C.35

Berkshire Healthcare Systems (2010) Pain Care Resource Manual: A Practical Guide for Health Care Professionals

Table of Contents

Table of Contents

We hope practitioners will find these tools and guidelines of value in understanding the complexity of patients with chronic pain and utilizing these tools to improve their care and management.

EXECUTIVE SUMMARY

Berkshire Health Systems Community Pain Management Project

I. *Introduction*

Management of acute and chronic pain has always presented the medical profession with special clinical and social challenges. The cause of chronic pain is often elusive and its diagnosis dependent largely upon the patient's subjective description. The absence of fully effective means to assess and treat complaints of pain, combined with conflicted social attitudes about pain itself, has historically resulted in widespread under-treatment of the problem, particularly in the elderly and in those with chronic or critical conditions. Concern about the extent of under-treatment has, in recent years, led respected professional societies and international health organizations to urge the medical profession to be more thorough and aggressive in combating patient pain.

At the same time, however, key pharmaceutical tools essential to the alleviation of chronic pain—particularly opioid medications—are increasingly diverted and misused for non-medical purposes, creating an alarming social and public health problem of prescription medication abuse. Within the past four years, prescription medications (most prominently, the opioids Vicodin and OxyContin) have ranked second only to marijuana as drugs of abuse, especially among young adults and teenagers. Some estimates indicate that 20% of all teenagers have abused Vicodin and 10% have abused OxyContin. Not only do diversion and misuse of these drugs create major health and safety concerns in their own right, the prevalence of abuse and diversion serves to further stigmatize the legitimate pain patient and diminish the accessibility of needed medical care.

II. *Effective Management of Chronic Pain and Prevention of Misuse and Diversion Is a Berkshire County Challenge*

Like their colleagues in every other part of the United States, Berkshire County healthcare providers face the challenge of assuring that effective and appropriate pain management remains available to those who need it while, at the same time, combating misuse and diversion of pain medication.

According to pharmaceutical company data, physicians and other healthcare providers in Berkshire County write prescriptions for *millions* of opioid tablets every year, along with other pain medications and treatments. Most of that medication is prescribed appropriately and taken appropriately. However, some patients receiving prescriptions for opioid tablets may benefit from other, non-pharmaceutical interventions, either in combination with or instead of drug therapies. In many cases, complaints of chronic pain are accompanied by or associated with conditions that may respond well to assessment and intervention by specialists in rehabilitation medicine, rheumatology, neurology, neurosurgery and behavioral health or substance abuse

services. Although a full spectrum of services for the assessment and treatment of chronic pain is available locally, those services have not been as well-coordinated as they could be or made easy for Berkshire County healthcare providers to draw upon for the benefit of their patients. The general health and well-being of many in our communities might significantly improve if all healthcare providers in Berkshire County who manage patients with chronic pain had ready access to the wealth of knowledge and experience of those physicians and other providers whose specialties include issues associated with chronic pain management.

The health and safety of our communities would also be enhanced if healthcare providers had information and tools immediately at hand that would help them recognize and respond effectively to situations of actual or threatened medication abuse or diversion. As in every other part of the country, prescription medications are becoming increasingly popular street drugs throughout Berkshire County, including among high school and middle school students in cities and towns from North Adams to Southfield. An insidious black market in prescription pain medication has taken root throughout the area, fueled, in significant part, through prescriptions issued by unwitting Berkshire County healthcare providers. As in other regions of the United States, Berkshire County has recently seen a marked rise in prescription drug-related overdoses, emergency room visits and deaths.

Berkshire Health Systems, its various departments and physician practices, together with the community physicians and other providers on its hospitals' medical staffs, are uniquely situated to accomplish the twin goals of improved service and diminished misuse and diversion. However, maintaining quality pain management services for those who require them and minimizing misuse and diversion of pain medication both require an efficient and timely means of sharing appropriate information among healthcare providers and an effective coordination of consulting and referral services. For that reason, Berkshire Health Systems has sponsored the Community Pain Management Project, a multi-disciplinary and multi-agency effort to develop the information and other tools including those reflected in this volume, the *Pain Care Resource Manual: A Practical Guide for Health Care Professionals.*

III. *The Community Pain Management Project Overview*

The Community Pain Management Project is designed to facilitate the exchange of appropriate information among healthcare providers and with local agencies in order to (a) improve the health care management of patients with complaints of chronic or acute pain and (b) reduce the risk of abuse and diversion of pain medication prescribed by Berkshire County healthcare providers. As of this time, the Community Pain Management Project has developed and instituted the following initiatives:

- *The Pain Care Resource Manual: A Practical Guide for Health Care Professionals*, a resource manual prepared by a wide range of Berkshire Health Systems affiliated practitioners and others engaged in specialties that involve pain management and which Berkshire Health Systems will make available to all physicians and other healthcare professionals in Berkshire County who are licensed to prescribe controlled substances

- Additional tools for the healthcare practitioner managing patients with chronic pain, including comparative data on prescribing practices of Berkshire County practitioners, tamper-proof prescription pads, and cautionary office signage

- The Multidisciplinary Pain Assessment and Treatment Program, an integrative assessment and treatment clinic sponsored by Berkshire Health Systems and through which patients with complaints of chronic pain are assessed and, when appropriate, referred to practitioners in a variety of specialties in order to assess and address identified pain-inducing conditions

- Coordination of necessary information and treatment plans for patients in pain management protocols

- Cooperation with and assistance to local court probation offices to facilitate successful completion of probation and conditions of pre-trial release for individuals with substance abuse concerns

IV. *The Pain Care Resource Manual: A Practical Guide for Health Care Professionals*

Berkshire Health Systems operates the New England Pain Practice at its Hillcrest Campus and also maintains practices in the specialties of behavioral health, substance abuse treatment (at the McGee Unit and in collaboration with the Brien Center for Mental Health & Substance Abuse Services), rehabilitative medicine, emergency medicine, rheumatology, neurology and neurosurgery. Collectively, providers in these specialties along with other community providers have collected or created the information for this *Pain Care Resource Manual*. The *Pain Care Resource Manual* is designed to serve as a clinical toolbox for Berkshire County practitioners, providing best practices guidelines for the assessment and treatment of the chronic pain patient, suggested forms and other resources to assist in the management of those patients, and informational aids useful in responding to situations of suspected misuse or diversion of pain medication.

