Consider tapering off opioid medication if the patient claims or exhibits:
 - Lack of efficacy: Continuing pain despite titration of dose to intolerable adverse effects
 - Lack of response despite trials of several different kinds of opioids
 - Decrease in overall function
 - Patient desires to discontinue therapy
 - Patient desires to change to non-opioid therapy
 - Resolution of the pain problem (i.e. patient gets better)

Is There Evidence of Non-Adherence or Medication Misuse Suggestive of Addiction to Prescribed Opioid?

1. Addiction in the context of pain treatment with opioids is characterized by a persistent pattern of opioid misuse that may involve any or all of the following:

Table 3: Predictors of Opioid Misuse ⁽¹⁾

Predictors of Opioid Misuse
Behavior that Suggests Addiction
<ul style="list-style-type: none"> ▪ Use of prescription opioids in an unapproved or inappropriate manner (such as cutting time-release preparations, injecting oral formulations, and applying fentanyl topical patches to oral or rectal mucosa) ▪ Obtaining opioids outside of medical settings ▪ Concurrent abuse of alcohol or illicit drugs ▪ Repeated requests for dose increases or early refills, despite the presence of adequate analgesia ▪ Repeatedly seeking prescriptions from other providers or from TTA or outside emergency rooms without informing the prescribing provider

- Evidence of deterioration in the ability to function in the prison setting, such as not participating in their work or education program, which appears to be related to opioid use
- Repeated resistance to changes in therapy despite clear evidence of adverse physical or psychological effects from the drug
- Positive urine drug screen—other substance use (cocaine, opioids, amphetamines or alcohol)
- Meets DSM IV criteria for dependence on opioids
- Ongoing serious dependence on alcohol or illegal drugs is incompatible with the prescription of opioids for chronic pain

j. Opioids on CDCR Formulary

Opioids
<p>Acute pain and /or breakthrough/flare-ups in chronic pain (in general use limited to 10 days):</p> <ul style="list-style-type: none"> • Tylenol #3 (There will be 10% of patients who cannot metabolize codeine and therefore will not respond to this medication. Tramadol can be considered as a short-term alternative) • Morphine IR • Tramadol (Nonformulary) <p>Chronic Pain:</p> <ul style="list-style-type: none"> • Morphine • Methadone

5. Pharmacologic Adjuvants for Pain Management ⁽¹⁷⁾

The usefulness of pairing adjuvant agents with pain medications is well known by pain management specialists. Some are used to treat the side effects associated with pain medications, while others potentiate analgesia. Below are the categories of agents generally used:

a. Anticonvulsants

1. A number of anticonvulsants are effective for chronic pain therapy, particularly for neuropathic pain.
2. Mechanisms of action for the anticonvulsants vary and are not fully understood.

3. Beyond the consistent selection of Carbamazepine for trigeminal neuralgia, physicians vary widely in their preferences for the use of these drugs.
4. The CPHCS Pain Committee has chosen the following medications as **preferred**:
 - a. Oxcarbazepine (Trileptal): Similar to Carbamazepine but does not carry the same risk of agranulocytosis or aplastic anemia, has less hepatotoxicity and therefore does not require the monitoring that Carbamazepine requires.
 - b. Gabapentin (Neurontin): Tablets and capsules are formulary (Not liquid)
5. The CPHCS Pain Committee has selected the following as an **alternate agent**:
 - a. Carbamazepine (Tegretol): first line for Trigeminal Neuralgia

Oxcarbazepine: (Trileptal)

- This is a compound with a similar chemical structure to Carbamazepine and likely a similar mechanism of action. It is used off-label in the treatment of neuropathic pain.
- It is generally thought to be equally efficacious with carbamazepine.
- Metabolism of Oxcarbazepine occurs in the liver, but only minimally affects the cytochrome P450 system. This represents a major advantage over carbamazepine, particularly in patients who require polytherapy.

Dosing Oxcarbazepine (Trileptal)	<ul style="list-style-type: none"> • Start with 300 to 600 mg/day • Increasing to a dose of 900 to 3000 mg/day in two or three divided doses.
Monitoring	<ul style="list-style-type: none"> • The FDA has warned of an increased risk of suicidal behavior or ideation when taking anticonvulsants
Adverse Effects	<ul style="list-style-type: none"> • The most common side effects, headache, dizziness, rash, vertigo, ataxia, nausea, hyponatremia, and diplopia. • Studies have also found decreased thyroid hormone levels in patients on both short and long-term treatment with Oxcarbazepine; the clinical significance of these findings is not yet known

Gabapentin:
(Nerontin)

- **Has received considerable attention in pain** management, partly because it has few side effects and no apparent drug interactions.
- The efficacy of gabapentin was shown in a double-blind multicenter trial to contribute to a *modest* but significant difference in pain scores at 10 days between the gabapentin and placebo groups (4.6 versus 5.4 on a scale of 1 to 10).
- The effect was most pronounced in patients with dysesthesias.
- Note: some CDCR institutions have noted that this medication can be a drug of abuse and has significant diversion risk. Gabapentin should be crushed and floated and be administered DOT.

- Pregabalin (Lyrica) can be given less frequently (twice daily) than gabapentin (usually three times daily) but may cause euphoria and is a schedule V controlled substance. (Lyrica is not on the CDCR Formulary and the CPHCS Pain Committee does not recommend its use.)

Dosing Gabapentin (Neurontin)	<ul style="list-style-type: none"> • To be administered DOT, crushed and floated • The usual starting dose is 300 mg at bedtime • May titrate as follows (if patient tolerating medication but no relief achieved): <ul style="list-style-type: none"> ○ 300 mg QD x 3 days ○ 300 mg BID x 3 days ○ 600 mg BID x 3 days ○ 900 mg BID x 3 days ○ 1200 mg BID x 14 days ○ 1600 mg BID x 14 days ○ 1800 mg BID x 14 days ○ Maximum dose 3600 mg/day (1800 mg bid) is listed for post-herpetic neuralgia but manufacturer states daily doses greater than 1800 mg do not generally show greater benefit. ○ Use TID dosing only when BID has failed because of early breakthrough (limit TID dosing to patients with neuropathic pain) • The dose should be reduced in patients with renal failure and titration should be slower.
Monitoring	<ul style="list-style-type: none"> • Serum concentrations do not need to be monitored.
Adverse Effects	<ul style="list-style-type: none"> • Side effects (somnolence, ataxia, dizziness) are not life-threatening.

Carbamazepine: (Tegretol) Alternate agent, (first line in trigeminal neuralgia)

Dosing Carbamazepine	<ul style="list-style-type: none"> • <i>Started at 100 mg twice daily and the dose is escalated until pain is relieved, toxicity occurs, or the safe serum concentration (12 µg/mL) is exceeded.</i>
-------------------------	---

<i>Monitoring</i>	<ul style="list-style-type: none"> • <i>A complete blood count and baseline liver function tests should be obtained prior to starting patients on Carbamazepine.</i> • <i>It is recommended that blood tests be followed for the first three weeks and periodically thereafter.</i> • <i>Blood levels do not generally correlate with efficacy; doses are gradually titrated upward until pain symptoms are improved or adverse effects occur.</i> • <i>Blood levels may be helpful in determining compliance during dose escalations.</i>
<i>Adverse Effects</i>	<ul style="list-style-type: none"> • <i>Among the common side effects that can be encountered are sedation, vertigo, ataxia, hyponatremia, nausea, and cutaneous reactions.</i>

k. NSAIDs

1. Generally select one and if that medication fails at reasonable dose, chose another NSAID from a different family.
2. NSAID's can be used in patients with Hepatitis C or other hepatic conditions if there is no evidence of significant liver disease/cirrhosis. (See Section V – G.3 – C.7 [Page 17])

NSAIDs	
Propionic Acids	Motrin-Ibuprofen Naprosyn
Salicylates	Disalcid-Salsalate
Indole and Indene Acetic Acids	Clinoril-Sulindac

l. Antidepressants

1. Anti-depressants may be prescribed by PCPs without guidance from Mental Health under the following conditions:
 1. If treatment is solely for the purpose of pain management and if the screen for depression contained in the Intake Tool is negative. Provider should document absence of depression symptoms in subsequent pain management visits as well.
 2. If screening is positive for depression or the patient is currently in EOP or CCCMS program, the provider will consult Mental Health prior to prescribing antidepressants for pain management.
 3. In addition, the provider will document a review of the patient's medication profile to avoid potential drug-drug interactions with prescribed psychotropic medications.
 4. Anti-depressants are to be administered DOT, and crushed, floated, or liquid.

5. Even with precautions noted above, these medications pose suicide risk and providers should be alert to this possibility. All anti-depressants carry a black-box warning which says: *Antidepressants increase the risk of suicidal thinking and behavior in children, adolescents, and young adults (18-24 years of age) with major depressive disorder (MDD) and other psychiatric disorders; consider risk prior to prescribing. Short-term studies did not show an increased risk in patients >24 years of age and showed a decreased risk in patients ≥65 years.*

SNRI

1. A randomized trial of venlafaxine (Effexor) in patients with painful polyneuropathy found that venlafaxine was superior to placebo and was similar in efficacy to imipramine.
2. Duloxetine (Cymbalta), another SNRI, is approved for the treatment of diabetic peripheral neuropathy. This medication is nonformulary and should be used only if formulary alternatives have failed or are contraindicated.
3. Neither medication can be used with MAOI's.

Dosing	<p>Venlafaxine: (Effexor)</p> <ul style="list-style-type: none"> ▪ Should be DOT ▪ Start at 37.5 mg/day ▪ Increase by 37.5 mg weekly ▪ Usual dose 75 mg (IR) BID or 150 mg (ER) QD ▪ Manufacturer notes onset of relief may occur in 1-2 weeks, or take up to 6 weeks for full benefit ▪ Dose adjust in renal and hepatic impairment 	<p><i>Duloxetine (Cymbalta-Nonformulary)</i></p> <ul style="list-style-type: none"> • <i>Should be DOT</i> • <i>Start at 30-60 mg QD</i> • <i>According to the manufacturer, doses up to 120 mg/day administered in clinical trials for diabetic neuropathy offered no additional benefit and were less well tolerated than dose of 60 mg/day</i> • <i>Dose adjust in renal impairment</i> • <i>Do not use in patients with Hepatic impairment</i>
Monitoring	<p>Venlafaxine</p> <ul style="list-style-type: none"> ▪ Blood pressure should be regularly monitored, especially in patients with a high baseline blood pressure; may cause mean increase in heart rate of 4-9 beats/minute 	<p><i>Duloxetine</i></p> <ul style="list-style-type: none"> • <i>Blood pressure should be checked prior to initiating therapy and then regularly monitored, especially in patients with a high baseline blood pressure</i> • <i>Mental status for depression, suicidal ideation (especially at the beginning of therapy or when doses are increased or decreased), anxiety, social functioning, mania, panic attacks</i> • <i>Glucose levels and Hb A1c levels in diabetic patients, creatinine, BUN, transaminases</i>
Adverse Effects	<p>Venlafaxine</p> <ul style="list-style-type: none"> ▪ Nausea, constipation, dizziness, drowsiness, hypertension at high doses ▪ Narrow-angle glaucoma: May cause mydriasis; use caution in patients with increased intraocular pressure 	<p><i>Duloxetine</i></p> <ul style="list-style-type: none"> • <i>Adverse Effects were nausea, somnolence, dizziness, decreased appetite, and constipation</i> • <i>Because nausea is common, patients are encouraged to take the drug on a full stomach</i> • <i>Duloxetine should not be taken with other serotonin or norepinephrine uptake inhibitors but can be combined with anticonvulsant therapy</i> • <i>Narrow-angle glaucoma: May cause mydriasis; use caution in patients with</i>

1. Tricyclic Antidepressants (TCAs)^{(7) (12)}

1. Although none of the tricyclic antidepressants (TCAs) carry an indication for pain management, they remain a pharmacological mainstay in the treatment of neuropathic pain, with or without coexisting depression.
2. TCAs are categorized as secondary amines (nortriptyline or desipramine) or tertiary amines (amitriptyline and imipramine).
3. Both classes are effective in the treatment of neuropathic pain, but the tertiary amines have more anticholinergic side effects and generally should be avoided in the elderly.
4. Analgesic effects of TCAs are independent of their antidepressant effect, and analgesia may be seen with lower doses.

Dosing Nortriptyline	<ul style="list-style-type: none"> ▪ Start 10-25 mg day ▪ Increase by 10-25 mg weekly up to 75 mg/day ▪ Maximum analgesic effect may take several weeks or longer to be seen
Monitoring	<ul style="list-style-type: none"> ▪ Baseline ECG is indicated in patients at risk for cardiac adverse effects
Adverse Effects	<ul style="list-style-type: none"> ▪ Common side effects include sedation, dry mouth, constipation and urinary retention ▪ Many of the unpleasant side effects, such as dry mouth, mental clouding, and others, may diminish in days to weeks

Special Cautions:

1. Use caution in patients with conditions that may be aggravated by TCAs, including heart disease, symptomatic prostatic hypertrophy, neurogenic bladder, dementia and narrow-angle glaucoma.
2. Use in the prison setting is controversial due to hoarding/suicide risk.
3. The CPHCS Pain Committee recommends use in carefully selected patients who have significant neuropathic pain and have been refractory to all other treatments.
4. Monitoring of blood for presence of TCA during therapy may help detect a patient who is not taking it regularly and may be hoarding medication.

m. Muscle Relaxants

1. A wide variety of pain conditions may be accompanied by painful muscle spasm.
2. Muscle relaxants can be useful in treating this aspect of the patient's symptoms, but their action may be more the result of sedation rather than muscle relaxation.
3. In general, muscle relaxants are indicated for short term use in acute pain and, if needed, methocarbamol (Robaxin) can be used for 10 days.
4. In selected patients with true spasticity from spinal cord pathology, longer term use of Baclofen may be indicated.

5. These medications may also cause CNS depression and should be used cautiously when combined with other CNS depressant medications.

Dosing	Methocarbamol <ul style="list-style-type: none"> ▪ 1500 mg 4 times/day for 2-3 days (up to 8 g/day may be given in severe conditions), then decrease to 4-4.5 g/day in 3-6 divided doses 	Baclofen -Formulary use restricted to spinal cord injury <ul style="list-style-type: none"> ▪ 5 mg 3 times/day, may increase 5 mg/dose every 3 days to a maximum of 80 mg/day ▪ Use with caution in elderly patients and those patients with seizure disorder or renal impairment ▪ Avoid abrupt discontinuation
Monitoring	Methocarbamol- no specific monitoring required	Baclofen- no specific monitoring
Adverse Effects	Methocarbamol- drowsiness, dizziness, blurry vision	Baclofen- drowsiness, dizziness, fatigue, hypotension, nausea, constipation

VI. Acute Pain: Description of Program

Section Outline

- | |
|---|
| <ul style="list-style-type: none"> A. Assessment B. Pain scales C. Diagnosis D. Treatment |
|---|

A. Assessment

- Acute pain is not a diagnosis, it is a symptom.
- Frequently its cause is obvious, such as after surgery or an acute trauma.
- Many times, however, the exact underlying etiology is not clear and a diagnostic workup is necessary.
- An interview with the patient or a responsible caregiver is essential to determine etiology.
- The interview and examination should cover the following:

1. General History

1. History of present illness (HPI)
2. Current medications
3. Medication allergies
4. Past medical history

5. Social history
6. Mental Health History (evidence of anxiety or depression)

2. Pain history

1. Onset, duration and location. Obvious injury? Surgery?
2. Description, quality, character- listen for descriptors consistent with specific pain mechanism
3. Prior pain problems? If so what, and how treated?
4. History of drug or alcohol abuse
5. Aggravating or alleviating factors
6. Patient rating on pain scale if possible (See below)

3. Clinical exam

1. Focused physical exam (part of body or region in pain), to include vital signs.
2. Increases in pulse, respiratory rate, and blood pressure are often but not always noted in the presence of acute pain. However, vital signs may be normal as a result of physiologic adaptation.
3. Functional assessment (See below)
4. Pain medications should generally not be withheld during initial evaluation for potential surgical abdomen.

4. Further Diagnostic Work-Up

1. Lab studies, x-rays or other diagnostic tests may be needed, depending on the results of the history and physical examination.

5. Specialty Consult

1. General surgical, orthopedic, anesthesiological or other consultation may be deemed necessary. (See Section VII – E.1 [Page 67])

6. Goals and Expectations

1. For most patients, their goal or expectation will be complete relief of pain. When that is possible, it should be attempted. It has been shown that poorly treated acute pain is one risk factor for the development of chronic pain.
2. In many conditions complete pain relief cannot be achieved safely. Education of the patient on the natural history/expected course of their condition can help to avoid unnecessary anxiety which can complicate the treatment of their pain.
3. Use of numeric rating scales can help patients identify changes in the intensity of their pain.

7. Follow-up

1. Close follow-up by the Primary Care Team until healing of the injury or resolution of the problem is recommended.
2. This will assure the patient that their condition will be monitored and the provider will be able to identify any unexpected change in condition or delay in recovery.

B. Pain Scales

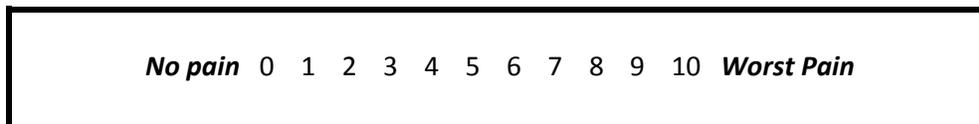
1. Based on the assumption that patient self-reporting is the "most reliable indicator of the existence and intensity of pain" (National Institutes of Health), a measure of self identified pain, along with objective measures of disease and pathology, will direct pain management.

2. In addition, these tools are applicable to any person regardless of age, race, creed, socioeconomic status, and psychological or emotional background.
3. There are multiple pain assessment tools available for determining the quantity and quality of a patient's pain experience. The pain committee has selected the Numeric rating scale, which is shown below.

Numeric Rating Scales:

- Can be administered verbally or visually
- Use has been validated in trauma, cancer, rheumatic and chronic pain patients
- Use has been validated in illiterate patients
- Can detect amount of pain relief associated with treatment
- Less reliable at extremes of age
- Less reliable in patients with visual, auditory or cognitive dysfunction

The Numeric Rating Scales have primarily been validated in patients with acute pain, but can also be used in patients with chronic pain. The CPHCS Pain Committee had selected the following Numeric Rating Scale for use in our Pain Guidelines.



If you have a patient who is having difficulty with the 1-10 Numeric Scale, you may utilize an alternative such as a simpler 0-3 scale, a color scale, or the facial expression scale.

C. Diagnosis/ Mechanism of Pain

1. If the above assessment identifies an acute injury/condition and the mechanism of pain is clear, one may go directly to treatment.
2. If after assessment a diagnosis is not clear, it can be helpful to differentiate between somatic/visceral and neuropathic pain in order to best guide treatment. (See Section V – B.2 [Page 7])
3. If a patient's pain has persisted for > 30 days (or longer than the anticipated healing time), a thorough evaluation for the cause of the chronic pain is warranted.

D. Treatment

1. General principles:

1. Management by Primary Care Provider is preferred
2. Develop a care plan
3. Set treatment goals and expectations
4. Arrange follow-up as appropriate until pain has resolved

2. Non-Pharmacologic Approaches

1. While there is growing interest among patients and providers in non-pharmacologic complementary therapies for acute pain, there is little conclusive advice that can be drawn from studies available to date.⁽⁶⁾
2. There are a broad range of therapeutic modalities, including:
 - Education

- Rehabilitative therapies as indicated:
 - Activity Modification, temporary restrictions and temporary use of braces
 - Physical (heat, cold if available)
 - Exercise (self-directed graded exercise)
 - Physical Therapy when indicated- usually evaluation and prescription of self-management rehabilitation/exercise program
 - Specific procedures when indicated
 - Psychologic: Cognitive/Behavioral techniques, relaxation, imagery
3. Non-pharmacologic treatment of low back pain appears to be the best studied. A recent extensive review found that for acute low back pain, only heat application bore strong evidence for efficacy.
 4. Conflicting evidence has been noted with transcutaneous electrical nerve stimulation (TENS), ultrasound and numerous other treatments. Nonetheless, even when a significant decrease in pain isn't shown, patient satisfaction can be substantially improved with non-pharmacologic approaches.

3. Pharmacologic

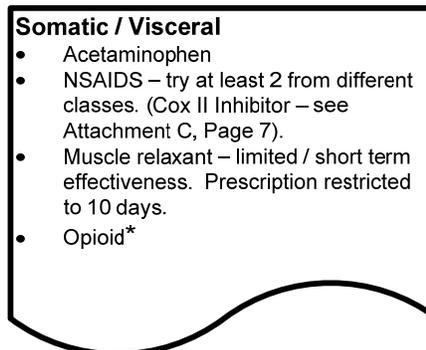
a. *Nonopioid Medication:*

1. Somatic/visceral pain:

The ICSI Acute Pain Guidelines tease out a few treatment differences between somatic and visceral pain:

- Treatment of somatic pain includes the use of acetaminophen, cold packs, corticosteroids, localized anesthetic (topical - nonformulary), NSAIDs, opioids and tactile stimulation.
- Treatment choices for visceral pain include corticosteroids, intraspinal local anesthetic agents, NSAIDs and opioids (via any route).

There is often overlap in the types of pain seen and for purposes of the CPHCS Acute Pain Management Algorithm (See Attachment B), the two types of pain are combined.



2. Neuropathic Pain:

1. Neuropathic pain may be resistant to nociceptive pain treatment strategies and is even considered relatively resistant to opioid therapy. Therefore, anticonvulsants and tricyclic antidepressants are mainstays of therapy. A few generalities on the use of these medications include:
 - Complaints of *continuous burning* may best respond to *antidepressants*.
 - Complaints of *lancinating pain* may best respond to *anticonvulsants*.
 - Failure to adequately relieve neuropathic pain with one anticonvulsant does not imply that alternative therapies will not work.

- Dose must be titrated and medication given time to work. Often efficacy is not achieved for 3-4 weeks. Educate patient to stick with the medication.
- 2. Other potential treatments include local anesthetics (topical – nonformulary, or intraspinal), and glucocorticoids. (Topical Lidocaine restricted to pain specialist use, ESI and other procedures have limited indications (See Attachment I) and follow InterQual criteria and MAR process.)
- 3. Although NSAIDs are not generally considered effective in pure neuropathic pain, they can be tried if mixed pain mechanism is suspected.

The following is the CPHCS Pain Committees recommendation for treatment of acute neuropathic pain.

Neuropathic

- Choose one:
 - Anticonvulsant (gabapentin, oxcarbazepine)
 - SNRI (venlafaxine, duloxetine-NF)
 - Tricyclic Antidepressant (nortriptyline+)
- (Titrate dose and allow adequate time. If no response, try another class. If limited response add another class.)
- If mixed pain consider adding NSAID – try at least 2 from different classes.
- Opioids*

+Nortriptyline: DOT

4. Opioid Medication:

The following general principles apply to opioid use in Acute Pain.

1. The patient must have an established diagnosis prior to starting opioids.
2. Use short acting medication; codeine in combination with acetaminophen.
 - If patient intolerant to Tylenol #3 (or it is ineffective), then short-term non-formulary use of Tramadol can be considered.
 - If above not 'strong enough', may use immediate release morphine (Morphine IR) if your facility is able to dose frequently. If dosing intervals are a concern then sustained release morphine (Morphine SR) can be prescribed and dose titrated using Morphine IR. (See Attachment C [Page 2])
 - Darvocet should not be used.
 - Oxycontin has a significant diversion risk and should not be used.
3. NSAID's can potentiate opioid effect, consider adding low-moderate dose if patient not already taking one.
4. Opioids for *acute pain* are indicated for short term use only. If patient reports needing continued opioid after expected healing of pain condition (generally < 30 days) refer to *Chronic Pain Guidelines*.

5. It is recommended that you write the indication and intended duration of the opioid on the medication order. (i.e. Tylenol #3 2 po t.i.d for acute ankle fracture x 10 days)
 - This will make it easier for medical leadership and P & T Committee to track appropriate use.
6. If a patient has been on a significant dose of opioid for more than a couple weeks, when discontinuing consider short taper of opioid to avoid withdrawal symptoms.
7. While completion of the CPHCS Patient Agreement/Informed Consent is generally not required for opioid use in acute pain, the provider should educate patient on risks/benefits of opioid use and the expectation that medication will be decreased then stopped as condition resolves.

***Opioids for Acute Pain**

- May be used only for severe pain for a short duration (i.e. post-op or post severe injury).
- Short acting opioids in combination with acetaminophen should be used for opioid dose sparing. (Formulary acetam/codeine).
- Educate patient that medication WILL be stopped when acute injury has healed.
- If some pain continues, more appropriate medication / treatment will be used long term (refer to Chronic Pain Algorithm.)

- + Requires Mental Health Evaluation if coexisting depression
- ✓ Limited indications restricted to use by pain specialist only
- NF Nonformulary

5. The WHO Pain Ladder Offers a Step Wise Approach:

1. **Step One:** (mild pain): Non opioid +/- adjuvant
 1. Starting off with low dose mild analgesics such as acetaminophen (maximum of 4000mg/day) or ibuprofen (maximum of 2400mg/day) is recommended for patients who have no contraindications.
 - Acetaminophen may be safely used in those with chronic liver disease in doses of less than 2000 milligrams a day, but would avoid in those patients with known cirrhosis.
 - NSAID's may be used in patients with Hepatitis C or other chronic liver conditions if there is no evidence or cirrhosis/End-Stage Liver disease. (See Section V – G.3 [Page 161])
 2. If one NSAID doesn't work, try switching to a different class; preferably one on formulary, before abandoning these medications. (See Attachment C [Page 7 – Table 6])
 3. Next add adjuvant medications if needed. (See Attachment C [Page 8 – Table 7])
2. **Step Two:** (worse pain): Weaker opioid +/- non opioid +/- adjuvant
 1. A specific diagnosis with objective findings is required prior to the initiation of opioid medication.

2. The CPHCS Pain Committee has identified Tylenol & Codeine #3 as the preferred ‘weak’ opioid of choice.
 - Tylenol#3 contains 325 mg of acetaminophen and 30 mg codeine.
 - Codeine is a ‘prodrug’ and 10% of people do not metabolize and therefore will not obtain analgesia with Codeine.
 - If Tylenol #3 is ineffective or contraindicated, Tramadol (nonformulary) may be used short-term.
4. Next, add additional adjuvant medications if needed. (See Attachment C [Page 8 – Table 7])

3. Step Three: (worst pain): Strong opioid +/- non opioid +/- adjuvant

1. The CPHCS Pain Committee recommends the following strong opioids:
 - **Acute Pain:** if a stronger opioid is required, Morphine IR can be used if your facility is able to dose frequently. If dosing intervals are a concern then Morphine SR can be prescribed and dose titrated using Morphine IR.
 - Some institutions believe that if dose titration with opioids is needed in acute pain, then patient should be in CTC setting. As many institutions do not have CTC’s this is not always practical.
 - **Chronic pain:** Methadone and Morphine SR are the preferred ‘strong’ opioids of choice in chronic pain.
2. There are risks and benefits to all opioids. Considerations for these two opioids include:

<p><u>Methadone</u> Effective analgesia Can be crushed Must monitor QT interval Half life variable Full effect in 2-4 weeks</p>	<p><u>Long-Acting Morphine</u> (Morphine SR) Effective analgesia Unable to crush long acting tablets Does not require monitoring Full effect varies</p>
<p>Black Box Warning: Opioid addiction QT prolongation Respiratory depression</p>	<p>Black Box Warning: Abuse/misuse/diversion Do Not crush or chew SR pills</p>

- Meperidine (Demerol) has toxic metabolites and should not be used.
- Oxycodone (Percocet, Oxycontin) is another strong opioid but its abuse potential is felt to outweigh its potential benefits and it should not be used.
- Transdermal Fentanyl (Duragesic) has limited indications and has abuse potential. CPHCS Pain Committee recommends use by Oncology, Hospice or Pain Specialists only.
- Hydromorphone (Dilaudid) has limited indications and has abuse potential. CPHCS Pain Committee recommends use by Oncology, Hospice or Pain Specialists only.

VII. Chronic Pain: Description of Program

Section Outline

- A. Evaluation/Assessment
- B. Diagnosis
- C. Treatment
- D. Monitoring During Treatment
- E. Special Clinical Situations
- F. Implementation

A. Evaluation/Assessment

1. History/Physical

Chronic pain is a disease state syndrome with numerous etiologies. As such, it must be addressed like one of our chronic diseases. This includes: ⁽¹⁾

1. The patient having an *established relationship* with a *Primary Care Provider*.
2. Initial assessment of *general health status* consisting of *History and Physical*.
3. Documentation of *co morbid medical conditions* on the *Problem List*.
4. *Scheduled follow up visits* at a frequency based on the disease status and degree of control.
5. In addition to the above usual evaluation the assessment and documentation of pain in a **systematic** and **consistent** manner is required.
6. At each visit the provider must evaluate and document treatment-related change and address/explain source of pain or comment that after thorough evaluation the source is unknown.
7. Since the goal of therapy is to alleviate pain and improve function, the assessment should focus on assessing the pain, functional status and psychologically status.
8. Components of a Pain Management Intake Assessment:
 - Pain onset and location, any injuries?
 - Pain description-listen for descriptors of specific pain mechanisms such as somatic or neuropathic
 - Prior pain diagnoses, testing- what are results?
 - Any prior procedures/surgery for pain problem? What was it? Where and when performed?
 - Prior pain medications: which ones? Effectiveness? Side effects?
 - Other prior pain treatments- nonpharmacologic such as physical therapy, TENS, or Mental Health counseling?
 - History of Mental Health disorder/treatment?
 - Screen for depression (Chronic Pain Intake Form has 2 question screening- see below)
 - Obtain history of drug/alcohol abuse-Current? Past? Substance of choice? Any prior treatment?
 - What factors aggravate or alleviate the pain?
 - Pain scale: severity of pain in last week, on average and currently
 - Assessment of level of function (activities of daily living. etc) –how is pain affecting ability to get in and out of bunk, shower, other self care, stand for counts, get down for alarms, and participate in prison program (whether job or education).
 - Assessment of how pain is affecting mood and sleep

9. Pain scales ⁽¹⁾

- There are advantages to using a numeric rating scale (NRS) for assessing pain and function. While the NRS has primarily been validated in acute pain it has been found to be valid and reliable, and to be sensitive to changes in acute, cancer, and chronic pain.
- Research indicates that “least” and “usual” pain ratings provide the best estimate of actual pain intensity.
- Treatment related changes/improvements in pain rating can be helpful in clinical decision making.
- If available, use the two-page CPHCS Chronic Pain Intake Form (See Attachment D [2 Pages]) which includes the recommended components.
- Some pain providers feel that a patient-completed pain questionnaire is valuable. A five-page Initial Pain Assessment Patient Completion Form (See Attachment E [5 Pages]) is available. Most providers who use this patient report will use only page two of the CPHCS Chronic Pain Intake sheet to avoid duplication of work.

2. Psychosocial Evaluation

Why do a Psychological Assessment?

1. Psychological factors may influence the experience, report, and display of pain.
2. Identification and management of co-morbid psychological disorders will facilitate appropriate biopsychosocial care.
3. Unmanaged disorders may interfere with the patient's ability to meaningfully participate in a collaborative plan of care and likely diminish treatment effectiveness.

How does one do a Psychological Assessment? ⁽⁷⁾

1. Assessment questions to ask the patient*:
 - Are you depressed or anxious?
 - Are you under any psychiatric care? At what level? CCCMS? EOP?
 - Are you receiving any medication? If so, what medication?
 - Do you have a history of substance abuse? If so, what were your substances of choice? Are you currently using any substances?

*For simplicity sake, the following screening questions have been added to the CPHCS Chronic Pain Intake Sheet:

History of mental health disorder in past?	Anxiety	Depression	Schizophrenia	Personality Disorder
Currently seeing mental health?	Yes	No		
During the last 2 weeks have you felt down, depressed or hopeless?	Yes	No		
Have you had little interest in doing things?	Yes	No		
History of substance abuse/illegal drugs?	Yes	No	Which drugs?	
Last use?	Route?	Oral	Nasal	Injection

What conditions might be identified?**i. Depression:**

- Commonly co-morbid with persistent pain condition.
- Research suggests 35%-50% of pain patients have depression.
- Duration and magnitude may signal need for specialty consultation/referral.

ii. Anxiety

- Increased prevalence in chronic pain samples.
- May be a risk factor for the development of chronic pain syndrome.
- Psychophysiological mechanisms can maintain and/or exacerbate chronic pain.
- Associated with fear of pain and fear of movement/reinjury, contributes to avoidant coping pattern.

iii. Substance Abuse and Dependence

- Increased prevalence of substance use disorders in chronic pain patient groups.
- Attend to historical and current use patterns and history of formal treatment.
- Substance use history needs to be considered in the decision to prescribe medication.

3. Functional Evaluation**a. Why do a functional assessment?**

1. This is the primary marker for patient outcome/ efficacy .

b. How does one do a Functional assessment? ⁽³⁾

1. Assessment questions to ask the patient:
 - Are you able to participate in prison program? Work or education?
 - Are you able to get in and out of your bunk?
 - Does your pain affect your relationship with others? Are you irritable? Withdrawn?
 - Do you have any hobbies that are affected by your pain?
 - Is your sleep disturbed by pain? If so, how?
 - Are you able to walk to meals? Participate in yard? Get down for alarms? Stand for counts?
 - Self-care behaviors; do you have any limitations with showering? Dressing? Grooming? Toileting?

4. Goals and Expectations**a. How does one elicit the patient's goals? Ask:**

- What is their expectation about achievable degree of pain relief?
(Is their expectation that they will be pain free?)
- What is their expectation about which treatments will be used?
- Do they have specific treatments or medications in mind? If so, which one(s)?
- What is their expectation about how fast the pain management process will occur?

- What is their expectation about their role/responsibility in the program? Document the patient's goals/expectations in the visit note, either in the subjective or assessment portion of the note.

B. Diagnosis

1. Establish Diagnosis/Medical Co- Morbidities

1. After completion of the above evaluation, the PCP may occasionally have a clear idea of the patient's diagnosis. But more likely further evaluation will be necessary. The PCP may need to:
 - Review prior CDCR medical records.
 - Obtain outside medical records.
 - Obtain imaging or physiologic study to help clarify diagnosis.
 - Obtain specialty consultant evaluation to help clarify diagnosis.
2. The PCP will need to consider all medical co-morbid diagnoses in chronic pain treatment decisions.
3. The PCP may begin chronic pain treatment using nonpharmacologic modalities such as physical therapy when indicated and may even begin nonopioid medication when indicated.
4. The PCP should generally defer the initiation of chronic opioid therapy until the patient's evaluation is complete and a diagnosis is established. If the provider feels an opioid should be initiated and there is no objective evidence of pathology, then a referral to medical leadership via the institutions existing committee structure is indicated.

2. Identify Psychosocial Complications

1. Co-morbid psychosocial conditions complicate pain management. Among the most common psychosocial issues in our patients:

Depression

Concurrent treatment of depression may lead to improved results. If after screening the patient you believe your patient shows signs of depression, a Mental Health consult should be obtained.

Anxiety

If you suspect or identify significant anxiety in your patient:

- Talk with their current Mental Health provider if they are enrolled in the Mental Health treatment program.
- Refer the patient to a Mental Health provider asking for evaluation and treatment if appropriate.

Substance Abuse and Dependence

- This is a difficult problem to manage. Both in the community and within CDCR, there are not enough Chemical Dependency/Addiction Specialty resources to effectively manage all the affected patients.
- This is one reason to institute "Universal Precautions" (See Section VII – G.1 [Page 71]) and to stringently weigh the potential risks and benefits of opioid use in each patient.
- If you have a particularly challenging patient you may:
 - Talk with their current Mental Health provider if they are enrolled in the Mental Health treatment program.

- Consider referral to a Mental Health provider, asking for evaluation and treatment if appropriate.

Other Emotional Disorders

- Patients with known affective disorders or active psychosis warrant discussion with the patients Mental Health provider prior to any determination to initiate opioid therapy.
- The presence of a personality disorder can be associated with patient management issues including manipulation, noncompliance, impulsiveness and emotional reactivity. Some disorders are not immediately apparent but will declare themselves over time. Careful attention should be given to their detection.

3. Identify Baseline Functional Status

Determine what the patient is able to do at the start of therapy and document any changes as treatments are used.

4. Setting Goals and Expectations of Chronic Pain Treatment

1. It is important that patients have a realistic expectation of what each proposed treatment is able to accomplish. The overriding message to the patient must be:
 - ***That nothing is likely to take away all of their pain.***
 - ***The goal will be to improve their function.***
2. Treatment, therefore, is focused on increasing the patients function.
3. Many of the treatments may also decrease the pain, but unfortunately, not as much as the patient would like or expects. For example, a recent comprehensive review (Turk 2002) of chronic opioid therapy found that:
 - The mean pain reduction is approximately 30% (compared to placebo approximately 15%).
 - The dropout rates due to adverse events are often greater than 30%.
 - ***Therefore, even with chronic opioid therapy, pain reduction is modest on average and the risk of adverse events may outweigh the benefit of modest pain reduction.***

5. Patient Education and Anticipatory Guidance

1. Treatment for chronic pain will fail unless the patient is educated about their condition, and more importantly, what is possible and what to expect.
2. The PCP must assist the patient to better adapt to their pain by increasing their understanding of chronic pain.
3. Although every effort will be made to obtain one, the patient will need to be advised that their chronic pain may not have a specific diagnosable cause.
4. It is important to educate the patient that the pain is and will be chronic, that it is not a sign of ongoing damage, and that flares are a part of chronic pain's natural history.
5. The patient should be reminded that the goal in managing chronic pain is not to eliminate the pain, but to decrease the impact it has on their day-to-day functions.

C. Treatment

1. Multidisciplinary Care/ Biopsychosocial Model

1. To maximize the success of treatment, a care plan must address the whole person in all of his/her complexity, including physical and biologic factors, psychological state and beliefs, as well as social and work environment (biopsychosocial model).
2. To do this, it is important to have a multidisciplinary team approach coordinated by the primary care physician/team that can coordinate the larger team, including specialty care, mental health, physical therapy and peer education.
3. A plan of care for all patients with chronic pain should address all of the following five major elements:⁽⁷⁾
 - Set personal goals
 - Improve sleep
 - Increase physical activity
 - Manage stress
 - Decrease pain

2. Primary Care Team:

a. *Role of Nursing:*

1. Nurses provide front line interface with patients on a daily basis through medication dispensing, triage of 7362's and triage in the TTA.
2. From observation of the patient, nurses can provide a patient advocate role by providing vital information to the care team regarding medication effectiveness, (the need to increase/decrease or change dose schedule) or the patient's needs for supports/equipment.
3. Nurses can provide education to the patient on the disease process, medication use/abuse, exercises, and use of symptom journals.
4. Nurses can facilitate continuity of pain care with intra and inter-facility transfers by ensuring the patients Pain Agreement/Plan and current medications follow them if they are moved.

b. *Role of Primary Care Provider*

1. The PCP is responsible for evaluating and diagnosing the patient.
2. The PCP is responsible for the care of the patients other medical problems. In most instances the PCP will be the person treating the patient's chronic pain.

Support for the Primary Care Provider:

- *Role of Provider Champion*

1. A few of our institutions have providers with special training or expertise in treating chronic pain.
2. Some institutions may choose to have one or more of their providers obtain additional training in pain management through Continuing Medical Education, or self-study.
3. Some institutions utilize community specialists who come to the institution on a regular basis to see patients with pain complaints.
4. These "Primary Care Pain Champions" are/can be a resource for the PCP when managing a challenging patient.

5. The Primary Care Pain Champion can provide treatment recommendations at P & T Committee, MAR Committee, or medical staff meetings (see below). In addition in limited circumstances can provide a 'second opinion' consultation.
6. In most cases, it is probably more helpful for the Primary Care Pain Champion to make recommendations and for the PCP, who has an ongoing relationship with the patient, to actually review and institute the appropriate recommendations.
7. The Primary Care Pain Champion can also help institution leadership with training on these Guidelines and in the pursuit of more objective and uniform care of these complex patients.

- ***Role of Local Institution Existing Committee Structure***

1. All of our facilities have a P & T and MAR Committee and many have a Narcotic/Pain Committee.
2. These committees include local medical and nursing leadership, usually including the CMO, CP & S, DON, SRN II, Pharmacist, and UM Nurse.
3. In order to support the primary care providers and facilitate objective and consistent pain management throughout our 33 prisons, each institution should use their existing P & T, MAR and any existing Narcotic/Pain Committee structure to monitor the following:
 - Continued opioid use for acute pain for longer than 30 days.
 - Facilities opioid prescribing data.
 - Reported cases of 'overmedication' of patients.
 - Inmate-patient suicides from the institution where pain management was part of the patient's treatment.
 - Requests for chronic opioid therapy for patients without clear and objective evidence of disease.
4. In addition, within the existing committee structure medical, nursing, and pharmacy leadership should:
 - Attempt to understand reasons behind any prescribers who are 'outliers', either over or under prescribing opioids compared to their peers. (A Provider caring for more patients who have a special needs designation may indeed have a higher proportion of chronic pain patients and should not be considered an "over-prescriber").
 - Coordinate a mechanism whereby reports of misuse of opioid medication by patients are reviewed and appropriate action is taken, such as informing the PCP and updating the medical record.
5. The goal of the committee will be to increase consistency in the delivery of evidence based pain management to our patients.