The *Pain Care Resource Manual* is divided into eight discrete sections and includes information, advice and tools concerning:

- universal precautions useful in the assessment and treatment of all patients with complaints of chronic pain

- a series of algorithms for evaluation and treatment planning for patients complaining of the most common types of chronic pain—back pain, complex regional pain, diffuse musculoskeletal pain, headache pain, neck pain and neuropathic pain

- essential information about opioid analgesics, non-opioid analgesics, antidepressants and anti-epileptic drugs for use in chronic pain syndrome, medication side effects and prescribing guidelines for benzodiazepines in the treatment of alcohol and sedative-hypnotic withdrawal syndromes, neuroleptic-induced akathisia, anxiety spectrum disorders, insomnia and acute agitation and psychosis

- informational tools including:
    - a suggested patient-provider contract setting out the benefits and risks of controlled substances therapy, the dangers of combining pain medication with mind-altering drugs and substances (including alcohol), the need for close management of the controlled substances therapy (including the potential for random urine screens and pill counts), prohibition on after-hours or early refills and the possibility of provider termination of the therapy in the event that the provider determines that contract has been breached to patient's potential detriment (available in English, Spanish, Portuguese and Russian)
    - recommendations for urine screening and interpretation of test results to verify that patient is not placing himself or herself in danger with therapy
    - information to assist in identifying potential abusers and diverters of pain medication
    - suggested strategies for managing patients who require discontinuation of controlled substances therapy and who require detoxification admissions
    - description of and advice for using electronic medical record alert system to assure safe treatment practices when patients seek pain medication from multiple providers

- suggested screening forms including:
    - pain and mental health conditions screening tool
    - primary care screening tool for depression, anxiety and substance abuse risk in patients with complaints of pain
    - pain inventory (long form and short form)
    - pain assessment and documentation tool
    - pain score tracking tool

- a description of the Multidisciplinary Pain Assessment and Treatment Program

- legal and regulatory information including:
    - FAQ concerning legal issues involving pain practice
    - Massachusetts regulations concerning (a) use of controlled substances in treating pain, (b) nurse practitioner prescribing of

controlled substances and (c) physician assistant prescribing of controlled substances

- Contact information for various Berkshire Health Systems and community resources

V. *Additional Tools for Healthcare Providers Managing Patients With Chronic Pain*

Berkshire Health Systems has arranged for local healthcare providers to obtain certain additional tools that may be helpful in managing patients with complaints of chronic pain.

Department of Public Health Prescription Information. The Massachusetts Department of Public Health Drug Control Program includes a Prescription Monitoring Program that collects information on all Schedule II drugs prescribed and dispensed in Massachusetts. The Prescription Monitoring Program utilizes the data collected to determine prescribing and dispensing trends; provide educational information to health care providers and the public; and provide case information to regulatory and law enforcement agencies concerning drug distribution and diversion. Aggregate data and data without prescriber identifying information is available to the Community Pain Management Project. Prescriber-specific data is available at the request of or with the consent of the prescriber.

On at least a quarterly basis, the Collaborative intends to collect the aggregate and prescriber de-identified data for Berkshire County in order to observe and comment upon prescribing patterns and trends. The Collaborative also intends to collect (with prescribers' permission), or facilitate prescriber's in obtaining, prescriber-specific information in order to allow prescribers to compare their prescribing practices against those of their local colleagues. The goal of this informational effort is to allow prescribers to understand their own prescribing practices in the aggregate and in comparison to those of their peers in order to make any adjustment they believe appropriate. This prescribing information will also allow prescribers to identify situations of successful prescription forgery (e.g., one local prescriber discovered such a forgery when records concerning her prescriptions show instances of her prescribing certain opioids that she never actually prescribes).

* * * * *

Tamper-proof Prescription Blanks. With the availability of sophisticated, but easy-to-use computer programs such as PhotoShop®, it is increasingly possible for patients or others to manufacture realistic-looking, original prescriptions. There are now available on the market "tamper-proof" prescription blanks that because of their design and features make counterfeiting extremely difficult.

Berkshire Health Systems has arranged for a supply of these "tamper-proof" pads to be available to county prescribers at little or no cost above traditional prescription pads.

* * * * *

Warning Signs In Massachusetts, it a crime, punishable by imprisonment for 4 years and/or a fine of $20,000 to "knowingly or intentionally acquire or obtain possession of a controlled substance by means of forgery, fraud, deception or subterfuge, including but not limited to the forgery or falsification of a prescription or the nondisclosure of a material fact in order to obtain a controlled substance from a practitioner." Massachusetts General Laws, Chapter 94C, §33. The crime expressly includes not only affirmative deception to obtain drugs, but also the failure to disclose a material fact in order to obtain the drug, such as the fact that the patient has already been to the Emergency Department or to another physician for the same purpose. An unsuccessful attempt to commit this crime is itself a crime under Massachusetts General Laws, Chapter 274, § 6.

Some physicians have found that posting a warning sign in the office describing the criminal statute has served as a deterrent to patients who might otherwise be tempted to seek pain medication for improper purposes. Berkshire Health Systems has arranged for the availability of 8-inch by 4-inch brass-colored signs that summarize the law and, if desired by the physician, warn of the office's policy of notifying the police in the case of violations.