3. Other Multidisciplinary Team Members:

a. Role of Pharmacist

1. The Pharmacist can identify potential drug-drug interactions.
2. The Pharmacist can assist with selection of the most cost effective treatments.
3. Can assist with adjusting dosing regimens.
4. The Pharmacist can track the opioid use in their facility and provide the P & T and medical and nursing leadership with reports.

b. Role of Mental Health

1. Mental Health providers are an integral part of the chronic pain management of patients with primary mental illnesses.
2. Mental Health providers can provide expertise in coordinating Mental Health medications and medications used for pain management, many of which interact.
3. Mental Health providers can also assist in the recognition and treatment of patients with previously undiagnosed depression or anxiety.
4. If resources allow, Mental Health providers can assist with Chronic Disease management groups that could include the chronic pain patients.
5. If resources allow, Mental Health providers can assist with patient education groups utilizing relaxation and imagery skills, as well as cognitive behavioral skills. (It has been suggested at some institutions Psych Techs may be able to assist with running education groups).

c. Role of The Peer Educator

1. If a facility has an established peer education program, the peer educators can receive training on chronic pain, especially regarding self-management techniques. The peer educators can then share this information with chronic pain patients.
2. Peer educators could work with Physical Therapy to develop self-managed exercise programs (see below).

d. Role of Physical Therapist

1. There are several orthopedic diagnoses that benefit from a specified exercise program. When these diagnoses are present and Physical Therapy is available it, should be ordered.
2. Physical Therapists can be of benefit in ‘teasing’ out specific dysfunction in the musculoskeletal system and can often aid the PCP in making a more specific diagnosis (i.e. rather than “shoulder pain, possible rotator cuff” the PT can specify “Supraspinatus tear”).
3. Regardless of specific pain etiology most, if not all, of our chronic pain patients are deconditioned. Physical therapy can direct a patient in a self-managed rehabilitation exercise plan.

e. Role of Outside Providers

(See Section VII – E.1 [Page 67])

f. Role of Custody

1. Custody staff often become aware of opioid misuse by direct observation of cheeking of medications or discovery of hoarding of medications in a cell search. They will follow their procedures when they witness such activity.
2. In the community, family and friends are utilized as sources of information to verify patient reports of medication usage or activity level. Some providers use custody observations to provide information on patient function within the institution.
 - Providers are cautioned that utilizing custody observations without informing the patients that you plan to do this may damage the patient-provider-trust.
 - Providers should recognize that while a custody officer can accurately report a fact, “ I saw him playing basketball” for example, the officer may not have the training to recognize subtleties in gait and may report “he was walking fine” when in fact, the patient did have a gait abnormality.

3. While Custody Staff remain an important part of the Healthcare Team, patient confidentiality and the provider-patient relationship limit the information a provider is able to share with custody.
4. However, because patient misuse/diversion of medication, especially opioids, puts patients and others at risk, the provider may need to share important information about misuse with custody colleagues.
 - The Opioid Agreement specifically informs the patient that custody may be notified if diversion or other misuse is suspected.
 - In some cases, the provider may choose to give custody a 'heads-up' about general concerns of diversion or other misuse without specifically identifying the patient in question.

4. Non-Pharmacologic Pain Adjuvants ⁽¹²⁾

1. Non-pharmacologic adjunctive therapies encompass a wide array of treatments which may be grouped into:
 - Physical interventions: including physical therapy and exercise.
 - Psychoeducational interventions such as cognitive-behavioral therapy, family therapy, patient education, and psychotherapy.
2. A meta-analysis considering the role of adjunctive therapies in the management of chronic, nonmalignant pain found that the combination of exercise and psychoeducational approaches can lead to a significant reduction in pain and improvement in functional status for a number of musculoskeletal conditions.
3. Many patients view these approaches with a sense of skepticism, believing them not to be helpful or appropriate to their circumstances.
 - It is up to the Primary Care team to send a clear message that chronic pain treatment is much more than medication.
 - If the patient is on opioid medication, this is a good time to remind the patient that on average, opioid medication achieves only a 30% decrease in pain level and adherence to other modalities is required in the Treatment Agreement.

a. Physical Activity ⁽¹⁴⁾

1. While patients with acute pain are often encouraged to rest to promote healing, patients with chronic pain do worse with decreased activity/deconditioning.
2. Patients with chronic, non-malignant pain should not be in work classifications that require activities that exacerbate their pain, such as heavy lifting or strenuous activity.
3. Chrono's should be supplied that state the specific limitation. Custody can then assign the patient an appropriate job. Just as in the community, it can actually be detrimental to the patient to be completely off work.
4. In addition, sports and gym activities should be evaluated and limited if indicated, especially if the pain is increased by such activities. A formal activity program may need to be instituted and adherence checked with the correctional staff.

b. Physical Therapy ⁽⁷⁾

1. Physical rehabilitation is essential for the patient with chronic pain because most are significantly deconditioned.
2. Focus on specific goals to restore function.
3. Self-management ensures active patient participation and includes:

- a graded gradually progressive exercise program, and
 - psychosocial management (e.g., cognitive behavioral therapy- see below).
4. Fitness includes:
 - endurance activities (aerobic, e.g., walking)
 - strengthening
 - balance activities
 - flexibility
 5. No one type of exercise has been shown to be more effective than another. Studies have shown benefit of flexion exercises, extension exercises, isokinetic intensive machine muscle strengthening, and group aerobic low-impact exercises.
 6. There was no significant difference in outcome comparing relatively inexpensive group aerobics/stretching to more traditional physiotherapy and muscle conditioning, suggesting low-cost alternatives may be effective.

c. Psychological Interventions

1. There are many psychological techniques that have been used as part of chronic pain treatment plans. The evidence for efficacy of these techniques is limited and varied from case studies to consensus statements supporting the use of specific modalities. To date, only Cognitive-Behavioral Therapy has randomized controlled trials supporting its efficacy in the chronic pain patient.
2. Many of these techniques are 'low tech' techniques. Relaxation, imagery or diaphragmatic breathing might be taught by peer educators using available audiotape tools or existing prison television information systems.
3. Certainly, a positive patient-provider relationship with continued support of realistic goals and reinforcement of the patient's role in his or her improvement is paramount.

4. Cognitive-Behavioral Strategies for Primary Care Physicians

There are a number of cognitive-behavioral strategies that primary care providers can utilize to help their patients manage chronic pain.

- Tell the patient that chronic pain is a complicated problem and for successful rehabilitation, a team of health care providers is needed.
- Tell the patient treatment often includes components of stress management, physical exercise, relaxation therapy and more to help them regain function and improve the quality of their lives.
- Let the patient know you believe that the pain is real and is not in his/her head. (Patients are concerned that their providers do not believe them when they report pain.)
- Let the patient know that the focus of your work together will be his or her improvement in function.
- Ask the patient to take an active role in the management of his/her pain. Research shows that patients who take an active role in their treatment experience less pain-related disability.
- Avoid telling patients to "let pain be their guide," whether it is stopping activity because of pain or taking medications or rest in response to pain.
- Prescribe time-contingent pain medications, not pain medications "as needed." Time-contingent medications allow a disruption in the associations between pain behavior and pain medication. The powerfully reinforcing properties of pain medicines are then not contingent upon high levels of pain and pain behavior.

- Schedule return visits on a regular schedule and don't let the appointments be driven by increasing levels of pain. Physicians are powerful reinforcers, too.
- Reinforce wellness behaviors such as increased activity or participation in an exercise program.
- Assist the patient in returning to normal activities. Do this in a stepwise fashion that is not dependent on level of pain.
- Fear of movement or fear of pain due to movement is a significant concern for many chronic pain patients. Inactivity or avoidance of movement leads to physical deconditioning and disability.
- Try not to rely on sedative or hypnotic medications to treat the fear many chronic patients show of activity or fear of increased pain. When chronic pain patients expose themselves to the activities that they fear significant reductions are observed in fear, anxiety and even pain level.
- If patient's fears are excessive, relaxation strategies may be helpful. Referral for more formal and intensive cognitive-behavioral therapy may be necessary.

5. Cognitive-Behavioral Interventions

a. Relaxation Therapies

1. Relaxation therapies include a number of strategies aimed towards promoting a state of relaxation, and include imagery, diaphragmatic breathing, and progressive muscle relaxation training.
2. It is believed that relaxation reduces levels of anxiety in chronic pain patients, which *enhances pain tolerance* and *decreases reports of pain*. Further, *relaxation techniques place greater responsibility on patients* to expand their repertoire of coping strategies for managing their pain.

Imagery

Imagery is a simple procedure designed to promote general relaxation. This technique involves imagining a pleasant or relaxing scene such as lying in the sun listening to the waves on a beach. With practice, imagery can be used to reduce autonomic arousal and be used as an effective attention diversion strategy.

Diaphragmatic Breathing

Diaphragmatic breathing, or breathing retraining as it is sometimes called, is a deceptively simple strategy that is easily under the patient's control. The goal is to teach patients correct diaphragmatic breathing, which incorporates both slowed breathing (five to eight breaths per minute) and even breathing with the same rate for exhaling and inhaling.

Progressive Muscle Relaxation Training

In this relaxation strategy, attention is focused on 14 different muscle groups throughout the body. With this strategy, patients learn to discriminate various forms of muscle tension and with this focus are able to achieve a state of deep relaxation with practice.

b. Cognitive Techniques for Patients

1. Cognitive therapy techniques are based on the notion that a person's cognitions, or how one thinks about oneself, others, and the future can have a major impact on his/her mood, behavior, and physiology.
2. The use of cognitive therapy in treating pain is focused upon helping patients notice and modify their negative thought.

d. Chronic Pain Groups

1. As mentioned above, these Groups could be run by Psychiatric Technicians, nursing and/or Mental Health providers (As resources allow at a specific institutions).
2. The class/group would meet weekly.
3. Inclusion criteria: Pain condition lasting more than 3 months.
4. Goal: For patients to develop skills that assist him or her in improving daily function and coping skills.

Learning Objectives

- Understand reactions to pain condition.
- Learn physical control and stress reduction techniques.
- Reduce negative thought content contributing to disruptions in daily living.
- Promote heightened self-concept.

Topics Areas/Self-care skills

- Understanding pain
- Mind-body connection
- Relaxation techniques
- Behavioral Modification
- Cognitive Techniques in Pain Management
- Problem-solving
- How to address interpersonal problems
- Anger management

e. Patient Education

1. The health education resources with CPHCS are limited at this time, and allotted medical staff time for education is even more limited. That being said, it is to the long-term benefit of the individual Primary Care team that the patient and our entire patient population to invest some time into educating patients on chronic pain, associated psychosocial complications and nonpharmacologic therapy.
2. Education can be done by the PCP, Primary Team nurse, Psychiatric Technician, Mental Health provider or other designee as determined by the individual institution.
3. Some patient education materials are attached. Including:
 - i. Dealing with Anxious Thinking (See Attachment K [2 Pages])
 - ii. Relaxation Techniques (See Attachment L)
 - iii. Anger Management (See Attachment M [2 Pages])

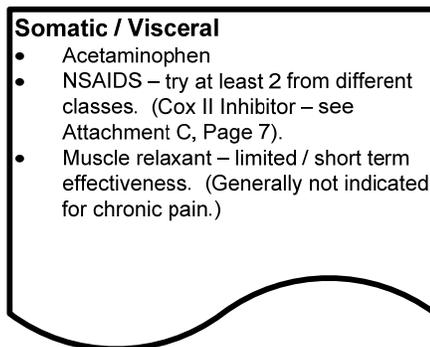
f. *Role of Peer Education*

1. Many institutions have an established Peer Education program, and these educators can be utilized to teach some of the basic exercise or relaxation classes with materials provided to them by the Primary Care Team.

5. Pharmacologic Treatment

g. *Nonopioid Medication:*

1. As with the Acute Pain Guidelines above, there are differences in the choice of Nonopioid therapy based on mechanism of pain. The primary decision point in a chronic pain patient with a poorly defined diagnosis is to determine whether there is a significant component of neuropathic pain.
2. Somatic/visceral pain:
The ICSI Acute Pain Guidelines tease out a few treatment differences between somatic and visceral pain as such:
 - Treatment of somatic pain includes the use of acetaminophen, cold packs, corticosteroids, localized anesthetic (topical or infiltrate), NSAIDs, opioids and tactile stimulation.
 - Treatment choices for visceral pain include corticosteroids, intraspinal local anesthetic agents, NSAIDs and opioids (via any route).
 - There is often overlap in the types of pain seen and for purposes of the CPHCS Chronic Pain Management algorithm (See Attachment C [Page 2]) the two types of pain are combined.



3. Neuropathic Pain:

1. Neuropathic pain may be resistant to nociceptive pain treatment strategies and is even considered relatively resistant to opioid therapy. Therefore, anticonvulsants and tricyclic antidepressants are mainstays of therapy. A few generalities on the use of these medications include:
 - Complaints of *continuous burning* may best respond to *antidepressants*.
 - Complaints of *lancinating pain* may best respond to *anticonvulsants*.
 - Failure to adequately relieve neuropathic pain with one anticonvulsant does not imply that alternative therapies will not work.
2. Other potential treatments include local anesthetics (topical – nonformulary, or intraspinal), and glucocorticoids.
3. Although NSAIDs are not generally considered effective in pure neuropathic pain, they can be tried if mixed pain mechanism is suspected.

Neuropathic

- Choose one:
 - Anticonvulsant (gabapentin, oxcarbazepine)
 - SNRI (venlafaxine, duloxetine-NF)
 - Tricyclic Antidepressant (nortriptyline+)

(Titrate dose and allow adequate time. If no response, try another class. If limited response add another class)

- If mixed pain consider adding NSAID – try at least 2 from different classes.
- Opioids*

6. Opioid Medication:

1. When to use:

- Contraindications to opioid (See Attachment C [Page 3])

Absolute	Relative	
Allergy (rare)	Psychiatric instability	Inability to manage therapy
Severe drug-drug interaction	History of adverse event or lack of efficacy	Sleep apnea not on CPAP
Active diversion of controlled substance	Current substance abuse disorder	
Unwillingness to comply with the treatment plan	Noncompliance with other treatment recommendations	

- Ongoing opioid medication in chronic pain patients should only be started when there has been a clear risk/benefit analysis supporting their use in a particular patient along with objective evidence of severe disease or pathology.
- These CPHCS Chronic Pain Treatment Guidelines require that prior to starting chronic opioid therapy, the patient have a clear indication with an established diagnosis supported by objective evidence.
- If there is no objective etiology for the patients pain after thorough evaluation and the patient continues to believe they need opioids for their pain, then the provider must refer the patient to one of the following for approval:
 - The institutions medical leadership via existing committee structure
 - The institutions Pain Champion (if one exists)
 - A Pain Management specialist as authorized by the institutions MAR committee

***Requirements for Opioid Prescribing in Chronic Pain**

Evidence supporting effectiveness of opioids for long term treatment of noncancer chronic pain is limited. Opioids are associated with potentially serious harm including opioid-related adverse events and abuse potential. When considering a patient for potentially long term opioid treatment:

1. You must have tried all other medication classes at adequate doses for adequate length of time without acceptable relief. Adequate trials should be documented in the UHR.
2. You must weigh the risks and benefits, especially considering the patient's co-morbid medical, psychiatric and if present, substance abuse history. This evaluation may take time and should not be rushed. Consider if giving an opioid is helping this patient's overall rehabilitation or hindering it.
3. You must have a **clear medical indication** with **objective data** supporting the diagnosis. (i.e. either radiologic evidence of severe degenerative disease; evidence of nonhealing fractures or tears; EMG evidence of neuropathy consistent with anatomic defects; non-healing wounds; or evidence of abnormal inflammation on lab studies)
 - a. If there is NO clear, objective medical indication and the patient continues to report persistent severe pain they should be referred to:
 - i. Local medical leadership via existing institution committee structure ie P & T, MAR, or if available Narcotic/Pain Committee.
 - ii. Pain Champion at the institution (if available).

Or

 - ii. Onsite Pain management Specialist as authorized through your facility MAR process or offsite Pain management Specialist approval through HQ Utilization Management. (See Guidelines for appropriate Referral process).
4. You must obtain informed consent and establish treatment boundaries using a Patient Agreement. (Attachment F)
5. Baseline urine tox screen can be considered in high risk patients.

2. Before Beginning:

- As noted above, before beginning chronic opioid therapy you must provide the patient with informed consent and establish treatment goals and boundaries using the Patient Agreement. (See Attachment F [English] and Attachment G [Spanish])
- A baseline screening urine toxicology can be considered in high risk patients.

3. Opioid Medication Selection and Initial dosingInitial Drug Choice

- No one opioid is more effective than another. However, due to variable inter-patient differences in response (efficacy & adverse effects), drug choice should be based on patient specific factors such as comorbidities, comedications, previous history and risk benefit assessment.
 - Long acting opioids are preferred for chronic pain in the correctional setting
 - Preferred formulary agents include methadone and morphine SR. Both have differing properties and associated risks. Table 1 includes a list of drug specific facts as well as the pros and cons of each agent which should be carefully considered prior to drug selection.

Dosing Principles

- Start low to achieve the best pain relief with fewest adverse effects. Carefully titrate until an adequate level of analgesia is obtained or until unmanageable, persistent adverse effects occur. In general, do not increase more frequently than every 5 half lives.
- Increase opioid dose by percentages, not milligrams.
- Use opioids in conjunction with acetaminophen, NSAIDs and/or adjuvants according to pain type and contributing comorbidity (opioid sparing).
- A lack of response despite dose escalation may indicate opioid non-responsive pain and opioid therapy should be discontinued.
- After pain control is established, the analgesic dose usually remains stable. Increased medication need requires complete reassessment.

- To elaborate on the above:

1. Medication choice:

In general for chronic pain, a long acting opioid medication will be used. The CPHCS Pain Committee has identified Methadone or Morphine SR as the opioids of choice in chronic pain treatment.

- a. There are pro's and con's for each medication- see below and Table 1 of the Chronic Pain Algorithm. (Attachment C [Page 4])
- b. The provider should be familiar with the pharmacokinetics of methadone, especially its variable half-life and the need for monitoring the QT interval with an ECG at baseline, 1 month and then annually.

<p><u>Methadone</u> Effective analgesia Can be crushed Must monitor QT interval Half life variable Full effect in 2-4 weeks Black box warning: Opioid addiction QT prolongation Respiratory depression</p>	<p><u>Long-Acting Morphine</u> (Morphine SR) Effective analgesia Unable to crush long acting tablets Does not require monitoring Full effect varies Black box warning: Abuse/misuse/diversion Do Not crush or chew SR pills</p>
--	---

2. Initial Dosing:

In general, long acting medications can be started in one of two ways:

- a. In chronic pain patients it is appropriate to start with a low dose of either of the long-acting medications:
 - o Methadone 2.5 – 5 mg once daily (Start with 1.0-2.5 mg in elderly or frail patients)
 - o Morphine SR 15 mg QHS
 - o Next step is to titrate to effect (see below). This will help reduce the risk of adverse effects and will establish the lowest effective dose for the patient.
- b. Alternatively, a patient can be started on short acting medication, usually Morphine IR:
 - o Dose can be titrated to effect.
 - o Once total daily dose is known, provider can convert to a sustained release morphine (Morphine SR).
 - o This is probably most appropriate for high risk patients who are in an OHU, CTC, or GACH.

3. Dose Titration:

In general, a dose should not be increased more frequently than every 5 half-lives. Dose titration can be done by:

- a. Increasing the long acting opioid at safe intervals
 - o Methadone every 7 days
 - o Morphine SR every 3-7 days
- b. Commonly, a low dose of long-acting medication is started and the patient has 'dose-finding' doses of short acting medication ordered to take at intervals as needed.
 - o In our setting, this poses additional challenges. Medication dispensing schedules are generally limited to 6 a.m.-6 p.m. (i.e. often there are 'pill calls' in the morning, mid-day and early evening only). While QHS medication is possible, it can be more difficult.

- After using short acting medication on a prn basis (b.i.d-t.i.d) for a week, the PCP should reassess the patient and his or her short acting medication use. The average daily use of short-acting opioid is added up and the dose of the long-acting medication is then recalculated and the new daily dose given in on a b.i.d schedule.
- c. The above is generally continued for 2-3 weeks at which time most patients who will benefit from chronic opioids will have shown an increase in function.
 - i. Those patients who continue to utilize most of the prn doses and who report little to no improvement should be reevaluated with the following in mind:
 - Reconsider whether the correct diagnosis has been made and whether the patients underlying condition is worsening or another medical problem has been missed.
 - Consider whether the patient is exhibiting behaviors suggesting co-morbid substance abuse or psychiatric disorders.
 - If so it may be appropriate to taper and stop opioids.
 - If the patient appears appropriately adherent to the Pain Treatment plan, yet is not getting relief with a specific opioid, most pain specialists will rotate the patient to at least one other different opioid.
 - This will help determine whether the pain is opioid responsive.
 - The patient is switched to another long acting opioid at an equianalgesic dose. If he or she continues to get no relief in the next week or so, then they can generally be considered to have opioid nonresponsive pain.
 - A urine screen for adherence can confirm that the patient is indeed taking the medication.
 - If the urine test is negative it can be confirmed with serum testing.
 - If serum test detected no prescribed medication in the patients system, this would confirm diversion and the opioid should be stopped. (No taper needed since there was no medication in the system).

4. Breakthrough Pain

- a. While patients may require 'breakthrough' doses of short-acting medications while titrating the dose of long acting medication, ongoing "breakthrough" or "prn" medication is generally not indicated in stable chronic pain.
- b. If patient has an occasional flare of his or her chronic pain, a short acting opioid such as Tylenol #3 or Morphine IR can be used for short periods.
- c. If patients experience flares with unexpected frequency or duration, then further evaluation is warranted.

- Short-acting opioids may be used for treatment of BTP during *initial titration* if pain is severe and escalating.
- Attempts should be made to manage BTP with non-opioid treatment modalities.
- Use of short-acting opioids should be minimized especially in high risk patients as they are highly reinforcing due to rapid onset and peak effect.
- Opioids for BTP are a temporary measure and should *not* be a part of long term management.
- Ongoing requirements for BTP treatment indicate the need for re-evaluation of the treatment plan.

5. Adverse Effects

See Attachment C (Page 6 – Table 5).

6. Indicators to stop therapy

<ul style="list-style-type: none"> ◦ Severe, uncontrollable adverse effects ◦ Dangerous behavior or behavior suggestive of abuse/misuse ◦ Patient dissatisfied 	<ul style="list-style-type: none"> ◦ Resolution of pain etiology ◦ Ineffective therapy
---	--

Opioids should not be abruptly discontinued. See page 5 for tapering information.

7. Putting it all together-WHO Pain Ladder offers step wise approach to meds:

1. Step One: (mild pain): Non opioid +/- adjuvant

1. Starting off with low dose mild analgesics such as acetaminophen (maximum of 4000mg/day) or ibuprofen (maximum of 2400mg/day) is recommended for patients who have no contraindications.
 - Acetaminophen may be safely used in those with chronic liver disease in doses of less than 2000 milligrams a day, but should be avoided in those patients with known cirrhosis.
 - NSAID's may be used in patients with Hepatitis C or other chronic liver conditions if there is no evidence or cirrhosis/End-Stage Liver disease.
2. If one NSAID doesn't work, try switching to a different class; preferably one on formulary, before abandoning these medications. (See Attachment C [Page 7 – Table 6])
3. Next add adjuvant medications if needed. (See Attachment C [Page 8 – Table 7])

2. Step Two: (worse pain): Weaker opioid +/- non opioid +/- adjuvant

1. A specific diagnosis with objective findings is required prior to the initiation of opioid medication.
2. The CPHCS Pain Committee has identified Tylenol & Codeine #3 as the preferred 'weak' opioid of choice.
 - While some providers have noted success with long-term use of Tylenol #3 in chronic pain, in most cases use of a long-acting 'strong' opioid is preferred. (See Step Three).
 - Codeine is a 'prodrug' and 10% of people do not metabolize and therefore will not obtain analgesia with Codeine. (In acute pain treatment if Tylenol #3 is ineffective or contraindicated Tramadol (nonformulary) may be used short-term.)
 - The CPHCS Pain Committee does not recommend long-term use of Tramadol.
 - Darvocet should not be used.
3. Next, add additional adjuvant medications if needed. (See Attachment C [Page 8 – Table 7])

3. Step Three: (worst pain): Strong opioid +/- non opioid +/- adjuvant

1. The CPHCS Pain Committee recommends Methadone and Morphine SR for use in treating chronic pain. (See discussion above).
 - Meperidine (Demerol) has toxic metabolites and should not be used.
 - Oxycodone (Percocet, Oxycontin) is another strong opioid, but its abuse potential is felt to outweigh its potential benefits and should not be used.
 - Transdermal Fentanyl (Duragesic) has limited indications and has abuse potential. CPHCS Pain Committee recommends use by Oncology, Hospice or Pain Specialists only.

- Hydromorphone (Dilaudid) has limited indications and has abuse potential. CPHCS Pain Committee recommends use by Oncology, Hospice or Pain Specialists only.

D. Monitoring During Treatment

As treatment is administered, close monitoring of outcomes (pain relief, adverse effects, physical and psychosocial functioning, or any aberrant drug-related behaviors) along with careful titration can establish successful long-term therapy.⁽¹⁾

1. Periodic Review/Documentation

1. The patient's *functional status* should be the marker for treatment efficacy, not pain relief.
2. Documentation can be done on a progress note or the CPHCS Chronic Pain Follow-up tool, but should contain the information outlined below.

2. Assess 4 A's at each visit

- Analgesia:
 - Using the pain scale, determine the patients self-reported pain level.
 - Has the pain level improved, worsened or remained the same?
- Activities of Daily Living:
 - How has the patients *functional capacity* changed from the last visit?
 - Has their mood, ability to exercise, sleep and ability to attend their program improved, worsened, or remained the same?
- Adverse Events:
 - Is the patient experiencing any side effects from their medication or other treatment?
- Aberrant drug-taking behavior:⁽¹⁶⁾
 - These behaviors are those that raise concern that the patient is not adhering to the Treatment Agreement.
 - It may be that the provider has concern that the patient is not taking their medication, but diverting it. In this case, random urine drug testing (UDT) may identify none of the prescribed medication in the patients system. (Note: care may be needed at lower doses of opioids which may result in levels under the threshold for detection in urine.)
 - The provider should investigate for the possibility of active substance abuse in any patient who:
 - Is far more interested in opioid medications (especially ER and non-generic) than in other medications or in any other aspect of treatment.
 - Believes higher doses than have been prescribed are needed.
 - Resists urine drug testing, referrals to specialists, diagnostic studies, and other aspects of treatment.
 - Resists changes to opioid therapy.
 - Repeatedly asks for higher doses, or particular medications.
 - Makes frequent requests to be seen, typically after regular clinic hours or when he knows the healthcare provider is unavailable.
 - Worries about being dependent.
 - Appears sedated.
 - Shows deteriorating function.
 - Develops an abscess that is in an area easily injected.
 - UDT shows medications not prescribed to him.

- Patient behaviors related to pain and addiction:⁽¹⁷⁾

Patient Behaviors: associated with pain	Patient Behaviors: associated with addiction
<ul style="list-style-type: none"> ▪ Not out of control with medication ▪ Medications improve the quality of life ▪ Aware of side effects ▪ Concerned about medical problems ▪ Follows the agreed-on treatment plan ▪ May miss dose if pain controlled 	<ul style="list-style-type: none"> ▪ Out of control with medications ▪ Medication decreases the quality of life ▪ Wants medications to continue or increase despite side effects ▪ In denial about medical problems ▪ Does not follow the treatment plan ▪ Always has a "story" about medications, abnormal UDT's

3. Adherence-Urine Drug Testing

1. Monitoring pain medication therapy, especially opioid therapy, is necessary but often difficult. Poor adherence can occur in many forms, including escalation (or reduction) of dosage, hoarding, or diversion.
2. **Testing for opioid in urine is generally of two types:** a screening method and a confirmatory test.
 - a. **Screening urine assay:**
 - This is done to determine if any illicit (i.e. unprescribed) medication is in the system . (Including cocaine, methamphetamine, MDMA [aka Ecstasy], natural opiates, marijuana and benzodiazepines).
 - The usual urine screening test does not look for synthetic opioids, such as methadone, fentanyl, Levorphanol, hydrocodone or oxycodone. You must specifically request screening for these medications by writing them in the orders.
 - Qualitative results are done as an immunoassay in urine (positive or negative).
 - If positive, then the lab automatically does quantitative results by GC/MS (gas chromatography-mass spectrometry) or HPLC (high performance liquid chromatography).
 - The threshold level of detection of 300mcg/ml may represent negative results in patients taking up to 30 mg of morphine equivalent.
 - b. **Confirmatory Testing:**
 - This testing is done to confirm that the medication prescribed is actually in the patients system.
 - Usually done unannounced 4-8 days after initiating opiate therapy, 3-9 days after dose change, then randomly thereafter as needed by risk stratification.
 - Clinician orders "GC/MS with no threshold limits for opioid prescribed".
 - Quantitative results done by GC/MS (gas chromatography-mass spectrometry) detect if the prescribed medication is in the patient's system and at what level.

- Generally the LOD (level of detection) is 100 mcg/ml. (It is possible that low doses of morphine equivalent i.e 10 mg bid may not yield a positive result because of this level of detection.)

3. Serum Testing:

- The sensitivity threshold for urine GC/MS is 100 mcg/ml if testing is negative, but questions remain about the presence of the medication in a particular patient then serum testing is needed. In this case, the provider can send the patient for “spot serum GC/MS testing for opioid prescribed”.
- With serum testing, only medications taken in the last 24 hrs are measured, because the test is detecting the actual medication itself. In contrast, in urine testing above the medication metabolites and the parent medication can be detected for up to 3 days.

4. Urine Sample

- **Urine creatinine, pH, and temperature** should be ordered and recorded to assist with results interpretation and to increase specimen reliability.
- The temperature of a urine sample within 4 minutes of voiding should fall within the range of 90-100 deg F.
- Urinary pH should remain within the range of 4.5 to 8.0.
- Creatinine varies, but normal human urine has a creatinine concentration >20 mg/dL; < 20 mg/dL is considered dilute and <5 mg/dL is not consistent with human urine.
- Results outside of these ranges should be discussed with the lab and the patient as necessary.

5. Other Considerations⁽¹⁸⁾

- Contact lab if you have a negative finding in a sample that should contain the substance ordered. There may be lab or clerical error.
- Because of the possibility of both false negatives and false positives, confirmatory testing should be done for unexpected results.
 1. False positive: codeine is metabolized into morphine and hydrocodone is converted into hydromorphone.
 2. Ciprofloxin can cause false positive opiate results on random drug screen, but not on GC/MS.
- Schedule an appointment to discuss abnormal/unexpected results with the patient. Use the results to strengthen the provider-patient relationship and to support positive behavior change.
- Testing should be presented to the patient as a monitoring tool, not as a punitive action.
- After having all results returned, involve the patient in the interpretation of unexpected results and in responding to those results. These conversations can reveal underlying issues relating to patient loss of control and misuse.

6. CPHCS Recommendations

- Many of our patients have a history of substance abuse which puts them in the high risk category for opiate use.
- However, because of the existing oversight of medication delivery in the CDCR system and the enhanced patient selection criteria in these guidelines, the CPHCS Pain Committee is not recommending universal urine screening.

- The CPHCS Pain Committee is recommending that providers be familiar with urine drug testing and utilize this testing when clinically indicated. Clinical indications would include:
 1. Patients requiring escalating doses of opioid medication without apparent benefit.

E. Specialty Referral (1) (18)

1. When to send a patient to a specialist.

In those patients suffering from moderate to severe chronic pain who continue to have impaired functionality, the provider may consider referral to a Specialist. Referral for medication management alone is generally not indicated. The general reasons to make a referral to a specialist include:

1. If a patient continues to have pain (usually localized) that remains unexplained despite primary care evaluation, the provider may refer the patient to the specialist most likely *to assist in the diagnosis* such as an orthopedist, dentist or neurologist.
2. If the patient agrees to pursue an evidence based medically necessary procedure and he or she meets the InterQual® criteria for such a referral. (See Attachment I)
3. A patient with longstanding pain problems or multiple issues beyond pain who has been treated unsuccessfully by the Primary Care Provider using all available modalities at their institution may benefit from a referral to a Pain Specialist for evaluation.
 - a. In general this can be done by a telemed appointment at the institution.
 - b. All referrals for Pain Management will be directed through the institutions MAR process and/or the other committee structure.
 - c. If a patient is referred for off-site Pain Management evaluation, the referral will require Headquarters UM approval.
 - d. The PCP needs to continue to lead the management of the patient utilizing the advice of the specialist.

2. Which specialist should the patient see?

Pain medicine referral:⁽²⁰⁾

1. Patients with uncontrolled, severe pain not responsive to therapy.
2. Provider should submit documentation of adherence monitoring with urine or blood quantitative GCMS of opioids and adjunctive medications.
3. Appropriate work-up of the complaint should have been completed and results documented, including lab studies, XR's, and MRI's or CT scans, EMG or NCS, if appropriate to the problem.
4. Patients with psychiatric co-morbidities should have been assessed by Mental Health for diagnosis and treatment, as well of documentation of Axis I and II problems including personality disorders, somatization disorders, and substance abuse history.

Pain Procedure Referral:

1. A patient who is being evaluated for a pain problem, with moderate to severe pain, and non-response to initial therapy with a minimum of two drugs from different classes, adherence monitoring.

2. Diagnostic procedure is requested to assist in diagnosis and possible treatment.
3. In general these patients have a localized pain disorder, with appropriate studies showing the area of concern, i.e. MRI.
4. In some cases, based on clear symptoms, testing would not be required.
5. The patient must agree to pursue the medically necessary procedure and he or she must meet the Interqual® criteria for such a referral.

Neurology Referral:

1. Patients with clear neurological symptoms, clear onset of symptoms which require neurological evaluation to aid in diagnosis and possible treatment.
2. This would include patients requiring EMG's or NCS. EMG's should be done to the level of the nerve root in syndromes that are not of clear etiology (e.g. asymmetric glove, stocking paresthesias, with normal pulses, and an abnormal, documented examination).

Surgical referral:

1. Orthopedist: Per criteria for joint replacement.
2. Spine surgeon in patient who meets criteria for spine surgery.

PMR referral:

1. Patients with musculoskeletal disorders, unable to take NSAID's, with significant functional decline due to somatic pain.
2. Particularly with post-operative joint replacement and spine surgery for evaluation of posture and gait, to direct physical therapy.
3. Evaluate need for specific assistive device (Physical Therapy can often do this as well).
4. Perform functional evaluation.
5. See Pain specialist and Pain procedure specialist guidelines. Considerable overlap.

3. Follow-up of Specialty Evaluation/Treatment:

Evaluation by the PCP after such consultations is mandatory to review with the patient what was recommended and if those recommendations are in line with treatment goals. Important points to review:

- After a procedure is performed, the PCP must re-evaluate the patient to determine the level of improvement the patient obtained from the procedure and discuss with the patient the prospective plan of care.
- Often, outside providers may not realize the constraints that may exist within the correctional setting and may recommend treatments not supported by the literature (i.e. double mattresses) or by the objective evidence (i.e. removal of security restraints, bottom bunk, etc.), but instead recommend them because the patient asked for them.

In the future, we hope to have CPHCS Guidelines for outside pain providers that explain our limitations.

F. Implementation (7)

What will the institution need to accomplish to implement this program?

- Educate the providers, nursing, pharmacy, Mental Health, Dentistry and Physical therapy on the Guidelines.
- Primary Care teams will already be in place for most patients and will be the logical place for most patients to receive their pain care.
- Determine whether your facility wants to pursue a PCP model or Pain Champion Model:

PCP model:

- All patients would be seen and managed by the Primary Care Team.
- PCP establishes diagnosis with help of imaging tests or specialist consult if needed.
- Step therapy for medications would be utilized.
- If/when the patient was considered for opioid therapy:

The PCP would confirm the presence of objective evidence of a medical condition potentially benefitting from opioid therapy. If objective findings are present, the PCP would educate the patient, review treatment agreement and collect the patient's signature, and write order for medication with diagnosis specified.

or

If objective evidence of medical condition is not available despite adequate work-up (i.e. patient has complaints of chronic axial low back pain only) and the patient persists in requesting opioid medication, and the PCP is considering this course of treatment, then referral to the medical leadership via existing institution committee structure is required to determine if the risk/benefit analysis favors use in the patient, despite absent objective criteria.

Pain Champion Model:

- The major difference in this model is that a given institution may have an identified provider(s) who is more expert in assessing/treating pain complaints.
 - If so, the institution may decide that all patients without objective findings require an 'in-house consult' with the Pain Champion if opioid medication is considered.
- Regardless of the model chosen above, each institution will be responsible for monitoring the opioid use in the institution.
 - Pharmacy will need to develop pharmacy reports for leadership and identified committees to review which may include:
 - Total number of formulary opioid prescriptions filled/month/PCP Team
 - Breakdown of the type of opioids prescribed
 - Breakdown of the diagnosis recorded on each opioid prescription
 - Total number of non-formulary opioids prescribed/month/PCP Team
 - Total number of medication adjuvants prescribed/type/month
 - Overall pain medication usage trend
 - Develop a process to work collaboratively with other care providers in prescribing opioids with shared patients (e.g., dentists, specialists).

- Identify how standardized tools will be utilized by providers at your institution when managing patients with chronic pain (i.e. Chronic Pain Opioid Agreement, Chronic Pain Intake Tool, Chronic Pain Follow-up Tool) Educate Health Information Services on where to place them in the UHR.
- Develop a mechanism for scheduling/tracking (if not already in place) on-site (Tele-Med) Pain specialist consults. (Usually will be referred to MAR committee).
- Incorporate off-site Pain Management referral evaluation into MAR committee review (Currently all off-site Pain Management referrals require HQ level approval- determine who will be responsible for tracking these referrals).
- Establish a local policy for monitoring and maintaining opioid agreements

G. Special Clinical Situations

1. Opioid Use in setting of history of substance abuse

These patients are high risk for reactivation of addiction and the serious consequences that go along with that. Therefore, the risk of medication often outweighs the benefit.

It may be difficult to determine which of our patients has an increased risk, so using ‘universal precautions’ for all of our patients can be considered.

1. Universal Precautions: ⁽²¹⁾

- No screening tool accurately predicts which patients should not be prescribed opioids.
- If initiating opioid therapy for a chronic pain patient is a possibility, a universal-precautions approach to treating pain is advised.
- This term emerged in the context of infectious disease treatment and referred to applying infection control procedures to all patients.
- In pain treatment, universal precautions refer to a minimum standard of care (outlined below) applied to all patients with chronic pain, regardless of their assessed risk for opioid addiction.
- This avoids the stigmatization of any one patient, improves care, and shows due diligence in an era of increasing illicit use of prescription opioids.

Universal Precautions 10 steps:

1. Make a diagnosis with an appropriate differential.

Identify treatable causes for pain and direct therapy to the pain generator. Age, gender, ethnicity and other life factors will have an influence on how a person experiences pain. They may have difficulty describing their symptoms. A comprehensive evaluation should be done on every patient who complains of chronic pain. This may take time, with the need to collect information from other healthcare providers.

2. Psychological assessment including risk of addictive disorders.

Inquiry into past personal and family history of substance misuse is essential to assess any patient. Discuss urine drug testing (UDT) with all patients regardless of what medications they are currently taking. UDT can be an effective tool to assist therapeutic decision making when an opioid trial is considered, where response to therapy is inadequate, and periodically to monitor adherence. A provider can obtain a fuller picture of the patient’s chronic pain and its effect on the patient’s functionality if the provider collects information from household members and others familiar with the patient. This is done with the patients consent. Patients refusing assessment should be considered unsuitable for pain management using controlled substances.

3. Informed Consent

Discuss with the patient the proposed treatment plan, including the anticipated benefits and foreseeable

risks. Answer and discuss any questions the patient may have about the treatment plan. Specific issues of addiction, physical dependence, and tolerance should be addressed at a level appropriate to the patient.

4. Use a Treatment Agreement⁽²²⁾

Written agreement about expectations and obligations of both the patient and the provider need to be clearly understood. This will help clarify boundary limits, making possible early identification and intervention around aberrant behavior.

5. Conduct a pre-intervention and post-intervention assessment of pain level and function

Emphasize that any treatment plan begins with a trial of therapy. Without a documented assessment of pre-intervention, pain scores and level of function, it is difficult to assess success in any medication or interventional trial. Ongoing assessment and documentation of successfully met clinical goals supports continuation of any mode of therapy. Failure to meet these goals will necessitate reevaluation and change in the treatment plan.

6. Appropriate trial of opioid therapy +/- adjunctive medication

Although opioids are not routinely treatment of first choice, they are also not considered agents of last resort. Individualized pharmacologic therapy is based on subjective and objective clinical findings.

7. Reassessment of Pain Score and Level of function

Regular assessment of the patient, combined with corroborative support from other knowledgeable third parties (nursing, correctional officers), will help document the rationale to continue or modify the current therapeutic trial.

8. Regularly assess the four A's of pain medicine⁽²³⁾

Routine, documented assessment of Analgesia, Activity, Adverse effects, and Aberrant behavior to direct therapy and support pharmacologic option taken.

9. Periodically review pain diagnosis and co-occurring conditions, including addictive disorders

Underlying illnesses evolve over time and diagnostic studies change. Treatment focus may change over time. If an addictive disorder predominates, aggressive treatment of the pain disorder will fail if not coordinated with the treatment of the concurrent addictive disorder. This can cause difficulty for the PCP due to the limited access to chemical dependency treatment, if a concern is raised, the PCP may refer to the local Pain Management Committee for guidance.

10. Documentation

A complete recording of the initial evaluation and each follow-up is both medico legally indicated and in the best interest of all parties.

VIII. Works Cited

1. *Assessment and Management of Chronic Pain: Institute for Clinical Systems Improvement*. July 2008, Vol. Third Edition.
2. *Department of Veterans Affairs-The Management of Opioid Therapy for Chronic Pain*. Vol. Version 1.0.
3. *Opioids in the Management of Chronic Non-Cancer Pain: An Update of American Society of the Interventional Pain Physicians (ASSIP) Guidelines*. Opioids Special Issue, Vol. Pain Physician 2008 .
4. *Adapted from General Considerations of Acute Pain in Bonica's Management of Pain; The Neurophysiology and Taxonomy of Pain in Management of patients with Chronic Pain*. **Bonica, J Coda**. s.l. : Crue,BL, 1983, Vols. pp17,222-223; pp 21-31.
5. *Adapted from General Considerations of Chronic Pain*. **Jacobson, L Mariano**. pp105-106, 2001, Vol. 45.
6. *Classification of Chronic Pain: Descriptions of Chronic Pain Syndromes and Definitions Pain*. **Merskeyh**. pp345-356, 1986, Vol. Supplemental 3.
7. *Managing Pain in Patients with Aberrant Drug-Taking Behaviors; Support Oncol*. **SD, Passik**. pp 479-96, 2005.
8. *Opioid Induced Hyperalgesia: Clinical Implications for Pain Practitioner*. **Silverman, Sanford M**. 12: 679-684, s.l. : Pain Physician, 2009.
9. *San Francisco General Hospital: Management of Pain Guideline*. **Robert V. Brody, MD**.
10. *Fast Facts and Concepts #78*. **S, Weissman D Gordon D Bidar-Sielaff**. Cultural Aspects of Pain Management, October 2002.
11. *Up to Date Overview of Treatment of Chronic Pain*. **Zahid H Bajwa, MD Carol A Warfield, MD R Joshua Wootom, MDiv, PhD**. Dec 2008
12. *Up to Date Overview of Treatment of Chronic Pain*. **Zahid H Bajwa, MD Carol A Warfield, MD R Joshua Wootom, MDiv, PhD**. Dec 2008.
13. *Clinical Guidelines for the Use of Chronic Opioid Therapy in Chronic Non-Cancer Pain The Journal of Pain*. 2, Vol. 10.
14. *Up to Date Pharmacologic Therapy for Cancer Pain*. **Zahid H Bajwa, MD Carol A Warfield, MD**. Jan 2009.
15. *Ohio Department of Rehabilitation and Correction: Office of Correctional Health Care-Chronic Pain Management*. Aug 2008, Vols. A-1.11.
16. *Adapted from Pain Medicine*. **Gourlay, Heit**. 6 (2), Vols. P107-112.
17. *Adapted from The Truth about Pain Management: The Difference Between Pain Patient and an Addicted Patient*. **Heit, H**. pg 272-9, s.l. : European Journal of Pain, 2001, Vol. 5 (suppl A).
18. *Adapted from Urine Drug Testing in Family Practice*. **Gourlay D, Heit H, Caplan Y**. pg 260-67, s.l. : California Academy of FP Monograph. Stamford,CT: Pharmacon Group 2004; and Heit H, Gourlay D Urine Drug Testing in Pain Medicine, March 2004, Vol. JPSM 27(3).