IV. Multidisciplinary Pain Assessment and Treatment Program

The Berkshire Health Systems-sponsored Multidisciplinary Pain Management Program promotes a comprehensive approach to the assessment and treatment of chronic pain—at biochemical, structural, psychological and spiritual levels. Rather than assuming that a pharmaceutical intervention offers the first, best (and often only) solution to alleviating chronic pain, the Multidisciplinary Pain Management Program allows a comprehensive patient assessment by a team consisting of a physical and rehabilitation medicine physician, a psychologist, an occupational therapist and a social worker. The team will either develop an individualized treatment program itself or, as appropriate, arrange for referral to specialists in behavioral health, substance abuse, neurology, neurosurgery or pain medication.

The goal of the Multidisciplinary Pain Management Program is to make available, through a single telephone call, a differential assessment of patients complaining of chronic pain, in order to identify as accurately as possible the most effective treatment approaches, including in situations where the patient may have one or more comorbidities associated with the chronic pain symptoms, such as (but not limited to) depression, anxiety or substance abuse.

VI. *Coordination of Information Necessary for Effective Co-Management of Patients With Chronic Pain and for Prevention of Misuse and Diversion*

Many Berkshire County healthcare providers are aware of patients who have sought prescription pain medications from multiple providers at the same time. Sometimes those patients are simply changing providers or have had difficulty securing an appointment with their customary provider. Oftentimes, however, patients simultaneously seeking prescription pain medication from multiple providers are abusing or diverting those drugs. Some prescription pain medications currently sell on Berkshire County streets for as much as $80 a tablet so that, with a

$20 deductible and a 30-day supply, a patient who is willing to harm others and break the law can realize a substantial financial profit.

The various hospital departments, physician offices and other service sites through which patients can obtain controlled substances have not historically had a means to easily or quickly share information about patients they are jointly treating and this deficiency sometimes leads to a lack of coordinated care in pain management and either the accidental or purposeful (on the part of the patient) over-prescription of medication and the risk of drug diversion.

One impediment to the sharing of information comes from an appropriate sensitivity to the confidentiality of patient information, both under traditional standards and the more recent HIPAA Privacy Rule. However, the legal constraints against disclosure include exceptions that allow exchange of information in treatment contexts and in situations where the patient is seeking pain medication for inappropriate purposes (such as abuse or diversion).

A second impediment to the sharing of such information has been the technological limitations of the existing information systems at Berkshire Health Systems and with other Berkshire County healthcare providers. With the advent of the outpatient component of the Berkshire Health Systems electronic medical record through Meditech, the appropriate exchange and monitoring of critical information is being greatly eased.

Prescribers of pain medication with access to the Meditech system can arrange to have a flag added to the patient's electronic medical record that identifies the patient as a participant in an existing pain management regimen and provides cautionary information for subsequent providers from whom controlled substances are sought. This information is important, of course, to the provider co-managing the patient (even unwittingly), so that the patient is not harmed by excessive or conflicting medications. Similarly, a patient who is reasonably believed to have a history of misuse or diversion of pain medication can be identified in the electronic medical record, so that subsequent providers can be mindful of that risk when considering the prescription of controlled substances or alternative therapies. A provider who is considering a course of pain management drug therapy can consult the patient's electronic medical record in order to determine whether the proposed therapy will conflict with or otherwise create risk to the patient.

The pain medication information within Meditech will be maintained in as secure and confidential a manner as is possible, with both access and content limited to that which is the minimally necessary information to keep the patient (and in the case of diverters, the community) safe from harm. Lorelei Barrett, Director of BMC Medical Records, is available for questions.

VII. *Cooperation With Local Law Enforcement and Courts*

Because the problem of abuse and diversion of prescription pain medication is a community-wide public health and public safety challenge, the Community Pain Management Project will work collaboratively with local law enforcement agencies and the courts.

Local law enforcement agencies, including the Berkshire County District Attorney's Office, have information about known or reasonably suspected diverters of prescription pain medication. To the extent that they lawfully and prudently can do so, those agencies will make that information available for inclusion in the Meditech alert system. The law enforcement agencies will ***not***, however, have access to the patient information stored in the Meditech alert system.

The Community Pain Management Project will work with local law enforcement agencies to assure prompt response to pain medication diversion situations that require police intervention. The Community Pain Management Project will also assist in arranging for expert consulting services to the law enforcement agencies about issues related to controlled substances to the extent that such services can be provided without compromising a provider's duties to his or her patients.

An increasing number of individuals making their way through the criminal court system in Berkshire County (as is true elsewhere) suffer from the consequences of substance abuse and addiction. Many of those need the assistance of the courts and the court probation offices in managing their substance abuse and addiction problems. The Community Pain Management Project has assisted the local district court in developing a consent form for probationers to sign that will allow local practitioners to provide appropriate information to the probation office when a probationer requires controlled substance medication and to otherwise facilitate in managing a probationer/patient with a substance abuse or addiction problem.

VIII. *Community Awareness Postcards for Parents*

In light of the serious rise in prescription pain medication abuse among Berkshire County middle school and high school children and the significant risk that such abuse can also lead to use of the substantially cheaper and more powerful heroin that is available on the local street, the Community Pain Management Project has initiated a series of informational postcards for distribution to all parents of all middle school and high school students in the county.

The cards are designed to be provocative, to emphasize that prescription drugs are not safe drugs when used improperly, to urge parents to manage controlled substances in the home carefully and to provide parents with ready access to local as well as national resources for addressing concerns about potential drug abuse by their children.

Three of these cards are distributed throughout the course of the school year.

Initial Approach

- Use a multidisciplinary approach
- Substance abuse warning signs are not always reliable
- Universal Precautions – standardize the approach

Universal Precautions for Treatment of Patients with Pain

Providing care for patients with chronic pain is a requirement that all health-care providers must face, regardless of specialty. Chronic pain patients have 20% more physician visits. Chronic pain can be disabling for patients and frustrating for the physicians and health-care providers trying to treat this population. Impacting the care of patients with chronic pain is the recognition that treatment choices include the potential use of narcotic pain medication can have medico legal and societal implications.