19. *Up to Date Overview of Treatment of Chronic Pain.* **Zahid H Bajwa, MD Carol A Warfield, MD R Joshua Wootom, MDiv, PhD.** Dec 2008
20. *Adapted from Pain Control in the Primary Care Setting.* **D, Gruener.** s.l. : Glenview IL APS, 2004.
21. *Pain Medicine.* **Gourley, Heit.** pg 107-112, 2005, Vol. 6 (2).
22. *Model Policy for the Use of Controlled Substances for the Treatment of Pain. Policy Statement: Federation of State Medical Boards of the United States, Inc; Implementing Opioid Agreements.* **H, Heit.** s.l. : Dis Manage Digest, May 2004, Vols. pg 2–3.
23. *Managing Chronic Non-Malignant Pain: Overcoming Obstacles to the Use of Opioids.* **Passik SD, Weinreb HJ, Dannemiller Ed.** pg 70-83, s.l. : Affect Lawful Opioid Prescribing and Prevention of Diversion, 2000, Vol. 5th Edition.
24. *Institute for Clinical Systems Improvement: Assessment and Management of Acute Pain.* March 2008, Vol. 6th Edition.
25. *Institute for Clinical Systems Improvement: Adult Low Back Pain.* Nov 2008, Vol. 13th Edition.
26. *Chronic Use of Opioid Analgesics in Non-Malignant Pain APS.* **Portnoy RK, Foley KM.** pp 276-281, 1992, Vol. 1.
27. *Referred: Opioid Therapy for Chronic Pain, NEJM.* **Ballantyne, Jane and Mao, Jianren.** pp 349, 1043, 1953.
28. *Pain Management: A Practical Guide for Clinicians.* **Jay, G.** From Psychics of the Body to Clinical Outcome vi Neurochemistry, 2002, Vol. 6th Edition.

IX. Attachments

A. Pain Management Formulary – Abbreviated (1 Page)

B. Pain Management – Acute Pain Algorithm (1 Page)

C. Chronic Pain

(Page 1) Pain Management – Evaluation & Assessment (1 Page)

(Page 2) Pain Management – Treatment Algorithm (1 Page)

(Page 3) Pain Management – Opioid Therapy (1 Page)

(Page 4) Pain Management – Opioid Therapy (1 Page)

(Page 5) Pain Management – Opioid Therapy (1 Page)

(Page 6) Pain Management – Opioid Therapy / side Effects (1 Page)

(Page 7) Pain Management – NonSteroidal AntiInflammatories (1 Page)

(Page 8) Pain Management – Adjuvant Medication (1 Page)

D. CPHCS Chronic Pain Intake Sheet (2 Pages)

E. Initial Pain Assessment – Patient Completion (5 Pages)

F. CPHCS Opioid Agreement & Informed Consent – English (1 Page)

G. CPHCS Opioid Agreement & Informed Consent – Spanish (1 Page)

H. Chronic Pain Follow Up Form (1 Page)

I. Diagnostic and Therapeutic Procedures (2 Pages)

J. Dealing With Depressive Thinking (2 Pages)

K. Dealing With Anxious Thinking (2 Pages)

L. Relaxation Techniques (1 Page)

M. Anger Management (2 Pages)

N. Cervical and Lumbosacral Dermatomes (1 Page)

Pain Management Formulary - Abbreviated

DRUG CLASSIFICATION		RESTRICTIONS / ADMINISTRATION	
NSAIDS	Propionic Acid	Ibuprofen (Motrin [®] , Advil [®])	
		Naproxen (Naprosyn [®] , Aleve [®])	
	Salicylic Acid	Salsalate (Disalcid [®])	
	Acetic Acid	Sulindac (Clinoril [®])	
Opioids	Short Acting or Acute Tx	Acetam / Cod #3 (Tylenol #3 [®])	NA/DOT only. Must be crushed/floated.
		Morphine IR (MSIR [®])	NA/DOT only. Must be crushed/floated.
		Tramadol (Ultram [®])	Nonformulary. NA/DOT only. Must be crushed/floated. See full guideline for place in therapy.
	Long Acting or Chronic Tx	Morphine SR (MS Contin [®] , Oramorph [®])	NA/DOT only. DO NOT CRUSH.
		Methadone (Methadose [®])	NA/DOT only. Must be crushed/floated.
Antidepressants	TCA	Nortriptyline (Pamelor [®])	NA/DOT only. Must be crushed/floated.
	SNRI	Venlafaxine (Effexor [®])	NA/DOT only.
		Duloxetine (Cymbalta [®])	NA/DOT only. Nonformulary. See full guideline for place in therapy.
Anticonvulsants	Preferred	Oxcarbazepine (Trileptal [®])	NA/DOT only.
		Gabapentin (Neurontin [®])	NA/DOT only. Must be crushed/floated.
	Alternate	Carbamazepine (Tegretol [®])	NA/DOT only.
Antispasmodics	Acute	Baclofen (Lioresal [®])	NA/DOT only. Prescription restricted to 10 day supply. No refills.
		Methocarbamol (Robaxin [®])	NA/DOT only. Prescription restricted to 10 day supply. No refills.
	Chronic	Baclofen (Lioresal [®])	NA/DOT only. Chronic use restricted to spinal cord injury or spasticity disorders.
Topicals		Lidocaine Patch (Lidoderm [®])	Nonformulary. Restricted to pain specialist.

Acute pain results from a specific injury / illness such as acute fracture, muscle tear, strain/sprain, acute shingles, or post-op condition. **Acute pain states** may be brief, lasting moments or hours, or can be persistent, lasting weeks until the illness / injury heals. Pain generally lasts < 30 days.¹

Pain Management Acute Pain Algorithm

This pathway does not replace sound clinical judgment or apply to all patients

Assessment

History & Physical (including Mental Health History)
Pain History :

- Onset
- Character
- Substance abuse history?
- Pain Scale
- Duration
- Quality
- Aggravating or alleviating factors?
- Location
- Prior pain problems?

Further diagnostic work-up if indicated
Specialty referral for diagnosis or treatment if indicated

Establish Diagnosis
(Determine Mechanism if possible)

Establish treatment plan/goals
Follow-up as appropriate until resolution

Nonpharmacologic Treatment

- Patient Education
- Heat / Cold if available
- Specific procedure when indicated
- Rest
- Physical Therapy when indicated
- Psychologic Modalities including relaxation

Pharmacologic Treatment
Consider pain type/mechanism if known
(Many pain conditions have mixed functions)

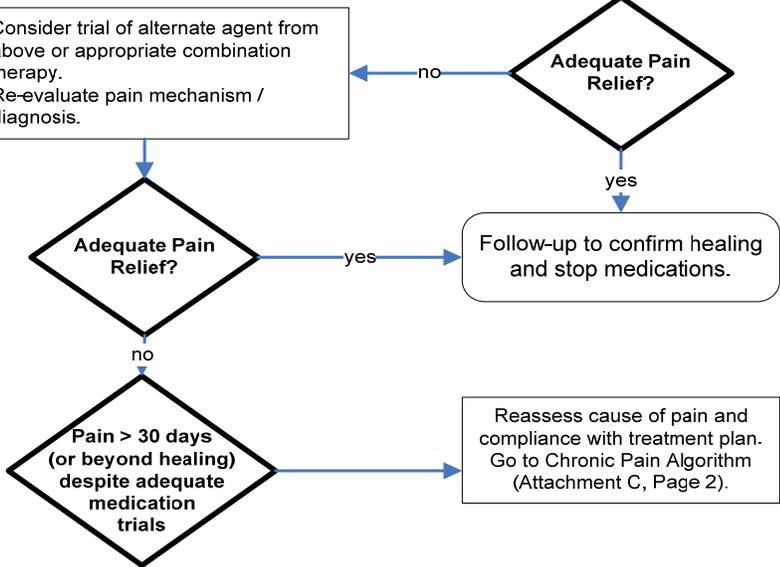
Somatic / Visceral

- Acetaminophen
- NSAIDS – try at least 2 from different classes. (Cox II Inhibitor – see Attachment C, Page 7).
- Muscle relaxant – limited / short term effectiveness. Prescription restricted to 10 days.
- Opioid*

Neuropathic

- Choose one:
 - Anticonvulsant (gabapentin, oxcarbazepine)
 - SNRI (venlafaxine, duloxetine-NF)
 - Tricyclic Antidepressant (nortriptyline+)
- (Titrate dose and allow adequate time. If no response, try another class. If limited response add another class.)
- If mixed pain consider adding NSAID – try at least 2 from different classes.
- Opioids*

• Consider trial of alternate agent from above or appropriate combination therapy.
• Re-evaluate pain mechanism / diagnosis.



***Opioids for Acute Pain**

- May be used only for severe pain for a short duration (i.e. post-op or post severe injury).
- Short acting opioids in combination with acetaminophen should be used for opioid dose sparing. (Formulary acetam/codeine).
- Educate patient that medication WILL be stopped when acute injury has healed.
- If some pain continues, more appropriate medication / treatment will be used long term (refer to Chronic Pain Algorithm [Attachment C, Page 2]).

+ Requires Mental Health Evaluation if coexisting depression
✓ Limited indications restricted to use by pain specialist only
NF Nonformulary

Pain Management Chronic Pain - Evaluation & Assessment

This pathway does not replace sound clinical judgment or apply to all patients

Definition of Chronic pain

Persistent pain lasting longer than 30 days (or the anticipated healing time) and of sufficient duration and intensity to adversely affect a patient's well-being, level of function, and quality of life. ¹

Initial Assessment

1. History/Physical

- History & Physical for assessment of general health status if new patient
- Documentation of co-morbid medical conditions on the **Problem List**

2. Assessment of pain should always be done in a *systematic and consistent manner*

Initial Chronic Pain Evaluation consists of:

- Pain onset and location, any injuries? (Pain diagram)
- Pain description, quality, character
- Pain History:
 - Prior pain diagnoses, testing- what are results?
 - Prior procedures/surgery for pain problem? What was it? Where and when performed?
 - Prior pain medications- which ones? Effectiveness? Side effects?
 - Other prior pain treatments- nonpharmacologic such as physical therapy, TENS, or Mental Health counseling?
- What factors aggravate or alleviate the pain?
- Pain scale- severity of pain in last week, on average and currently
 No pain 0 1 2 3 4 5 6 7 8 9 10 **Worst Pain**

3. Psychosocial assessment:

- History of Mental Health disorder/treatment? Screen for depression (2 questions on Chronic Pain Intake Form {CDCR 7473 12/09})
- Obtain history of drug/alcohol abuse- Current? Past? Substance of choice? Any prior treatment?

4. Functional assessment:

- Are you able to participate in prison program? Work or education?
- Are you able to get in and out of your bunk?
- Does your pain affect your relationship with others? Are you irritable? Withdrawn?
- Do you have any hobbies that are affected by your pain? .
- Is your sleep disturbed by pain? If so how?
- Are you able to walk to meals? Participate in yard? Get down for alarms? Stand for counts?
- Self-care behaviors- do you have any limitations with showering? Dressing? Grooming? Toileting?
- Is pain affecting your Sexual function?

5. Goals and Expectations: Elicit the patient's goals. (Document in chart).

- What is their expectation about achievable degree of pain relief?
- Is their expectation that they will be pain free?
- What is their expectation about treatments that will be used?
- Do they have specific treatments or medications in mind? If so, which one(s)?
- What is their expectation about how fast the pain management process will occur?
- What is their expectation about their role/responsibility in the program?

6. Establish diagnosis or continue work-up by obtaining studies or consultation as needed.

Guiding Principals of Treatment

- ▶ **Establish a primary care relationship.** No long term changes to the treatment plan should be made outside of the primary care team.
- ▶ **Multidisciplinary care.** In addition to PCP; Primary Care Nurse, Pharmacist, Physical Therapy, Psych Tech, Peer Educator and Specialists all may contribute to care.
- ▶ **Assessment and Plan to incorporate functional and rehabilitation potential.**
- ▶ **Psychosocial management**
 - Address possibility of co-existing anxiety or depression. Consult Mental Health if indicated.
 - Address history of substance abuse and complete risk assessment if considering opioids. Refer to Mental Health if indicated.
- ▶ **Close and frequent follow-up to monitor patient's condition.**

Pain Management Chronic Pain – Treatment Algorithm

This pathway does not replace sound clinical judgment or apply to all patients

Nonpharmacologic Treatment
(refer to full guidelines)

Patient education
Rehabilitative therapies as indicated in the presence of functional limitations including:

- Physical therapy, Physical agent modality (heat / cold, TENS)
- Therapeutic exercise (ROM, stretching, energy conservation);
- Proper independent exercise program; Protective body technique

Specific procedure when indicated
Psychological modalities including cognitive/behavioral therapy, relaxation, imagery.

+ Requires Mental Health Evaluation if coexisting depression
✓ Limited indications restricted to use by pain specialist only
NF Nonformulary

Pharmacologic Treatment
Consider pain type/mechanism if known
(Many pain conditions have mixed functions)

Somatic / Visceral

- Acetaminophen
- NSAIDS – try at least 2 from different classes. (Cox II Inhibitor – see Attachment C, Page 7).
- Muscle relaxant – limited / short term effectiveness. (Generally not indicated for chronic pain.)
- Opioids*

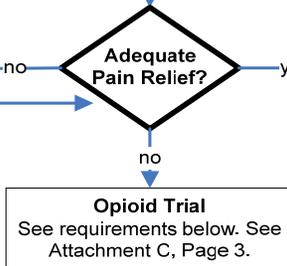
Neuropathic

- Choose one:
 - Anticonvulsant (gabapentin, oxcarbazepine)
 - SNRI (venlafaxine, duloxetine-NF)
 - Tricyclic Antidepressant (nortriptyline+)

(Titrate dose and allow adequate time. If no response, try another class. If limited response add another class)
If mixed pain consider adding NSAID – try at least 2 from different classes.

- Opioids*

- Consider alternate medications if no relief or complimentary combinations of above if some relief from primary agent.
- Always assess compliance and assure adequate dose/duration given prior to changing therapy.
- Re-evaluate pain mechanism / diagnosis.



Continue treatment plan with careful follow-up.

*Requirements for Opioid Prescribing in Chronic Pain

Evidence supporting effectiveness of opioids for long term treatment of noncancer chronic pain is limited. Opioids are associated with potentially serious harm including opioid-related adverse events and abuse potential. When considering a patient for potentially long term opioid treatment:

1. You must have tried all other medication classes at adequate doses for adequate length of time without acceptable relief. Adequate trials should be documented in the UHR.
2. You must weigh the risks and benefits, especially considering the patient's co-morbid medical, psychiatric and if present, substance abuse history. This evaluation may take time and should not be rushed. Consider if giving an opioid is helping this patients overall rehabilitation or hindering it.
3. You must have a **clear medical indication** with **objective data** supporting the diagnosis. (i.e. either radiologic evidence of severe degenerative disease; evidence of nonhealing fractures or tears; EMG evidence of neuropathy consistent with anatomic defects; non-healing wounds; or evidence of abnormal inflammation on lab studies)
 - a. If there is NO clear, objective medical indication and the patient continues to report persistent severe pain they should be referred to:
 - i. Local medical leadership via existing institution committee structure ie P & T, MAR, or if available Narcotic/Pain Committee.
 - ii. Pain Champion at the institution (if available).
 - Or
 - ii. Onsite Pain management Specialist as authorized through your facility MAR process or offsite Pain management Specialist approval through HQ Utilization Management. (See Guidelines for appropriate Referral process).
4. You must obtain informed consent and establish treatment boundaries using a Patient Agreement. (Attachment F)
5. Baseline urine tox screen can be considered in high risk patients.

Pain Management Chronic Pain - Opioid Therapy

This pathway does not replace sound clinical judgment or apply to all patients

Contraindications to Opioid Therapy			
<p>Absolute</p> <ul style="list-style-type: none"> Allergy (rare) Severe drug-drug interaction Active diversion of controlled substance Unwillingness to comply with the treatment plan 	<p>Relative</p> <ul style="list-style-type: none"> Psychiatric instability History of adverse event or lack of efficacy Current substance abuse disorder Noncompliance with other treatment recommendations 		
Initial Drug of Choice & Dosing			
<p>Initial Drug Choice</p> <ul style="list-style-type: none"> □ No one opioid is more effective than another. However, due to variable inter-patient differences in response (efficacy & adverse effects), drug choice should be based on patient specific factors such as comorbidities, comedications, previous history and risk benefit assessment. <ul style="list-style-type: none"> - Long acting opioids are preferred for chronic pain in the correctional setting - Preferred formulary agents include methadone and morphine SR. Both have differing properties and associated risks. Table 1 includes a list of drug specific facts as well as the pros and cons of each agent which should be carefully considered prior to drug selection. <p>Dosing Principals</p> <ul style="list-style-type: none"> □ Start low to achieve the best pain relief with fewest adverse effects. Carefully titrate until an adequate level of analgesia is obtained or until unmanageable, persistent adverse effects occur. In general, do not increase more frequently than every 5 half lives. □ Increase opioid dose by percentages, not milligrams. □ Use opioids in conjunction with acetaminophen, NSAIDS and/or adjuvants according to pain type and contributing comorbidity (opioid sparing). □ A lack of response despite dose escalation may indicate opioid non-responsive pain and opioid therapy should be discontinued. □ After pain control is established, the analgesic dose usually remains stable. Increased medication need requires complete reassessment. 			
Dose Titration			
<ul style="list-style-type: none"> □ Generally, start with initial dose of LA opioid and a small dose of SA opioid PRN for 1 week at a time. If patient requires SA opioid, add up the amount needed after 1 week and readjust LA opioid dose. SA opioid use would be expected to last only a few weeks. If adequate pain control or improved functioning are not achieved after several dose titrations, consider opioid nonresponse, diversion and/or referral to pain committee. 			
Breakthrough Pain			
<ul style="list-style-type: none"> □ Short-acting opioids may be used for treatment of BTP during <i>initial titration</i> if pain is severe and escalating. □ Attempts should be made to manage BTP with non-opioid treatment modalities. □ Use of short-acting opioids should be minimized especially in high risk patients as they are highly reinforcing due to rapid onset and peak effect. □ Opioids for BTP are a temporary measure and should <i>not</i> be a part of long term management. □ Ongoing requirements for BTP treatment indicate the need for re-evaluation of the treatment plan. 			
Side Effects (see Table 5)			
<ul style="list-style-type: none"> □ Side effects are largely predictable and controllable. Tolerance to most side effects develops in about 7-10 days (excluding constipation). □ The most common side effects include nausea, vomiting, constipation, sedation and itching. 			
Monitoring, Assessment & Follow-up			
<ul style="list-style-type: none"> □ Give each medication an adequate therapeutic trial. Any change in dose should be done during a clinic visit. Frequent office visits may be necessary during the titration phase. Follow-up should follow patient acuity. □ <u>Assess the four A's at each clinic visit:</u> <ul style="list-style-type: none"> - Adverse Events - Adherence to complete treatment plan & signs of aberrant drug related behavior (urine drug testing) - Activity (functional status, both physical and psychosocial) - Analgesic efficacy (pain, functioning, satisfaction) 			
Dose Adjustment or Change in Therapy			
<p><u>Reassess treatment plan before making any changes:</u></p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> <ul style="list-style-type: none"> Was an adequate trial given? Was the dose given prior to activity? Was the dose given as ordered? Were adjunctive medications given? Are there new conditions or cormorbidities? </td> <td style="width: 50%; vertical-align: top;"> <ul style="list-style-type: none"> Was the dosing interval appropriate? Was the patient compliant? Is there a need for upward titration? Has the patient's condition worsened? </td> </tr> </table> <p>For most agents, when converting to a different opioid the starting dose (total daily dose) of the new opioid should be 50-67% of the equianalgesic dose because of incomplete cross tolerance. Equianalgesic dosing provided in Table 3.</p>		<ul style="list-style-type: none"> Was an adequate trial given? Was the dose given prior to activity? Was the dose given as ordered? Were adjunctive medications given? Are there new conditions or cormorbidities? 	<ul style="list-style-type: none"> Was the dosing interval appropriate? Was the patient compliant? Is there a need for upward titration? Has the patient's condition worsened?
<ul style="list-style-type: none"> Was an adequate trial given? Was the dose given prior to activity? Was the dose given as ordered? Were adjunctive medications given? Are there new conditions or cormorbidities? 	<ul style="list-style-type: none"> Was the dosing interval appropriate? Was the patient compliant? Is there a need for upward titration? Has the patient's condition worsened? 		
Indicators to Stop Therapy			
<ul style="list-style-type: none"> ◦ Severe, uncontrollable adverse effects ◦ Dangerous behavior or behavior suggestive of abuse/misuse ◦ Patient dissatisfied ◦ Resolution of pain etiology ◦ Ineffective therapy <p style="text-align: center;"><i>Opioids should not be abruptly discontinued. See Attachment C, Page 4 for tapering information.</i></p>			

Pain Management Chronic Pain - Opioid Therapy

This pathway does not replace sound clinical judgment or apply to all patients

Opioid Tapering

There is no single protocol that has been proven more efficacious than another. The schedule should be made on an individual basis given the patients complexity. Generally, the longer a patient is on an opioid and the higher the dose, the slower the taper should be. Methadone can be particularly difficult to taper. A typical taper involves a dose reduction of 20%-50% per week until lower doses are reached, then slower taper until patient completely off medication. Examples are given below:

Symptoms of opioid withdrawal may be relieved with clonidine 0.1-0.2 mg BID. However, clonidine can also cause side effects, including low blood pressure, drowsiness, restlessness, insomnia, irritability, faster heartbeat, and headaches.

<p>Katrina Disaster Working Group Tapering Regimens [AAPM 2005]</p> <ul style="list-style-type: none"> • Reduction of daily dose by 10% each day, or... • Reduction of daily dose by 20% every 3-5 days, or... • Reduction of daily dose by 25% each week. <p>VA Suggested Tapering Regimens for Short-Acting Opioids [USVA 2003]</p> <ul style="list-style-type: none"> • Decrease dose by 10% every 3-7 days, or... • Decrease dose by 20%-50% per day until lowest available dosage form is reached (e.g., 5 mg of oxycodone) • Then increase the dosing interval, eliminating one dose every 2-5 days. 	<p>VA Suggested Tapering Regimens for Long-Acting Agents [USVA 2003]</p> <p><i>Methadone</i></p> <ul style="list-style-type: none"> • Decrease dose by 20%-50% per day to 30 mg/day, then... • Decrease by 5 mg/day every 3-5 days to 10 mg/day, then... • Decrease by 2.5 mg/day every 3-5 days. <p><i>Morphine SR (controlled-release)</i></p> <ul style="list-style-type: none"> • Decrease dose by 20%-50% per day to 45 mg/day, then... • Decrease by 15 mg/day every 2-5 days.
--	--

Table 1: Methadone & Morphine Facts

Drug	Methadone	Morphine
Pros & Cons	Tablets are crushable. Provider must be knowledgeable regarding the pharmacokinetics / dynamics. Requires careful monitoring during titration. * See Table 2: Special Methadone Concerns, Attachment C, Page 5.	SR tablets must be swallowed whole. Do not break, crush or chew. Whole tablets may be easier to cheek and divert. Improper use of various morphine dosage forms are associated with increased risks.
Dosage Forms	Tablet: 5mg, 10 mg, Soln: 10mg/ml	IR: 15mg, 30mg tab SR: 30mg tab Soln: 10mg/5ml
Initial Dose *	2.5 mg to 5 mg QHS [1 mg QD to BID for elderly]	15 mg SR QHS
Titration	2.5 mg – 5 mg BID x 7d 5–10 mg BID x 7d 7.5 mg BID x 7d 10 mg BID x 7d 10 mg TID x 7d 20 mg BID * See Attachment C, Page 3 for dose titration guidance	15 mg SR BID Titrate by 15 mg Q 3-7 days * See Attachment C, Page 4 for dose titration guidance
Recommended Max Daily Dose	60 mg	240 mg
Full Effect	2-4 Weeks	Varies
Contraindications / Precautions	Hypersensitivity BPH, urethral stricture Significant pulmonary disorder Severe hepatic or renal insufficiency Elderly QT prolongation	Hypersensitivity Significant pulmonary disorder Paralytic ileus Bleeding diathesis Head Injury Severe Renal or hepatic insufficiency Elderly
Adverse Events	Nausea Vomiting Constipation	Dizziness Resp. Depression Sedation
Significant Drug Interactions	Azole Antifungals Benzodiazepines Cimetadine Delavirdine Macrolides SSRIs TCAs	Many HIV Meds Carbamazepine Phenobarbitol Phenytoin Rifampin Risperidone
Monitoring Parameters	ECG baseline, month 1, annually If QTc is > 450 ms but < 500 ms; consider risk vs. benefit Monitor more frequently If QTc is > 500 ms, consider alternate therapy, dose reduction or elimination of contributing factors (i.e. other medications)	No lab monitoring required.

* Initial Dose for patients previously on codeine/hydrocodone products or opioid naive. This list is not intended to be all inclusive. Refer to full prescribing information, Drugs with clinically significant drug interactions should be used cautiously with careful monitoring. Alternatives should be considered.

**Pain Management
Chronic Pain – Opioid Therapy**

This pathway does not replace sound clinical judgment or apply to all patients

Table 2: Methadone Specific Concerns

Patient Counseling Regarding Methadone:

- ❑ Pain relief builds gradually over time.
- ❑ Taking methadone as frequently as other opioids (such as Vicodin or Percocet) every 4 to 6 hours may produce a fatal overdose.
- ❑ Non-prescribed use of methadone in combination with other opioids, other drugs, or alcohol may be fatal.
- ❑ You should refrain from driving or other prison program activities requiring balance or focused concentration until the effects of methadone are known, typically a week or longer.
- ❑ Inform all other medical providers you are taking methadone. Adding medications or changing dosing of other medications can affect methadone and should be coordinated with your methadone prescriber.

General Dosing Considerations with Methadone:

- ❑ Duration of analgesia is approximately 3-6 hrs extending to 6-24 hrs with repeated dosing. Due to its long half-life (8-59 hrs), methadone plasma levels may take 5-7 days to stabilize.
- ❑ Dosing increases should not be made more frequently than every 5-7 days.
- ❑ Any indication of overmedication during the 3-8 hour post-dose period is a basis for dose reduction, regardless of condition at 24 hours
- ❑ Death by accumulated toxicity may result from overaggressive titration.
- ❑ No further increase is required the following day if the patient was comfortable, without overmedication, during 3-8 hours after dosing.
- ❑ Remember: Patient may need more time, not more methadone.
- ❑ If pain relief does not last for 12 hours, increase the dosing frequency (BID / TID / QID) as necessary.
- ❑ High doses increase the risk of conduction abnormalities. Doses > 120 mg are unlikely to produce an effect if low to moderate doses provided little to no relief.
- ❑ Overdose can occur from a single large dose, accumulated toxicity or as a result of drug interactions.

Table 3: Equianalgesic Opioid Conversion Ratios

Opioid	Equianalgesic Dose (mg)	Duration	Recommended Frequency
Morphine	30	8-12 hr (SR) / 3-4 hr (IR)	q12 hr (SR) / q4-6 hr (IR)
Oxycodone	20	8-12 hr (SR) / 3-4 hr (IR)	q12 hr (SR) / q4-6 hr (IR)
Hydromorphone	7.5	3-4 hr	q4-6 hr
Codeine	200	3-4 hr	q4-6 hr
Hydrocodone	30	3-4 hr	q4-6 hr
Levorphanol	4 Acute 1 Chronic	4-30 hr	q6-8 hr
Methadone	2 to 4 Chronic (See Table 4) 20 Acute	3-24 hr	q6-24 hr

Table 4: Sample Morphine to Methadone Conversion Ratio (this rotation should not be used in reverse)

Morphine (mg/d)	30 - 90	90 - 300	300 +
Morphine : Methadone	4 : 1	8 : 1	** Consider consultation with a pain specialist or other practitioner with experience using methadone for chronic pain
Example Equivalent Dose Conversion	MOR 60 mg = MET 15 mg	MOR 240 mg = MET 30 mg	

General Conversion Considerations

- ❑ Equianalgesic doses are approximate. Initial doses should be individualized. The patient's medical condition, the potency, dose, and type of previous opioid, the patient's degree of opioid exposure and tolerance, the patient's past analgesic response and adverse experiences, and the accuracy and reliability of opioid conversion factors may all influence the choice of starting dose.
- ❑ For methadone
 - Most published narcotic equivalence charts report only single-dose equivalence. No single ratio is suitable for converting a morphine equivalent dose to methadone. Systemic toxicity-including respiratory depression and death (in extreme cases)-can result from relying on these tables. Substantial overdose may not be apparent for several days.
 - A 30-mg dose of oral morphine has the approximate analgesic equivalent of 20 mg of oral methadone; however, with repeated dosing, relatively small doses of methadone may have the analgesic efficacy of much larger doses of morphine.
- ❑ In general, start low and go slow with careful monitoring.

Instructions for Using the Opioid Equianalgesic Conversion Chart

- 1) Calculate the total 24 hour dose of patients current opioid regimen. (scheduled plus PRN).
- 2) Locate the new opioid on the equivalence chart.
- 3) Calculate the new 24 hour dose

$$\frac{\text{Total mg new opioid / 24hrs OR (X)}}{\text{Equianalgesic Dose of new opioid from chart}} = \frac{\text{Total mg of present opioid / 24 hrs}}{\text{Equianalgesic Dose of present opioid from chart}}$$
- 4) Solve for X
- 5) Reduce the calculated dose of the new opioid by 25%-50% for incomplete cross tolerance.
- 6) Divide the total daily dose of the new opioid by the number of doses given per day.

**Pain Management
Chronic Pain – Opioid Therapy-
Side Effects**

This pathway does not
replace sound clinical
judgment or apply to all
patients

Table 5: Management of Opioid Side Effects

Adverse Event	Action
Constipation	<ul style="list-style-type: none"> <input type="checkbox"/> Anticipate and treat prophylactically. Goal is 1 BM every 1-2 days. <input type="checkbox"/> Encourage increased fluids, fiber and physical activity. [calcium polycarbophil / fiber tabs – 2 to 4 tabs BID] <input type="checkbox"/> As a preventive measure a bowel regimen should be prescribed with the initial opioid prescription consisting of at least a stool softener and a laxative. (docusate 100 mg BID & bisacodyl 10-15 mg HS) <input type="checkbox"/> For treatment of constipation, additional agents may be provided as needed. <ul style="list-style-type: none"> - milk of magnesia 15-30 ml HS - lactulose 15-30 ml BID - senna 1 tab BID titrated to 4 tabs BID (nonformulary) - If no bowel movement in 3 days, consider magnesium citrate or enema
Dizziness	<ul style="list-style-type: none"> <input type="checkbox"/> Usually resolves as body adjusts to medication. <input type="checkbox"/> Encourage patient to contact PCP if condition persists more than 1 week or is bothersome.
Nausea	<ul style="list-style-type: none"> <input type="checkbox"/> Take medication with food. <input type="checkbox"/> Encourage patient to contact PCP if condition persists more than 1 week or is bothersome.
Respiratory Depression	<ul style="list-style-type: none"> <input type="checkbox"/> Infrequent, but requires immediate medical attention. <input type="checkbox"/> May occur from drug accumulation as a result of overaggressive titration.
Sedation	<ul style="list-style-type: none"> <input type="checkbox"/> Can be reduced or avoided with slow titration. <input type="checkbox"/> Check for concomitant CNS depressants. <input type="checkbox"/> Consider dose reduction with slower titration.
Sweating	<ul style="list-style-type: none"> <input type="checkbox"/> Relatively uncommon. Consider dose reduction with slower titration.
Vomiting	<ul style="list-style-type: none"> <input type="checkbox"/> May resolve as body adjusts to medication. Hold the next dose. Increase fluids as appropriate. Progressive alimentation. <input type="checkbox"/> Consider short term use of meclizine, metoclopramide or prochlorperazine.
Itching	<ul style="list-style-type: none"> <input type="checkbox"/> Itching is often self limiting but may be dose related. Consider antihistamine.
Urinary Hesitation	<ul style="list-style-type: none"> <input type="checkbox"/> Go back to previously tolerated dose with gradual titration. <input type="checkbox"/> Consider fecal impaction as a potential cause for urinary retention. <input type="checkbox"/> If the patient has the urge to urinate but is unable to void after 6 hours, immediate medical attention is required.
Overdose (in chronic opiate use)	<ol style="list-style-type: none"> 1. Patients should meet all of the following criteria before naloxone is administered: <ol style="list-style-type: none"> a. Depressed mental status: difficult to arouse or unarousable b. Shallow respirations or rate < 8 associated with evidence of inadequate ventilation (e.g. low oxygen saturation, hypotension). 2. Dilute 0.4 mg naloxone (one ampule) with normal saline to a total volume of 10 ml (1 ml = 0.04 mg). 3. Remind the patient to breathe; though narcotized, patients report hearing concerned staff and being unable to open their eyes or respond. Reminders to “take a deep breath” are often followed. 4. Administer 1 ml IV (0.04 mg) q1 min until the patient is responsive. A typical response is noted after 2-4 mls with deeper breathing and greater level of arousal. Gradual naloxone administration should prevent acute opioid withdrawal. 5. If the patient does not respond to a total of 0.8 mg naloxone (2 amps), consider other causes of sedation and respiratory depression (e.g. benzodiazepines, CVA). 6. The duration of action of naloxone is considerably shorter than the duration of action of most short-acting opioids. Repeated doses of naloxone may be needed. <p style="font-size: small;">Adapted from Fast Fact and Concept #039: Using Naloxone. American Academy of Hospice & Palliative Medicine.</p>

Pain Management Chronic Pain – NonSteroidal AntiInflammatories

This pathway does not
replace sound clinical
judgment or apply to all
patients

Table 6: Nonsteroidal Anti-Inflammatory Agents for Chronic Pain

NSAID	Class	Available Dosage Forms	Dosing	Relative Cost
Sulindac (Clinoril [®])	Acetic Acid	150 mg, 200 mg	150 mg – 200 mg BID MAX: 400 mg/day	\$
Ibuprofen (Motrin [®])	Propionic Acid	200 mg, 400 mg, 600 mg, 800 mg	400 – 800 mg Q 6-8 hrs MAX: 3200 mg/day	\$
Naproxen (Aleve [®])	Propionic Acid	250 mg, 500 mg	250 mg – 500 mg BID MAX 1375 mg/day	\$
Salsalate (Disalcid [®])	Salicylic Acid	500 mg, 750 mg	500 mg – 1500 mg BID up to 1000 mg TID MAX: 3000 mg/day	\$
Celecoxib (Celebrex [®])	Selective COX-2	100 mg, 200 mg	100 – 200 mg/day MAX: 400 mg/day	\$\$\$\$\$

Shaded items are nonformulary. Monthly Cost : \$ < 10; \$\$ 11-20; \$\$\$ 21-60; \$\$\$\$ 61-100; \$\$\$\$\$ > 100

COX-2 Inhibitor Considerations

COX-2 inhibitors are not recommended for routine use in patients with acute pain or general musculo-skeletal complaints. COX-2 inhibitors are indicated for patients with confirmed chronic conditions such as rheumatoid arthritis or osteoarthritis that are:

- considered at high-risk for a serious GI event or
- have experienced therapeutic failure with at least 2 nonselective NSAIDs from different classes

Patients considered at the high risk are those with a previous history of a gastroduodenal ulcer, perforation or GI bleed. Other risk factors include: advanced age (> 65 years), concomitant anticoagulant or oral glucocorticoid therapy. For patients at intermediate GI risk (such as those on daily low dose aspirin) or with high cardiovascular risk, utilization of a proton-pump inhibitor (PPI) in combination with a nonselective NSAID should be considered versus a COX-2 selective.

Pain Management Chronic Pain – Adjuvant Medication

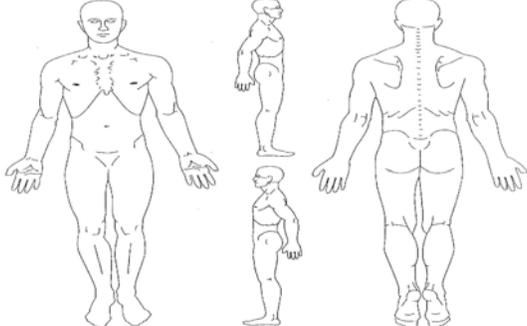
This pathway does not replace sound clinical judgment or apply to all patients

Table 7: Pain Management Adjuvant

Drug	Dosage Forms	Initial Dose	Titration	Full Effect	Comments	Side Effects	Relative Cost
<i>Anticonvulsants</i>							
Gabapentin (Neurontin [®]) Preferred	100 mg, 300 mg, 400 mg, 600 mg, 800 mg	300 mg QD	300 mg QD x 3 days 300 mg BID x 3 days 300 mg AM & 600 mg PM x 3 days 600 mg BID x 3 days Increase by 300 mg weekly - up to 1800 mg/day	3 months including titration	Must be NA/DOT & crushed/floated. Dose adjust in renal impairment.	dry mouth, edema, dizziness, cognitive impairment	Tab/Cap - \$\$ Liquid - \$\$\$\$
Oxcarbazepine (Trileptal [®]) Preferred	150 mg, 300 mg, 600 mg	300 mg BID	Increase every 1-2 weeks by 600 mg Max dose 1800 mg.	3 months	Dose adjustment required if CrCl < 30.	drowsiness, dizziness, ataxia, nystagmus, rash, hyponatremia, NV	\$\$ - \$\$\$
Carbamazepine (Tegretol [®]) Alternate or Trigeminal neuralgia	100 mg, 200 mg	100 mg BID	Increase by 100 mg – 200 mg Weekly up to 1200 mg/day (200 mg – 400 mg BID-TID, BID PREFERRED)	3 months	Contraindicated in agranulocytosis, AV block, bone marrow suppression, MAOIs, TCAs. Monitor CBC (baseline, 12wks for 2 months, annually, LFT, electrolytes. HLA-B 1502 allele test prior to initiation for Asian ancestry. Enzyme inducer. BBW: agranulocytosis, anemia, serious dermatologic reactions & HLA-B * 1502 allele	drowsiness, ataxia, blurry vision, anemia, N/V, SJS, hyponatremia, agranulocytosis, anemia, teratogenic, thrombocytopenia, Increased LFTs	\$
<i>Antidepressants</i>							
Nortriptyline (Pamelor [®])	10 mg, 25 mg, 50 mg, 75 mg	10 – 25 mg QHS	Increase by 10 – 25 mg weekly up to 75 mg daily.	Duration of adequate trial: 3 months at maximum tolerated doses	Contraindicated with MAOIs, conduction disorders, QT prolongation, and ileus. Requires baseline ECG and Mental Health evaluation BBW: Increased suicidality	dry mouth, sedation, hypotension, urinary retention, constipation	Cap - \$ Liquid - \$\$\$
Venlafaxine (Effexor [®]) Preferred	IR (BID): 25 mg, 37.5 mg, 50 mg, 75 mg, 100 mg ER (QD): 37.5 mg, 75 mg, 150 mg, 225 mg	37.5 mg QD	Increase by 37.5 mg weekly. Usual dose is 75 mg (IR) BID or 150 mg (ER) QD.	2 months	Dose adjust in renal & hepatic impairment Contraindicated with MAOIs. BBW: Increased suicidality	nausea, constipation, dizziness, drowsiness, hypertension at high doses	IR - \$\$ ER - \$\$\$\$
Duloxetine (Cymbalta [®]) Alternate	20 mg, 30 mg, 60 mg	30 – 60 mg QD	Higher doses have not shown benefit and are less well tolerated.	2 months	Not recommended with hepatic impairment or severe renal impairment. Contraindicated with MAOIs, hepatitis and closed angle glaucoma BBW: Increased suicidality	drowsiness, dry mouth, constipation, insomnia, nausea	\$\$\$\$
<i>Muscle Relaxants</i>							
Baclofen (Lioresal [®])	10 mg, 20 mg	5 – 10 mg QD	5 – 10 mg, QHS x 7 days 10 mg BIX x 7 days 10 mg TID x 7 days Increase weekly up to 80 mg/day	Onset 3-4 days	Avoid abrupt discontinuation. Caution in renal impairment, seizure, and elderly. Formulary use restricted to spinal cord injury.	drowsiness, vertigo, dizziness, hypotension, rash, N/V	\$
Methocarbamol (Robaxin [®])	500 mg, 750 mg	1500 mg QID	NA	Onset within 30 minutes	Limited short term efficacy only. Prescription restricted to 10 days.	Drowsiness, dizziness, blurry vision	\$\$\$ < 10 days = \$
<i>Topicals</i>							
Lidocaine (Lidoderm [®])	5% Patch	Apply up to 3 patches	NA	1 month	Indicated for localized postherpetic neuralgia. Do not apply > 3 patches.	Burning, itching, depigmentation, edema	\$\$\$\$
Shaded items are nonformulary. Monthly Cost : \$ < 10; \$\$ 11-20; \$\$\$ 21-60; \$\$\$\$ 61-100; \$\$\$\$\$ > 100							

CPHCS Chronic Pain Intake Sheet

(Recommended questions to elicit accurate pain history)

Tell me about your pain – when did it start?	<p>Mark the diagram below with the type of pain you have:</p> <p>△△△ Aching === Numbness ○○○ Pins & Needles XXX Burning /// Stabbing</p> 
How did it start? Were you injured?	
Where is it? Where does it go?	
What are your goals?	