It has long been recognized that optimal care of chronic pain is most effectively delivered with a formalized multidisciplinary approach. In general, a formalized multidisciplinary approach to the assessment and care of patients with chronic pain has not been available to patients cared for in Berkshire County. In recognition of this problem, there has been a commitment by the hospital administration and the medical staff of Berkshire Medical Center to develop and implement a comprehensive multidisciplinary pain clinic in order to serve its patient population. This project has been under construction for some time and is finally coming to fruition. In the near future, a true multidisciplinary pain clinic will be up and running, available to see patients with the goal of both effectively caring for patients in need while at the same time serving the needs of the referring medical community.

Most care providers understand the rationale in using "Universal Precautions" as a tool aimed at preventing spread of infection while not stigmatizing patients who might harbor hidden infection. By approaching all patients as if a hidden infection might be present, we minimize the risk to ourselves as health-care providers while the same time providing optimal care to patients in need. This same "Universal" approach has been advocated in dealing with patients with chronic pain. This is particularly true in patients who might require use of chronic narcotic pain medication or the use of other controlled substances such as benzodiazepines.

It has long been recognized in the field of pain medicine, that while there may be some warning signs increasing the index of concern for substance abuse and inappropriate use, these signs are often unreliable. For instance, a patient who asks for stronger medication than an NSAID or a higher dose of their current narcotic may be inappropriately seen as "drug seeking" when in fact their pain may be undertreated while others who might be at significant risk for substance abuse go unrecognized. When treatment requires the use of chronic narcotic analgesics or substances such as benzodiazepines that also might be subject to misuse or abuse, a "Universal Precautions" model of treatment can help mitigate both the risk of under-treating of the pain condition and of promoting or supporting addictive behavior. Such precautions involve the consistent use of narcotic agreements, initial and random urine toxicologies but also involve a multidisciplinary set of assessment and treatment modalities.

By documenting with a patient that a multidisciplinary approach will be utilized to maximize the outcome and that random urine drug testing will likely be a part of the

follow-up care, health-care providers can be comfortable in knowing they are providing excellent care for their patients and are using appropriate medico legal diligence and protecting the needs of the community. In addition, the patient is likely to feel he or she is getting a comprehensive and protective level of care thereby enhancing patient satisfaction.

This packet contains tools that can assist both specialists and primary care physicians in providing a "Universal" approach to the care of patients with chronic pain, with or without the involvement of the multidisciplinary pain clinic. While we advocate this "Universal" approach, health-care providers are free to utilize any and all of the tools contained within this packet as they treat these often-complicated patients. The packet includes care algorithms that can guide practitioners in the evaluation and referral of patients presenting to an outpatient setting with a primary complaint of chronic pain. With each algorithm is a list of risk factors for acute pain progressing to chronic pain. While the list is not exhaustive, it reflects the importance of including behavioral and psychosocial factors in treatment planning for patients with pain syndromes. Also included within the packet, is a sample of pain agreement that can be used in patients in whom prolonged narcotic analgesic use is anticipated. Guidelines for analgesic medication use, a screening questionnaire that can be used to identify psychiatric dysfunction, information regarding the laboratory screening of patients on controlled substances, pertinent specialty and administrative phone numbers and useful references are but a few of the additional offerings of this packet.

In summary, the purpose of this packet as well as that of the multidisciplinary pain clinic is to give assistance to providers when that assistance is desired. It is not meant to usurp authority and/or second-guess the clinical judgment of well-trained practitioners, as they make difficult decisions aimed at providing the best of care to complicated pain patients. It is our sincere hope that you will find both the contents of this packet and referral to the multidisciplinary pain clinic helpful, as you strive to provide top quality care to the patients entrusted to you. We seek your thoughts, insights and constructive criticism on how to make this worthwhile initiative succeed as well as how we can improve upon it.

Algorithms

- Watch for red flag symptoms
- Refer appropriately
- Consider psychologic factors
- Algorithms reflect "best practices"
- Algorithms **do not** replace clinical judgment

Primary Care Algorithm: Chronic Pain

More than 60 million people suffer from persistent or recurrent pain sufficient in duration and intensity to adversely impact a patient's well-being, level of function and quality of life. The goal is to establish the patient's ability to self-manage their symptoms.

Guiding Principles of Treatment Of Chronic Pain

Referral to Specialized Pain Program

- Diagnostic assistance
- Advice on suitability of treatment
- Treatment planning for initial & long-term pain management
- Comprehensive management
- Advice on optimal pharmacology
- Multidisciplinary evaluation and care

Pharmacotherapy

- Thorough medication history is critical
- All drugs have risks and benefits
- Define goals of drug therapy before prescribing
- Base choices of analgesic on type and severity of pain
- Give drugs an adequate therapeutic trial
- Give adequate doses and titrate to dose that balances pain relief with dose-limiting side effects
- Two or more drugs with complementary mechanisms may provide greater relief with less toxicity
- Be alert to drug interactions and add non-drug therapies
- Taper and discontinue drugs that don't meet your treatment goals

Psych Assessment & Therapies

- Diagnostic responsibilities
- Psychological Treatment
  - Individual Cognitive Behavioral psychotherapy
  - Hypnotic Analgesia
  - Pharmacologic Treatment
  - Vocational Counseling
  - Group and Family Cognitive behavioral Psychotherapy
  - Biofeedback Treatment

Rehabilitation Intervention

- Comprehensive assessment
- Treatment
  - Physical and occupational therapy
  - Exercise
  - Work conditioning/ work hardening
  - Ergonomic modifications
  - Modalities - used on conjunction with active exercise
  - Behavioral/psychological therapy
  - Vocational rehabilitation
  - Medications

Interventional Approaches

- Diagnostic Blocks, Injection Procedures
- Therapeutic Blocks
- Neuroaugmentative Procedures
- Intraspinal Drug Delivery Systems
- Neuroablative Procedures
- Surgical Approaches

Alternative Therapies

- Yoga
- Massage
- Acupuncture
- Music Therapy
- Art Therapy

Monitoring & Outcome Assessment

- Objective Measure: ROM, strength
- Patient ratings: Pain, function, emotional status
- Standardized instruments: QOL, function, affect, pain impact
- Documentation of improved functional & vocational performance, return to work
- Patient's ability to self-manage
- Increasingly spaced follow-up appts.
- Medication Quantification

Reference: Wisconsin Medical Society, Task Force On Pain Management (2004).Guidelines for the Assessment & Management of Chronic Pain, Wisconsin Medical Journal, Vol. 103:3. (www.guidelines.gov)

These guidelines are recommendations based upon best scientific evidence but are not intended to replace medical judgment.