What have other doctors told you was causing your pain?			
What tests have you had in the past? (results)			
Have you ever had surgery because of your pain? Yes No If yes, when? Did it help?			
What medications have you tried in the past for your pain and were they helpful? Side effects? <table style="width: 100%; border: none;"> <tr> <td style="width: 33%;">Name</td> <td style="width: 33%;">Effects</td> <td style="width: 33%;">Side Effects</td> </tr> </table>	Name	Effects	Side Effects
Name	Effects	Side Effects	
What other treatments have you tried and when? Physical therapy Counseling TENS Other: Were they helpful?			
History of mental health disorder in past? Anxiety Depression Schizophrenia Personality Disorder Currently seeing mental health? Yes No			
During the last 2 weeks have you felt down, depressed or hopeless? Yes No			
Have you had little interest in doing things? Yes No			
History of substance abuse/illegal drugs? Yes No Which drugs? Last use? Route? Oral Nasal Injection			
What do you believe is causing your pain?			
What do you find makes your pain better (e.g. rest, medicine, etc.)?			
What makes the pain worse (e.g. walking, lying, resting, etc.)?			

For the following questions, use the *Pain Rating Scale*: 0 = No Pain 10 = Worst Pain

a. Please use the pain scale to describe your pain at its worst in the last week:	No pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain
b. Please use the pain scale to describe your pain at its best in the last week:	No pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain
c. Please use the pain scale to describe your pain on average:	No pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain
d. Please use the pain scale to describe your pain right now:	No pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

CDCR Stamp:
Patient Name:
CDCR #
DOB:

Can you do the following activities? a. Getting in or out of bunk/shower: Yes No Sometimes b. Transfer from/to floor: Yes No Sometimes c. Self-care Yes No Sometimes (bathing, grooming, dressing, toileting, bed mobility)	How much can you exercise? (minutes/days) Type of exercise? Walking Jogging Other:
---	---

How does your pain affect your mood/relations with other people?	None	Some	Very Much
Is your pain worse when you are anxious, stressed, depressed or angry?	None	Some	Very Much
How does your pain affect your ability to work?	None	Some	Very Much
How does your pain affect your sleep?	None	Some	Very Much

Chart Review – significant past medical history, chronic conditions and medications:

Physical Exam

Ht:	Wt:	BMI:	BP:	P:
-----	-----	------	-----	----

Exam of Area of Pain:

	<p>Include</p> <ul style="list-style-type: none"> • Inspection • Palpation • Range of Motion • Soft tissue • Neuro • Sensory exam <ul style="list-style-type: none"> ◦ Light touch ◦ Pinprick • Other • Reflexes • Gait

A/P chronic pain due to (location and etiology) :

Notes: _____

Patient Education: _____

- Ordered**
- Referrals
 - Diagnostics
 - Mental Health Referral
 - Physical Therapy
 - Exercise Prescription/Diet
 - Medications
 - Patient Education
 - Labs, UOT, Other
- If Opioids Prescribed**
- Pain Agreement Completed
 - Referral to Medical Leadership via existing Committee structure
 - Meets medical criteria with Objective

Follow up in:
Provider (print name):
Provider (signature):
Date:

CDCR Stamp:
Patient Name:
CDCR #
DOB:

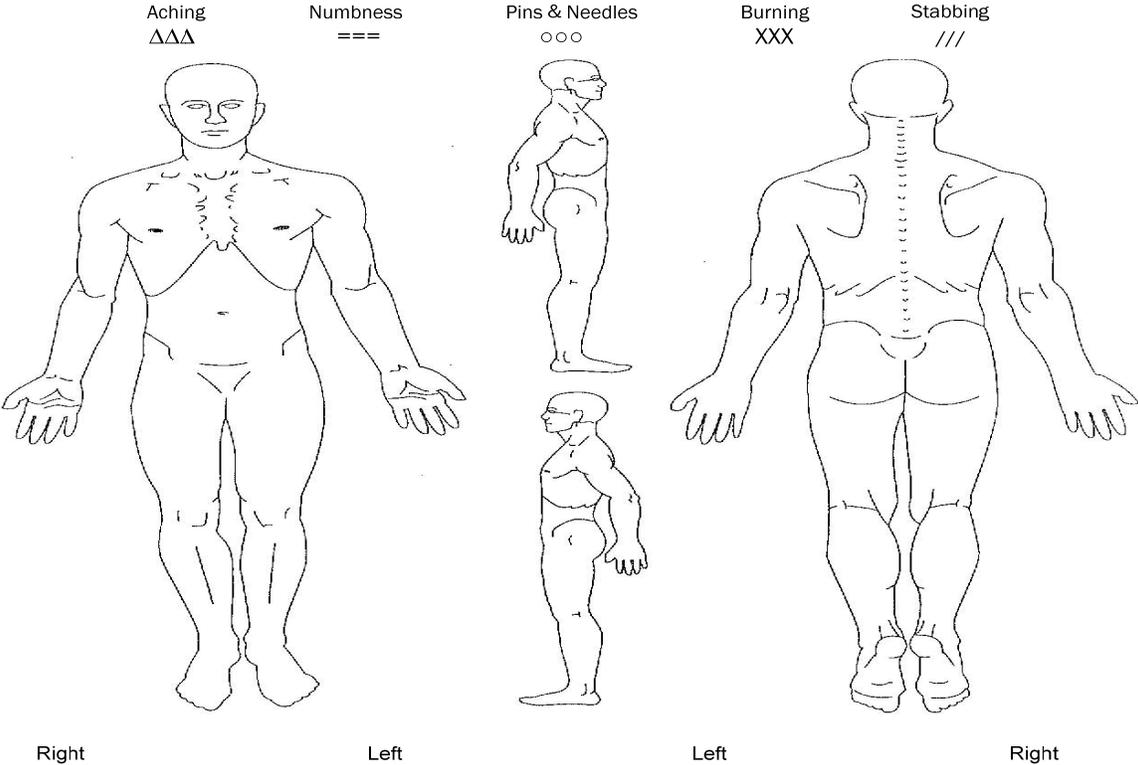
Initial Pain Assessment Patient Completion

Name: _____

Date: _____

What is the problem you would like me to help you with?

Please use the following diagram to show us where you are experiencing pain and numbness:



Circle all of the following words that describe your pain:

- | | | | |
|----------------|-----------------|------------------|-----------------|
| Dull | Shooting | Throbbing | Tingling |
| Aching | Electric | Sharp | Other: |
| Burning | Cold | Tight | _____ |

CDCR Number, (Last, First, MI) & Date of Birth

HISTORY OF PRESENT ILLNESS:

1. How long have you had this pain?

2. Please mark the event or events that led to your present pain:

- | | |
|--|---|
| <input type="checkbox"/> Accident | <input type="checkbox"/> Approximate Date |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Following an Operation |
| <input type="checkbox"/> Other Disease | <input type="checkbox"/> No Obvious Cause |
| <input type="checkbox"/> Other Injury | |

3. How often does the pain occur?

- Continuously (Non-Stop)
- Several Times a Day
- Once or Twice a Day
- Several Times a week
- Less Than 3 or 4 Times per Month

4. How has the intensity of the pain changed during the time you have had it?

- Increased Decreased Stayed The Same

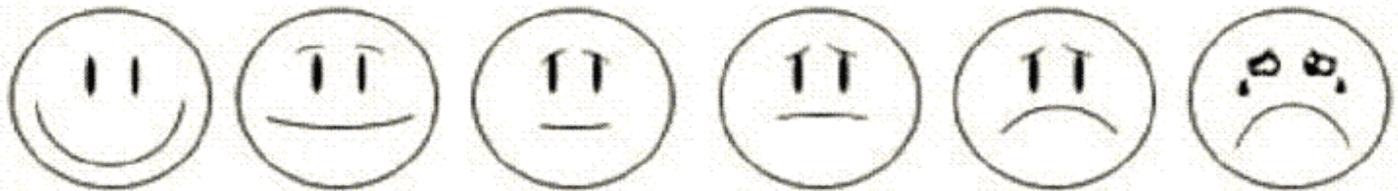
5. Which of the following affect your pain? Indicate better (+), worse (-) or no affect (0).

- | | | |
|--|---|------------------------------------|
| <input type="checkbox"/> Heat | <input type="checkbox"/> Cold | <input type="checkbox"/> Noise |
| <input type="checkbox"/> Standing | <input type="checkbox"/> Lying Down | <input type="checkbox"/> Walking |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Anxiety/Emotions | <input type="checkbox"/> Sitting |
| <input type="checkbox"/> Climate | <input type="checkbox"/> Massage/Emotions | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Alcoholic Beverage | <input type="checkbox"/> Caffeinated Drinks | <input type="checkbox"/> Vibration |
| <input type="checkbox"/> Particular Position or Movement | | |

Explain _____

6. Please mark on the line below where you would rate your pain on average

0 1 2 3 4 5 6 7 8 9 10



No Pain

Moderate Pain

Worst Possible Pain

10. What specialists have you seen for your pain? (Orthopedic surgeon, neurologist, etc.)

11. Previous studies done (date, area of body)

_____	MRI	_____
_____	CT	_____
_____	X-Ray	_____
_____	Sleep Study	_____
_____	EMG	_____

12. In the past what medications have you taken?

Drug:	Dose:
_____	_____
_____	_____
_____	_____
_____	_____

13. What medications are you currently taking?

Medication	Dose	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ALLERGIES

Do you have allergies?

Yes No

List all of your allergies: _____

Do you have any of the following: (circle all that apply)

- | | | | |
|------------------------------------|--------------|---------------------|------------------|
| Headaches | Stomach Pain | Chest Pain | Fevers |
| Vision Problems | Nausea | Shortness of Breath | Chills |
| Hearing Problems | Vomiting | Urinary Problems | Night Sweats |
| Dizziness | Diarrhea | Rashes | Appetite Changes |
| Difficulty Swallowing | Constipation | Swollen Joints | Weight Loss |
| Color Changes in the Feet or Hands | | Chronic Fatigue | |

PAST SURGICAL HISTORY

Please list all surgeries, surgeons and the dates of the surgeries:

Operation	Surgeon	Date
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

SOCIAL HISTORY:

What is your education level?

What type of work did you perform?

HABITS:

Do you smoke cigarettes? Yes No

When did you quit?

Do you use alcohol? Yes No

How frequently?

Do you use any "street drugs"? Yes No

CPHCS
Chronic Pain Provider-Patient Agreement/Informed Consent
for Opioid Pain Medication

This is an agreement between _____ (the patient) and _____ (the provider) concerning the use of opioid medications for the treatment of a chronic pain problem.

1. I understand that opioid medications are used as one part of a chronic pain treatment program and that they have risks and side effects involved with taking them. I have been informed of these risks and discussed them with my provider.
2. I understand that the medication will probably not eliminate my pain, but will be used to attempt to reduce my pain enough that I may become more active. Most patients see about a 30% decrease in their pain.
3. Chronic pain is a difficult problem that requires a team approach. I must keep all the appointments (Physical Therapy, specialist clinicians, pain groups and counselors) that my pain management provider recommends for my treatment, or my opioid medication may be stopped.
4. I understand that treatment with opioid pain medications is being started on a trial basis. I will get more medications depending on the benefits I show and also the problems that develop.
5. In particular, I understand that opioid medications can cause physical dependence. If I suddenly stop or decrease the medication, I could have withdrawal symptoms (flu-like syndrome such as nausea, vomiting, diarrhea, aches, sweats, chills) that may occur within 24-48 hours of the last dose. I understand that opioid withdrawal is quite uncomfortable, but not a life-threatening condition.
6. Overdose on this medication may cause death by stopping my breathing; this can be possibly be reversed by emergency medical personnel if they know I have taken opioid medications.
7. If the medication causes drowsiness, sedation, or dizziness, I understand that if my job requires, I must not drive a motor vehicle or operate machinery that could put my life or someone else's life in jeopardy.
8. I understand it is my responsibility to inform the provider of any and all side effects I have from this medication.
9. I agree to take this medication as prescribed and not to self diagnose, or demand the provider change the amount or frequency of the medication without a medical reason. Running out early, needing early refills, or increasing doses or more frequent dosing may be signs of misuse of the medication and may be reasons for the provider to discontinue prescribing to me.
10. Seeking opioid medication from other providers may be a reason for my provider to discontinue the opioids.
11. I agree not to sell, lend, or in any way give my medication to any other person. If I am found to be checking my medicine it will be stopped. If I am suspected of hoarding my medication, custody may be notified and a search of my housing may result.
12. I agree not to drink alcohol or take other non-prescribed mood-altering drugs while I am taking opioid medication.
13. My provider may request urine or blood drug screens from time to time to monitor my use of pain medications, and to detect improper use of medications not prescribed. I agree to submit to these tests and understand if I refuse the testing, my provider will need to stop my opioid medication. In the event that these tests indicate that my use of opioids or other medications presents a health risk to myself or to others, my provider may taper and stop the opioid medication. If my test results indicate a danger to myself or others, I authorize my medical provider to notify Custody. _____ (pt. initial).
14. I understand that there is a risk that opioid addiction could occur. This means that I might become psychologically dependent on the medication, using it to change my mood or get high, or be unable to control my use of it. People with past history of alcohol or drug abuse problems are more susceptible to addiction. If this occurs, the medication will be discontinued. I have read the above, asked questions, and understand the agreement. If I violate the agreement, I know that the doctor may discontinue this form of treatment.

Patient Signature: _____
Provider Signature: _____
Date: _____

CDCR Stamp:
Patient Name:
CDCR #
DOB:

CDCR 7474 (12/09)

**CHRONIC PAIN PROVIDER-PATIENT AGREEMENT (SPANISH)
INFORMED CONSENT FOR OPIOID PAIN MEDICATION**

Acuerdo entre el Proveedor Médico y el Paciente y Consentimiento para el Uso de los Analgésicos Opiáceos

Este es un acuerdo entre _____ (el paciente) y _____ (el proveedor médico) en relación al uso de los analgésicos opiáceos para el tratamiento del dolor crónico.

1. Entiendo que los analgésicos opiáceos se utilizan como una fase del programa para tratar el dolor crónico y que hay riesgos y efectos secundarios al usarlos. Se me ha informado sobre los riesgos y he conversado con mi proveedor médico acerca de ellos.
2. Entiendo que probablemente el medicamento no eliminará mi dolor, pero será usado para reducir mi dolor suficientemente para que pueda ser mas activo. La mayor parte de los pacientes obtienen una disminución alrededor de 30% en su dolor.
3. El dolor crónico es un problema difícil que requiere un tratamiento coordinado. Debo acudir a todas las citas (fisioterapia, especialistas, grupos de tratamiento del dolor y consejeros) que mi proveedor médico recomienda en el curso de mi tratamiento de otra manera mi medicamento podría ser descontinuada.
4. Entiendo que este tratamiento utilizando los analgésicos opiáceos se esta estableciendo en base de prueba. Recibiré mas medicamentos según los beneficios o los problemas que resultan.
5. En particular, entiendo que los analgésicos opiáceos pueden causar una dependencia física. Si de repente dejo de tomarlos o me decido disminuir la dosis del medicamento, podría sufrir síntomas de abstinencia (mareos, vómito, diarrea, malestar, sudores, escalofríos) 24 a 48 horas después de tomar la última dosis. Entiendo que esta condición puede ser incomoda pero no amenaza la vida.
6. Una sobredosis de este medicamento puede causar la muerte al parar la respiración; posiblemente esto puede ser revertido por personal médico de emergencia si saben que he tomado analgésicos opiáceos .
7. Si este medicamento causa somnolencia, sedación o mareos, entiendo que si mi trabajo me obliga a conducir vehículos o a operar maquinaria, no debo hacerlo si esto podría poner en peligro mi vida o la vida de otras personas.
8. Entiendo que yo soy responsable de informar al proveedor de cualquier efecto secundario que provoca este medicamento.
9. Acepto tomar este medicamento según lo prescrito y no diagnosticarme, o exigir que mi proveedor médico cambie la cantidad o frecuencia del medicamento sin una razón médica. El hecho de acabar el medicamento o de necesitar renovar la receta antes de tiempo, o el aumento de la dosis o de la frecuencia de la dosis pueden ser prueba del uso indebido del medicamento y podrían ser razones por lo cual el proveedor médico anule mi prescripción.
10. Pedir analgésicos opiáceos a otros proveedores médicos puede ser razón por lo cual mi proveedor médico anule mi receta.
11. Acepto no vender, prestar, o regalar este medicamento a cualquier otra persona. Si se descubre que estoy escondiendo el medicamento en la boca en vez de tragarlo mi receta será anulada. Si se sospecha que estoy acumulando el medicamento, los oficiales de custodia podrían ser notificados y esto podría resultar en un registro de mi celda.
12. Acepto no tomar alcohol u otro medicamento no recetado que afecte la conducta mientras esté tomando los analgésicos opiáceos.
13. De vez en cuando mi proveedor médico podrá solicitar exámenes toxicológicos de orines o de sangre para verificar mi uso de los analgésicos y para detectar el uso indebido de medicamentos no recetados. Acepto someterme a estos exámenes y entiendo que si los rehúso mi proveedor médico tendrá que anular mi receta. Si los resultados de los exámenes muestren que mi uso de los analgésicos opiáceos u otros medicamentos representa un riesgo a mi salud o a la salud de otros, mi proveedor médico podrá disminuir la dosis hasta discontinuar el medicamento. Si los resultados indican un peligro para mi o para otros, autorizo a mi proveedor médico a notificar a los oficiales de custodia. _____ (iniciales del paciente)
14. Entiendo que hay riesgos de adicción con el uso de los analgésicos opiáceos. Esto significa que pueda desarrollar una dependencia psicológica, usándolos para cambiar mi estado de ánimo, para estimularme y que sea incapaz de controlar mi uso de los medicamentos. Los individuos con antecedentes de abuso de alcohol o de drogas son más susceptibles a la adicción. Si esto ocurre el medicamento será discontinuado.

He leído lo anterior, he hecho preguntas, y entiendo el acuerdo. Si no cumplo con el acuerdo, reconozco que el médico podrá discontinuar esta forma de tratamiento.

Firma del Paciente: _____

Firma del Proveedor Médico: _____

Fecha: _____

CDCR Stamp:
CDCR #:
Patient Name:
DOB:

Chronic Pain Follow-Up

Reason for visit: <input type="checkbox"/> Scheduled follow-up <input type="checkbox"/> New complaint	Current pain medications: Aberrant drug-taking behavior: how often are you taking your medications? <input type="checkbox"/> All the time <input type="checkbox"/> More than 50% of the time <input type="checkbox"/> Less than 50% of the time <input type="checkbox"/> Not taking Adverse effects from medications? <input type="checkbox"/> None <input type="checkbox"/> Sleepiness <input type="checkbox"/> Nausea <input type="checkbox"/> Confusion <input type="checkbox"/> Vomiting <input type="checkbox"/> Other: <input type="checkbox"/> Constipation <input type="checkbox"/> Fatigue
--	---

Analgesia (for the following questions, use the *Pain Rating Scale*: 0 = No Pain 10 = Worst Pain)

a. Please use the pain scale to describe your pain at its worst in the last week:	0	1	2	3	4	5	6	7	8	9	10	
	No Pain			Some Pain			Worst Pain					
b. Please use the pain scale to describe your pain at its best in the last week:	0	1	2	3	4	5	6	7	8	9	10	
	No Pain			Some Pain			Worst Pain					
c. Please use the pain scale to describe your pain on average :	0	1	2	3	4	5	6	7	8	9	10	
	No Pain			Some Pain			Worst Pain					
d. Please use the pain scale to describe your pain right now :	0	1	2	3	4	5	6	7	8	9	10	
	No Pain			Some Pain			Worst Pain					

Activities of Daily Living (since the last clinic visit how have the following changed?)

Your mood/relations with other people?	Worsened	Same	Some Improvement	Significant Improvement
Your ability to exercise, attend work/school?	Worsened	Same	Some Improvement	Significant Improvement
Your ability to sleep?	Worsened	Same	Some Improvement	Significant Improvement
Your overall degree of discomfort?	Worsened	Same	Some Improvement	Significant Improvement

Physical Examination

BP:	HR:	RESP:	WEIGHT:	HEENT:	HEART:	LUNGS:
-----	-----	-------	---------	--------	--------	--------

Focused examination pain site:	<u>Labs</u> <input type="checkbox"/> UDT <input type="checkbox"/> Results
Impression (including pain location and etiology, and pain control):	
Plan/discussion (including medications dispensed, refills, diagnostic studies, treatment modalities, labs ordered, UDT ordered and follow up):	

Provider (print name):
Provider (signature):
Date:

CDCR Stamp:
Patient Name:
CDCR #
DOB:

Diagnostic Procedures

Procedure	Description	Proposed Value	Indications/Interqual® Criteria*	Comments/Pitfalls
EMG/NCV	Electrical evaluation of muscle and nerve function of lower motor neurons	Adjunct in diagnosis of peripheral neuropathies, nerve injury, radicular and multi-radicular problems	Interqual®: mild to moderate unilateral weakness or pain not responsive to 3 week trial of NSAID, or patient unable to have CT or MRI Refinement: consider trial oral steroids	Recommended in patients with neuropathic pain who are unresponsive to adjuvant meds prior to use of opioids Will not diagnosis CRPS. Not helpful in painful myopathies.
MRI	Magnetic resonance imaging: no radiation, magnet	Diagnosis of pathology in neurologic and musculoskeletal entities related to pain		Optimal technique of evaluating structures in brain and spine, internal derangement joints Cannot use in patients with retained metal hardware
CT	Computed tomography	Evaluation bony abnormalities: osteophytosis, bony degenerative changes, cortically destructive lesions		Can be used with Interthecal contrast in spinal stenosis or evaluation in patients with hardware from spine surgery.