Primary Care Algorithm: Chronic Pain

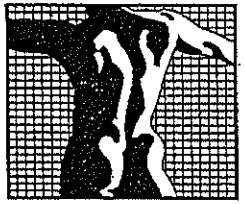
More than 60 million people suffer from persistent or recurrent pain sufficient in duration and intensity to adversely impact a patient's well-being, level of function and quality of life. The goal is to establish the patient's ability to self-manage their symptoms.

Risk Factors for Progressing to Chronic Pain Syndrome
Hx of Multiple Surgeries, Long Recovery from Previous Injuries
Chronic Illnesses, Acute Co-morbidities, Sleep Disorder
Risk Factors Complicating Assessment of Pain Experience
Secondary Gains: Legal, Disability, Housing or Job Problems
Personal or Family Hx of Substance Abuse, Request for Spec. Meds
Active Depression or Grieving, Anxiety, Poor Coping Skills
Hx of Physical or Emotional Trauma, Psychopathology

History: Pain history, History of treatment, Psychological history, Vocational and medical legal issues, General medical history, Pt's ideas about the cause of pain, Pt's goals for evaluation and treatment

Key Principles of Evaluation:

- Recognize multiple dimensions of chronic pain
- Identify & understand the nature of the patient's problem, if possible, the cause of the pain
- Identify & understand comorbid conditions that may affect treatment
- Identify & understand the patient's goals & expectations



Dx Testing:

Will testing help formulate the clinical diagnosis?
Will testing impact treatment?
- If Yes, Radiological, Laboratory, Electrodiagnostic studies, Dx nerve blocks, Psyc Testing, Functional assessment

Diagnosis:

- Primary pain diagnosis
- Medical comorbidities,
- Psyc comorbidities,
- Impact of pain on function

Physical & Psychological Examination:

MS Exam, Neuro Exam, Psychological Exam,

Functional abilities & deficits

A Written Pain Treatment Plan:

- Clearly define the pts overall condition
- Define treatment goals & expectations
- Goals should be "SMART"
- Outline specific goals with the patient
- Determine and address the pt's expectations
- Communicate the physician's expectations
- Determine & document endpoints
- Empower patient & families, enable them to control their course to the extent possible
- Schedule periodic reevaluation or team conferences, document progress

SMART Goals
S - Specific
M - Measurable
A - Achievable
R - Realistic
T - Time based

Specific Goals & Outcomes:

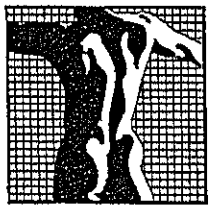
- Improve physical and psyc. function
- Improve pain and/or sleep
- Reduce HC services, ED utilization, medications
- Improve coping skills & reduce anxiety or depression
- Return to work or normal activities
- Increased ability to self-manage pain

Reference: Wisconsin Medical Society, Task Force On Pain Management (2004).Guidelines for the Assessment & Management of Chronic Pain, Wisconsin Medical Journal, Vol. 103:3.

These guidelines are recommendations based upon best scientific evidence but are not intended to replace medical judgment.

Primary Care Algorithm: Acute Back Pain or Back Related Leg Symptoms < 6 wks

LBP occurs in 80% of people and within 6 weeks, 90% will resolve satisfactorily
Pts disabled more than 1yr., 90% will never work again.



Risk Factors for Progressing to Chronic Pain Syndrome
Hx of Multiple Surgeries, Long Recovery from Previous Injuries
Chronic Illnesses, Acute Co-morbidities, Sleep Disorder
Risk Factors Complicating Assessment of Pain Experience
Secondary Gains: Legal, Disability, Housing or Job Problems
Personal or Family Hx of Substance Abuse, Request for Spec. Meds
Active Depression or Grieving, Anxiety, Poor Coping Skills
Hx of Physical or Emotional Trauma, Psychopathology

Traumatic

- Red Flags: Cauda Aquina Syndrome, Bowel and bladder Symptoms → Immediate referral to Neurosurgery for Imaging and Definitive Care
- No Red Flag → Obtain X-Ray to Rule Out Fracture
  - + For Fracture → Refer to Neurosurgery or Continue Medical Management
  - − For Fracture → 1) Medical Support 2) NSAIDS 3) Follow-Up in 2 wks 4) Evaluate Risk Factors
    - Better
    - Not Better → Multidisciplinary Pain Program Referral

Red Flags for Serious Disease
Progressive Neurological Deficit
Cauda Aquina Syndrome
Saddle Anesthesia
Steroid Use History
Age Greater than 50
Male with Osteoporosis,
Male with Compression Fx
Cancer History
Diabetes Mellitus
Insidious Onset or Worsens at Night
Fever, Weight Loss
S/S of UTI, Infection,
Recent Surgery
IV Drug Use, HIV,
Immune Suppression

Atraumatic

- Red Flag
  - Cauda Aquina Syndrome → Immediate referral to Neurosurgery for Imaging and Definitive Care
  - Weight Loss, Fever, Night Pain → Obtain Work-Up including CBC/ESR/ UA, Chem Profile, + Xray > MRI
    - If pathology, appropriate referral
    - If no pathology, Support and Multidisciplinary Pain Program Referral
- No Red Flag → Medical Support: Ice, Return to usual activities, NSAIDS, Follow-Up in 14 days for evaluate pain & activity, Evaluate Risk Factors
  - Better
  - If work disability persists → Multidisciplinary Pain Program Referral
  - Radicular pain, by 2-4 wks,

If no improvement, obtain MRI, if not diagnostic obtain EMG. If pathology, refer to Multidisciplinary Pain Program, NEPDTC referral or surgical evaluation

If pathology not proven, refer to Multidisciplinary Pain Program

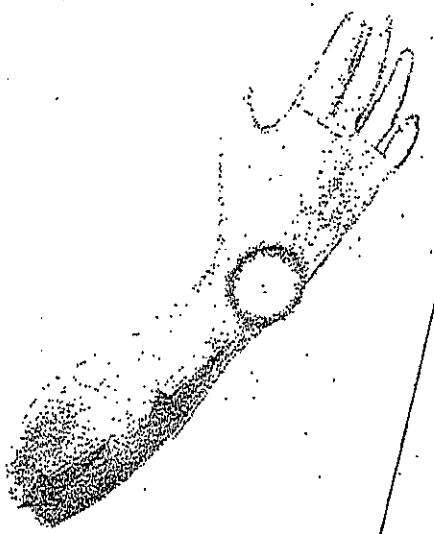
Reference:University of Michigan Practice Guidelines Committee 2003. (www.guidelines.gov)

These guidelines are recommendations based upon best scientific evidence but are not intended to replace medical judgment.

Primary Care Algorithm for Complex Pain Syndrome

Complex regional pain syndromes are uncommon painful conditions that usually affect the distal part of an upper or lower extremity and are associated with characteristic clinical phenomena. It is not associated with widespread extremity pain.

Risk Factors for Progressing to Chronic Pain Syndrome
Hx of Multiple Surgeries, Long Recovery from Previous Injuries
Chronic Illnesses, Acute Co-morbidities, Sleep Disorder
Risk Factors Complicating Assessment of Pain Experience
Secondary Gains: Legal, Disability, Housing or Job Problems
Personal or Family Hx of Substance Abuse, Request for Spec. Meds
Active Depression or Grieving, Anxiety, Poor Coping Skills
Hx of Physical or Emotional Trauma, Psychopathology



Complex Regional Pain Syndrome

Red Flags and Rule Out
S/S Thrombophlebitis
S/S Lymphedema
S/S Occult Fx, Infection or Tumor with imaging studies

•X-rays, EMG, Nerve Conduction Studies, CT, MRI may all be normal

→ Medical Management or Appropriate Specialty Referral → Negative Specialty Evaluation → Multi-Disciplinary Pain Clinic Referral

No Flag → **Early referral to New England Pain Diagnosis and Treatment Center:**

Goals of Referral

1) Educate about therapeutic goals
2) Determine contribution of sympathetic nervous system (Sympathetic Blocks)
3) Minimize pain through sequential drug trials (Avoid shot gum approach) **First Line:**
4) Encourage normal use of the limb (PT)
5) Review risk factors for progression to chronic pain syndrome

Diagnosing CRPS:
Pain and mobility problems out of proportion to the initial injury.
Abnormal sympathetic skin changes, can be either warm or cold to touch.
Pitting or hard (brawny) edema that is usually diffuse and localized to the painful and tendor region.
Decreased mobilization of extremity can lead to wasting of muscles

Reference:

These guidelines are recommendations based upon best scientific evidence but are not intended to replace medical judgment.

Primary Care Algorithm: Diffuse Musculoskeletal Pain

5% of Adults experience chronic poorly defined musculoskeletal pain

Risk Factors for Progressing to Chronic Pain Syndrome
Hx of Multiple Surgeries, Long Recovery from Previous Injuries
Chronic Illnesses, Acute Co-morbidities, Sleep Disorder
Risk Factors Complicating Assessment of Pain Experience
Secondary Gains: Legal, Disability, Housing or Job Problems
Personal or Family Hx of Substance Abuse, Request for Spec. Meds
Active Depression or Grieving, Anxiety, Poor Coping Skills
Hx of Physical or Emotional Trauma, Psychopathology

Diffuse Musculoskeletal Pain

Red Flags
S&S and Imaging Suggest:
Infection
Metabolic Disturbance
Malignancy/ Lymphoproliferative Disease
Connective Tissue Disease
Suicidal Ideation / Psychosis

→ Medical Management or Appropriate Specialty Referral → Negative Specialty Evaluation → Multi-disciplinary Pain Prog.

No Flag

Sleep Disturbance → Medical Management or Sleep Clinic if Primary Sleep Disorder Suspected or Needs Sleep Hygiene Education
- Good Response
- Poor Response → Specialty or Multidisciplinary Pain Program

Psychiatric Disorder
Anxiety / Depression → Initiate SSRI w/follow-up in 2 wks. to Assess Tolerability & R/O Suicidal Ideation; w/follow-up in 2-3 wks. to Assess Effectiveness
Pain Program Referral

Lack of Effectiveness. Consider Change in Therapy or Referral

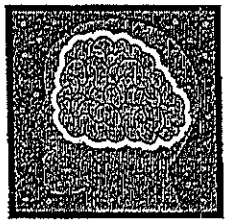
No Obvious Primary Disorder → Initiate Medical Management
This may include Tricyclic Antidepressants
Consider Specialty or Multidisciplinary Pain Program Referral, may include referral for cognitive behavioral therapy

Reference: VHA/Dept of Defense clinical practice guideline for the management of medically unexplained symptoms: chronic pain and fatigue.
Management of Medically Unexplained Symptoms: Chronic Pain and Fatigue Working Group. Washington (DC): Veterans Health Administration, Department of Defense; 2001 Jul. Various p. [148 references] (www.guidelines.gov)

Primary Care Algorithm: Chronic Headaches

Tension Headache is the most common headache disorder seen by PCPs.
Migraine success is to decrease HA by 50% or more & have an acceptable side effect profile.