Therapeutic Procedures

Procedure	Description	Indication	Comments	Value
Lumbar epidural steroid injection (ESI)	Injection of steroid into the epidural space	Lumbar radicular pain not responding to 6 weeks of conservative therapy. Interqual®: used as diagnosis for back pain non-responsive to 4-6 wks of conservative treatment with no radicular findings.	No value in axial spine pain. Interqual® contradicts recommendations by professional pain organizations.	Limited effectiveness, usually less than 6 wks *Use in sciatica supported for short- term relief. Not recommended for spinal stenosis for non-specific low back pain.

- Epidural glucocorticoid injections have been used in patients with sciatica, spinal stenosis, and nonspecific low back pain.
- Epidural glucocorticoids do not provide benefits beyond six weeks, and have not consistently been shown to delay surgery in patients who are surgical candidates.
- Up to Date suggests a trial of epidural glucocorticoids for patients with sciatica who desire short-term pain relief and do not wish, or are unable, to undergo surgery (Grade 2B). They suggest not advising epidural steroid injections for spinal stenosis or non-specific low back pain (Grade 2C).
- Evidence is unavailable, unreliable, or contradictory regarding the effectiveness of glucocorticoid injections for other sites, including intradiscal injections, facet joint injections, medial branch blocks, sacroiliac injections, or piriformis injections. Up to Date suggests not performing these procedures for chronic low back pain (Grade 2C).

Reference:

Subacute and Chronic Low Back Pain: No surgical Interventional Treatment. **Roger Chou MD, Steven J Atlas MD MPH, H Nancy Sokol MD.** Last literature review version 17.1: January 2009; last updated: September 25, 2008.

Dealing with depressive thinking

What is depressive thinking?

When you are depressed there are changes in the way you think, as well as in how you feel. You tend to look on the black side of everything, see the worst in yourself, in your life and your future. Once you are feeling down, you are more likely to remember the bad things that have happened and ignore the good ones. Negative thinking can also trigger depression and it slows down recovery. Everyone has negative thoughts, but they also have positive ones. A healthy balance seems to be about two positive thoughts to 1 negative one. When you are depressed, this balance is disturbed. You may also have thoughts that are distorted and don't fit the facts, such as 'I am a waste of space' and 'I am a complete failure.'

Have you noticed differences in the way people think about events? Can you relate to the example below?

Another inmate was picked for a work assignment rather than you...

Person A

He is more experienced
He has been here longer
He has the necessary skills
It will be my turn next time
Disappointment

Person B

I will never get promoted
I am not appreciated
I am not liked
I am worthless
Prolonged unhappiness

Learning to recognize unrealistic, negative thoughts and to balance them with more realistic, positive ones can be very helpful. However, changing your way of thinking is quite difficult at first and you will need to keep working at it. It may help to enlist the help of someone you trust.

Identifying negative thinking

Negative thoughts can be difficult to spot because they become a habit, they can flash quickly into your mind and most of us are not used to noticing our thoughts. Learning to spot and catch these negative thoughts is a skill you can master with time.

When you are depressed, you tend to think in particular ways that are distorted in a negative way. These are called 'thinking errors'. Here are some common examples. Try to spot the ones which apply to you. Mark them in the box.

- Thinking the worst*, eg your boy/girl friend doesn't phone. You assume they don't like you any more.
- Thinking that everything is going wrong when only one thing has gone wrong (over-generalizing)*. For example, you make one mistake at work and think 'I'll never succeed. I can't do anything.'
- Ignoring the positive and only seeing the negative*, eg 'The shelves I put up are no good because a screw fell out.'
- Arguing away anything positive*, eg 'He said he liked what I did because he is sorry for me.'
- Making negative predictions*, eg 'It's no good my doing that, I'm bound to fail. It will be a disaster.'
- Taking things personally and blaming yourself for what others do*, eg 'My son failed that exam. I should have helped him more. I am a bad parent' or 'My partner has left me. I am no good.'
- Exaggerating the negative*, eg 'This is a complete disaster, a total failure.'

You may also have beliefs about yourself and about how the world is and should be that are unrealistic. These beliefs may be making it harder for you to deal with the problems in your life and so may be contributing to your depression. Here are some examples of beliefs that make people more likely to get depressed.

- I should be happy all the time.
- To be a good person, I have to be nice to everyone.
- If someone is hurt by something I say or do, I am a bad person.
- If I show emotion, it means that I am weak.
- It is shameful for me to show any sign of weakness.
- If someone does not like me, it means there is something wrong with me.
- If I argue or disagree, people won't like me.
- If I am criticized, it means I am wrong.
- If I don't succeed, I am worthless.
- I cannot handle it when things go wrong.

Changing negative thinking

It is likely that you have been thinking in a negative way for sometime now. It will take a lot of practice to change these ways. You may find it quite difficult at first and this may trigger more negative thoughts, such as 'I'm useless. I can't do anything right'. You may need help from a friend or from your health worker. Give yourself time. **Remember you can learn to think more positively and this will make a huge difference in your life.**

Here are some suggestions:

First, write down your negative thoughts as soon as possible. If it's difficult to notice any thoughts, try noticing when you feel down and ask 'What went through my mind just before I started feeling sad.'

Second, ask yourself "*is what I believe TRUE?*"

- It will be useful to consult someone outside the situation for their opinion
- Ask yourself if everyone would have the same belief in this situation
- Examine other possible explanations for the event occurring
- Ask yourself if you could be making a mistake in the way you are thinking
- Try a real-life experiment. For example, if your friend doesn't phone, call him or her to ask why. Check out if your assumption that he or she no longer likes you is true.

Third, balance each negative/unreasonable thought with more realistic ones

- These should be different to the unreasonable belief
- Try to make them realistic statements
- Try to make as many counters as possible

Now, read the following example and work out your own examples using the same format. You can do this with the help of your friend, doctor and/or your counselor.

Example

The example below shows how negative and positive thoughts lead to different reactions to the same situation.

SITUATION: Was not chosen for the job

Unreasonable/negative thoughts:

- Just as well I didn't get the job, I would have failed at it anyway.
- I am no good/stupid.
- I am a failure.
- I should give up.
- I will never succeed.

Resulting feelings: Worthlessness, depression.

Now let's look at the same situation from a different angle;

Reasonable/positive thoughts:

- Many people do not get the job they want.
- I need to practice some interview techniques.
- I am not a failure, I have achieved many good things in the past.
- I will not get anywhere by giving up.
- If I persevere I can succeed.
- I have succeeded in the past and I will continue to succeed.

Resulting feelings: Disappointment, but enthusiasm and hope.

Now you can work through your own examples. Write down a situation that has made you unhappy and any negative thoughts you may have had and the resulting feelings. Next, opposite each negative thought, write down a more balanced thought and any new feelings. You will find that after practicing this technique for a while, you get much better at balancing your thoughts.

Remember it will take time to change the way you think and feel

Finally

- Doing the exercises when you are depressed can be difficult.
- It might be useful to work through them with a trusted friend or family member.
- If you need extra help you can always talk to your doctor and/or your counselor.

You can overcome your depression.

Dealing with anxious thinking

What is anxious thinking?

When you are anxious there are changes in the way you think, as well as in how you feel. Once you are feeling anxious. You tend to look on the black side of everything and imagine that unpleasant and frightening things are going to happen. These thoughts then make you even more anxious. Everyone looks ahead and tries to foresee and avoid problems. But in anxious thinking, the balance between expecting the worst and expecting good things is disturbed. Anxious thinking is distorted thinking. It is when you worry before anything happens, when you expect the worst, when you tell yourself that you won't be able to cope and there is no real reason to think this. Unrealistic and negative thinking can trigger anxiety and slow down recovery.

Can you relate to the example below?

Disagreement with a cellie...

Person A

He doesn't agree with me;
He thinks what I said was stupid
I am a fool, I should not talk
I can not handle it;
I am getting out of here

Anxiety/panic

Person B

So we have a different point of view. That is OK.

It was interesting to discuss our different ideas
If he has a problem, then too bad

Interested/stimulated

Learning to recognize unrealistic, frightening thoughts and to balance them with more realistic, reassuring ones can be very helpful. However, changing your way of thinking is quite difficult at first and you will need to keep working at it. It may help to enlist the help of someone you trust.

Identify anxious and negative thinking

Negative and frightening thoughts can be difficult to spot because they become habit, they can flash quickly into your mind and most of us are not used to noticing our thoughts. Learning to spot and catch these troublesome thoughts is a skill you can master with time. When you are anxious, you tend to think in particular ways that are distorted. These are called 'thinking errors'. Here are some common examples. Try to spot the ones that apply to you.

- Thinking the worst*, eg 'The pain in my chest means there is something wrong with my heart.'
- Predicting that the worst will happen*, eg 'They won't like me. They'll think I'm stupid.'
- Exaggerating negatives* eg 'I made a complete mess of it. It was an absolute disaster.'
- Overgeneralizing - if something happens once, you think it will always happen*, eg if you feel anxious at the supermarket checkout, thinking 'I'm always anxious when I go out.'
- All of nothing thinking*, eg 'Unless I do it with no mistakes at all, I have failed.'
- Imagining that you know what other people are thinking*, eg 'I can tell they are thinking what a fool I am.'

You may also have beliefs about yourself and about other people that are unrealistic. Anxious people often imagine that other people are judging them harshly. Here are some examples of beliefs that make people more likely to be overly anxious. Mark the ones that apply to you.

- When people look at me they are examining what I do.
- If I get criticized it means that I am wrong.
- If I make a mistake that means that I am stupid.
- If I don't agree with people they won't like me.
- To be a good person I have to be nice to everyone.
- If someone is hurt or offended by what I do, this means I am a bad person.
- If I show emotion it means that I am weak.
- People will think that there is something wrong with me if they see that I am anxious.
- The opinions of other people about me are very important.
- I am afraid that I look or sound silly to other people.
- I can tell that people will evaluate me negatively.
- I have to be very careful about what I say in case I offend someone.
- Approval is very important to me.
- Being anxious is a sign of weakness.
- When people see me behave like this they will talk badly of me to others.

Now if you have other unrealistic beliefs write them below or use separate sheet of paper

Eg If someone tells me "No," I assume it is because they hate me.

.....

.....

How do you change the way you think?

It is likely that you have been thinking in an unrealistic or a negative way for some time now. You may find it quite difficult at first to change the way you think and this may trigger more negative thoughts, such as "I'm useless. I can't do anything right". You may need help from a friend or from your health worker. Give yourself time. ***Remember you can learn to think more realistically and this will make a huge difference in your life.***

Here are some suggestions:

First, write down your negative or frightening thoughts as soon as possible. If it's difficult to notice any thoughts, try noticing when you feel down and ask 'What went through my mind just before I started feeling anxious.'

Second, ask yourself is this belief that I have true? In order to do this, it may help to...

- ask someone outside the situation for their opinion
- ask yourself whether everyone would have the same belief in this situation
- ask yourself if the belief is true in every situation
- examine the other similar situations
- examine other explanations for the event occurring
- ask yourself if you could be making a mistake in the way you are thinking

Third, counter each unrealistic/negative thought with a more realistic, reassuring one

- These should be different to the unrealistic belief
- Try to make them realistic statements
- Try to make as many counters as possible

Examples

Please read the following example and try to create your own examples. Try to find solutions to them using the same method.

SITUATION: Anxious eating in the cafeteria:

Unreasonable frightening or negative thoughts:

- I am sure they know that I am anxious and my fork is shaking.
- They will think that I am strange.
- They will think that I am a fool.
- I hope they will not tell anyone.
- I wish I could get out of here.

Resulting feelings: Panic

Balancing reassuring or positive thoughts:

- It is unlikely that they have noticed my anxiety.
- It is more noticeable to me than to them.
- If they were to think anything they would probably think that I was shy.
- Even if they did think that I was anxious they would not think badly of me.
- I will try to stay focused on the meal and our conversation.

Resulting feelings: Manageable anxiety

It is important that you make these statements even when you don't really believe them. If you make reassuring or positive statements often, you will find that the frightening or self-critical thoughts that used to occur automatically gradually disappear.

Now you can work through your own examples. Write down a situation that has made you anxious and any thoughts you may have had and the resulting feelings. Next, opposite each frightening thought, write down a more balanced thought and any new feelings. You will find that after practicing this technique for a while, you get much better at balancing your thoughts.

Remember it will take time to change the way you think and feel.

Relaxation Techniques

RELAXATION BREATHING

Proper breathing can be an antidote to stress. It cleanses and refreshes your body. This technique is portable and easy to do.

1. Begin by sitting or standing up straight.
2. Inhale through your nose, expanding your diaphragm. An indication that you are breathing properly is that your stomach will rise when you inhale.
3. Hold the breath briefly.
4. Slowly exhale through the mouth, allowing your stomach to fall.
5. As you exhale tell yourself "my body is relaxed and calm."

PROGRESSIVE MUSCLE RELAXATION (PMR)

PMR helps to condition your body to respond when muscles are tense. This technique can be practiced lying down or in a chair. Tense each muscle group holding it for a few moments and then let it relax. This will allow you to experience the muscle in a tense state and then a relaxed one. Here are some examples of how to tense muscle groups. This exercise is not limited to these muscle groups. Separately tense your muscles then relax them.

Head

1. Wrinkle your forehead.
2. Squint your eyes tightly.
3. Open your mouth wide.
4. Push your tongue against the roof of your open mouth.
5. Clench your jaw tightly.

Thighs, Calves, Ankles and Feet

1. Tighten your thigh muscles, trying not to involve abdominal muscles.
2. Tense the calf muscles.
3. Point your toes out directly in front of you, feeling the tension in your ankles.
4. Curl your toes under, as if to touch the bottom of your feet.
5. Bring your toes up as if to touch your knees.

VISUALIZATION

You can significantly reduce stress with your imagination. In creating your own special place you can make a retreat for relaxation. Here are a few guidelines:

- Allow a private entry into your place.
- Make it peaceful, comfortable and safe.
- Fill your place with sensuous detail.
- Allow room for an inner guide or other person to be with you comfortably.

MASSAGE

Massage can help you relax by increasing blood flow to tense areas (i.e. shoulders, back and neck). Increased blood flow relaxes muscles and removes build-up of waste products caused by tension.

MUSIC

Listen to some soothing, calm music. Often music can help us relax and retreat from the day.

EXERCISE

Physical activity can help relieve tension and refresh the body. Get a good 30-45 minute workout at least three days a week. While you are studying, take periodic breaks such as a brisk walk, to rejuvenate your body and make you more productive.

Anger Management



Anger is a normal emotion. It is common for people to experience anger in everyday life. When anger is expressed in a controlled manner it is healthy for a person to communicate their feelings. When anger takes over and a person loses control, anger may be expressed in a negative and hurtful manner. It is important to watch for signs of uncontrolled anger and learn to manage this anger so that your feelings are communicated in a healthy, appropriate way.

SIGNS OF ANGER

- You say or do things when you get mad that you later feel bad about.
- You hang on to your anger for a long time - you won't or don't let go of it.
- You hit, shove, slap, pinch or threaten when you get angry.
- It feels like you're almost always angry about something.
- Sometimes you can't stop arguing even when you want to.
- Your anger is "all or nothing." You're either furious or calm; you're never just a little angry.
- You always have to get the last word and win every battle.
- You've been suspended from school, lost jobs, have been arrested or gotten kicked out of your house because of your anger.
- You often hate yourself and do things to hurt yourself.
- You believe other people are the cause of most of your problems.

RATE AND RECORD

When you begin to feel anger building, rate your level of anger from one to ten. Your anger will be more or less intense in different situations. Your own thoughts and perceptions of a situation can cause level two anger to increase to level ten. Take note and record the instance so you understand that you have different levels of anger at different times of the day.

PREVENTING YOUR ANGER

- Change your environment
- Schedule time for yourself when you know you will be encountering stressful situations. Remove yourself from a situation so you can have the time to think about what you are really upset about.
- Find alternatives to your daily routine that are more soothing. Breaks throughout the day can help you stay focused and relaxed.

Cognitive Restructuring - Change the way you think

Have a positive outlook. Remember that it is not the end of the world and that getting angry is not going to fix the problem. Utilize "positive self-talk" to restructure how you are thinking about the problem.

Remember that getting angry escalates the situation and heightens emotions. Logic can overcome anger. Give yourself time to think through the best solution to the problem, rather than just reacting.

Improve Your Communication Skills

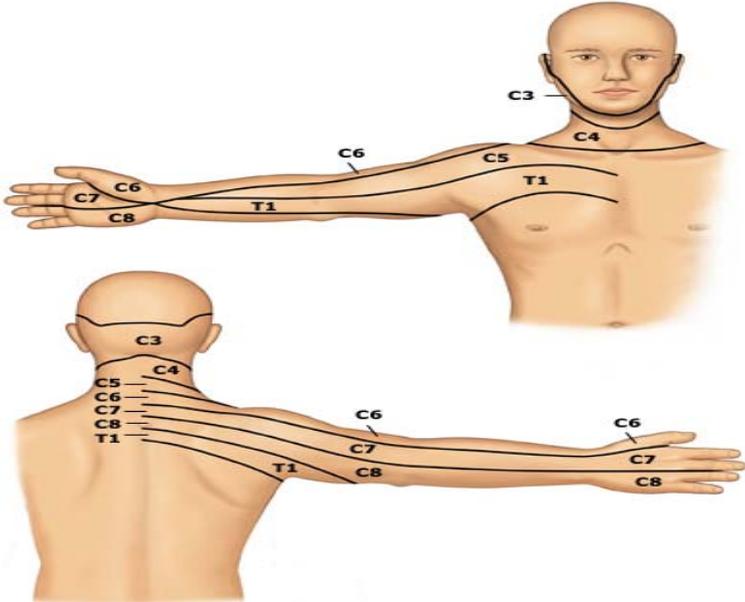
- Don't let your anger build. Slow down and rethink the first things that come to mind when a heated discussion takes place. Your choice of words is very important.
- Attack the problem not the person. Listen carefully to what they have to say and try not to argue.
- Take a few moments and decide the best course of action. Be patient with the other person and avoid putdowns.
- Compromise may be an option and lead to an amicable resolution.
- Respect each other and recognize when to quit. When it is over, let it be over.

MANAGING YOUR ANGER

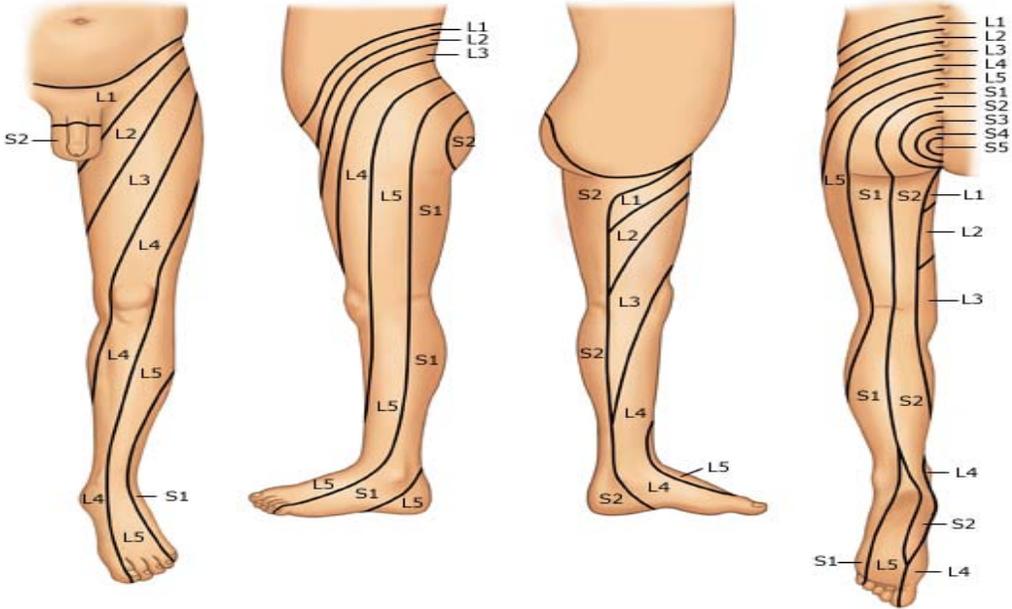
- Use simple relaxation techniques to calm yourself if you feel your anger might get out of control.
- Take slow, deep diaphragmatic breaths. These will help slow down your body's reaction and help you relax.
- Use imagery to relax and escape. Use your memory or your imagination to visualize a relaxing experience.
- Try exercising or engaging in non-strenuous exercise like yoga.
- Focus on finding a solution(s) to the problem. Avoid taking your anger out on someone. Place that energy into developing a plan that will resolve the situation and put it into action.
- Use humor to distract yourself and cope when possible.

If you are concerned about any difference in your treatment plan and the information in this handout, you are advised to contact your health care provider.

Cervical Dermatomes



Lumbosacral Dermatomes



ATTACHMENT N