Risk Factors for Progressing to Chronic Pain Syndrome
Hx of Multiple Surgeries, Long Recovery from Previous Injuries
Chronic Illnesses, Acute Co-morbidities, Sleep Disorder
Risk Factors Complicating Assessment of Pain Experience
Secondary Gains: Legal, Disability, Housing or Job Problems
Personal or Family Hx of Substance Abuse, Request for Spec. Meds
Active Depression or Grieving, Anxiety, Poor Coping Skills
Hx of Physical or Emotional Trauma, Psychopathology



Red / Yellow Flags - If Yes:
Immediate Referral to Medical Care
A new or different headache
"Thunderclap" headache
Worst headache ever
Focal neuro S & S
New onset of HA > age 50
Headaches associated with systemic symptoms

Cluster Headache Algorithm - 0.24% of the population, 90% Male, Age of onset 27-31 yrs,
Dx - Strictly unilateral, severe, 15-90 min duration, autonomic symptoms. No diagnostic studies needed.

→ Neurology Consult
Initial Treatment: Medrol Dose Pack and Verapamil SR 180-240 mg per day

Tension Headache Algorithm- 30-80% of population
Dx: Bilateral, mild-mod, 30 min-7 days
Pressing/tightening/ No assoc s/s, F>M
Is the patient a candidate for Prophylactic Therapy?
Pt Education and Lifestyle Modification

Acute Treatment: NSAIDS
Acetaminophin, Aspirin
Midrin
Stress Management, MPC

→ Prophylactic Tx: Amitriptyline
Other TCAs, Venlafaxine XR, Tizanidine
Stress Management, Referral to Multidisciplinary Pain Program

Migraine Headache Algorithm - 18% F, 6%M
Categorize and select TX based on peak Severity, functional impairment, & time to peak impairment
Consider special Tx (Including DHE)
Pt. Education and Lifestyle Modification
Hormone-Related Migraine -refer to algorithm

Mild/Moderate: APAP/ASA/Caffeine
Lidocaine nasal, Midrin, NSAIDS
5HT Agonists, Stress management, MPC

Severe: Chlorpromazine, Depacon, DHE
Ketorolac IM, Magnesium Sulfate IV, 5HT agonists

Status: > 72 Hr Duration > Call / Urgent Referral to Neurology/ ED

Adjunctive Therapy for All Types
- Rest in quiet dark room
- IV Rehydration
- Antiemetics
- Caffeine

Patient Criteria for Migraine Prophylactic Treatment
3 or more severe HA/ month that fail to respond to Tx
Less frequent but protracted attacks which impair quality of life
Patient is interested in prophylactic treatment

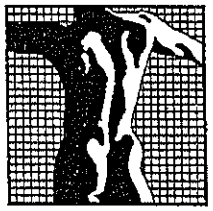
Prophylactic Treatment for Migraines for 6-12 months, repeat 6-12 mon eval
Trigger Assessment
1^0 treatment: Beta-blocker or TCA or
2^0 drugs in combination
Antiepileptic drugs
Reinforce education and lifestyle management
Consider specialty consult

Reference: Elkind, MV (2004)
Standards of Care for Headache Diagnosis and Treatment, Nat'l Headache Foundation (www.guidelines.gov)

These guidelines are recommendations based upon best scientific evidence but are not intended to replace medical judgment.

Primary Care Algorithm: Chronic Neck Pain or Neck Related Arm Symptoms

Risk Factors for Progressing to Chronic Pain Syndrome
Hx of Multiple Surgeries, Long Recovery from Previous Injuries
Chronic Illnesses, Acute Co-morbidities, Sleep Disorder
Risk Factors Complicating Assessment of Pain Experience
Secondary Gains: Legal, Disability, Housing or Job Problems
Personal or Family Hx of Substance Abuse, Request for Spec. Meds
Active Depression or Grieving, Anxiety, Poor Coping Skills
Hx of Physical or Emotional Trauma, Psychopathology



Traumatic

- Red Flags: Severe Cervical Radiculopathy → Immediate referral to Neurosurgery for MRI and Definitive Care
- No Red Flag → Obtain X-Ray to Rule Out Fracture
  - + For Fracture → Refer to Neurosurgery or Continue Medical Management
  - − For Fracture → 1) Medical Support 2) NSAIDS 3) Follow-Up in 2 wks 4) Evaluate Risk Factors
    - Better
    - Not Better → Multidisciplinary Pain Program Referral

Red Flags for Serious Disease
Progressive Neurological Deficit
Symptoms of Myelopathy (Dx criteria?)
Hx of urinary urgency,
Steroid Use History
Age Greater than 50
Male with Osteoporosis,
Male with Compression Fx
Cancer History
Diabetes Mellitus
Insidious Onset or Worsens at Night
Fever, Weight Loss
S/S of Infection, Recent Surgery
IV Drug Use, HIV,
Immune Suppression

Atraumatic

- Red Flag
  - Severe Cervical Radiculopathy → Immediate referral to Neurosurgery for Imaging and Definitive Care
  - Weight Loss, Fever, Night Pain → Obtain Work-Up including CBC/ESR/ UA, Chem Profile, + Xray > MRI
    - If pathology, appropriate referral
    - If no pathology, Support and Multidisciplinary Pain Program Referral
- No Red Flag → Medical Support: Ice, Return to usual activities, NSAIDS, Follow-Up in 14 days for evaluate pain & activity, Evaluate Risk Factors
  - Better
  - If work disability persists → Multidisciplinary Pain Program Referral
  - Radicular pain, by 2-4 wks,

If no improvement, obtain MRI, if not diagnostic obtain EMG. If pathology, refer to Multidisciplinary Pain Program, NEPDTC referral or surgical evaluation

If pathology not proven, refer to Multidisciplinary Pain Program

Reference: Carette, S., Fehling, MG. (2005). Cervical Radiculopathy, NEJM 353:392-9

These guidelines are recommendations based upon best scientific evidence but are not intended to replace medical judgment.

Primary Care Algorithm: Neuropathic Pain

Neuropathic pain is described as "burning", "electric", "tingling", and "shooting" in nature. It can be continuous or paroxysmal in presentation. Neuropathic pain is produced by damage to, or pathological changes in the peripheral or central nervous systems. 50% of diabetics develop neuropathy-related pain. Physical findings are numbness in the pain territory, sensitivity to non-noxious stimulus or coolness of the skin

Risk Factors for Progressing to Chronic Pain Syndrome
Hx of Multiple Surgeries, Long Recovery from Previous Injuries
Chronic Illnesses, Acute Co-morbidities, Sleep Disorder
Risk Factors Complicating Assessment of Pain Experience
Secondary Gains: Legal, Disability, Housing or Job Problems
Personal or Family Hx of Substance Abuse, Request for Spec. Meds
Active Depression or Grieving, Anxiety, Poor Coping Skills
Hx of Physical or Emotional Trauma, Psychopathology

Neuropathic Pain

1) Hx & Exam, Lab Studies,

MRI, EPS, Biopsy

2) Pain & Psychological Assessment

3) Ancillary studies:NCT, EMG,

Quant Sensory Testing

4) R/O Red/Yellow Flags & Refer

appropriate medical specialty:

- Compartment Syndrome
- Severe Spinal Stenosis
- Toxic Exposure (Heavy metal)
- Transverse Myelitis
- Mononeuritis Multi-plex

These guidelines are recommendations based upon best scientific evidence but are not intended to replace medical judgment.

Symptom Management

W/U Suggests Disease-specific Etiologies → Tighter glucose control in Diabetes
Use of disease-modifying agents in MS
Surgery, chemotherapy or XRT for nerve compression
Infection control: HIV infection, herpes zoster, Lyme disease, syphilis
Metabolic Disturbances: Hypothyroidism, Vitamin Deficiencies,
Immune mediated and Toxin Exposure → If not meeting goals, refer to Neurology

Systemic Treatment → First Line Medications: Cymbalta ® Lyrica® Gabapentin, Short acting opioid analgesics for 1-2 wks, Tramadol HCl or Tricyclic antidepressants
Second Line:Other anticonvulsants or other antidepressants → If not meeting goals, refer to Multidisciplinary Pain Program

Local or Regional Treatment

- Ablative procedures: phenol alcohol nerve ablation, cordotomy / rhizotomy
- Rehabilitation measures: splinting, ROM exercises, ergonomic methods
- Neuromodulation: TENS, acupuncture, Spinal cord stimulation,massage
- Regional anesthetics: sympathetic blocks, epidural/intrathecal blocks,selective nerve root blocks, epidural/intrathecal pumps
- Topical agents: 5% lidocaine patches, anesthetic creams

Adjuvant Treatment
Mental Health Referral
Massage, Yoga
Physical Therapy

Reference: Dworkin, RH, et al. (2003) Advances in neuropathic pain: diagnosis, mechanisms and treatment recommendations. Arch Neurology Nov; 60 (11) 1524-34 (www.guideline.gov)

Distinct treatment guidelines for trigeminal neuralgia with carbamazepine, phenytoin and baclofen

Medication Information

- Use long acting medications for chronic use, when possible
- Watch the total acetaminophen dose when using combination products
- Use the complete arsenal
- Know your medications. Know their toxicities
- Know withdrawal risks, especially benzodiazepines

Non-Opioid Analgesics

Medication	Usual Adult Dose	Maximum Adult Dose/ Daily Dose	Usual Pediatric Dose	Comments
Aminophenolol Derivatives				
Acetaminophen (Tylenol)	650-975 mg PO q 4-6 hr	4000 mg	10-15 mg/kg PO q 4-6hr	Lacks the peripheral anti-inflammatory activity of NSAIDs
Salicylates				
Aspirin	650-975 mg PO q 4-6 hr	4000 mg	10-15 mg/kg PO q 4-6 hr*	Inhibits platelet aggregation, may cause postop bleeding
Choline magnesium trisalicylate (Trilisate)	1000-1500 mg PO q 12 hr	3000 mg	10-25 mg/kg PO q 12 hr	Effectiveness compared to aspirin not clear; onset of analgesia probably slower; less gastropathy and impairment of platelet function
Diflunisal (Dolobid)	1000 mg PO initial dose followed by 500 mg q 12 hr	1500 mg		500 mg superior to 650 mg of aspirin or acetaminophen, with longer duration
Magnesium Salicylate (Doan's Pills)	650 mg PO q 4-6 hr			Many brands and generic forms available; does not effect platelet function
Salsalate (Disalcid)	500 mg PO q 4 hr	3000 mg		Appears to provide anti-inflammatory activity equivalent to aspirin; does not inhibit platelet aggregation
Sodium Salicylate	325-650 mg PO q 3-4 hr			
Other NSAIDs				
Sulindac (Clinoril)	200 mg PO q 12 hrs, after satisfactory response is achieved, dose may be decreased accordingly	400 mg		Comparable to aspirin with a lower overall incidence of total adverse effects.
Diclofenac potassium (Voltaren)	50 mg PO q 8 hr	150 mg		Comparable to aspirin with longer duration; available with misoprostol to decrease GI toxicity
Etodolac (Lodine)	200-400 mg PO q 6-8 hr	1200 mg		200 mg comparable to, and 400 mg possibly superior to 650 mg of aspirin
Fenoprofen calcium (Nalfon)	200-600 mg PO q 6 hrs	3200 mg		Comparable to aspirin; contraindicated in patients with impaired renal function
Ibuprofen (Advil, Motrin)	400-800 mg PO q 6-8 hrs	2400 mg	10 mg/kg PO q 6-8 hrs	200 mg equal to 650 mg of aspirin and acetaminophen; 400 mg superior to 650 mg of aspirin and acetaminophen; 400 mg comparable to acetaminophen/codeine combination
Indomethacin (Indocin)	25-50 mg PO q 8 hrs	200 mg	0.3-1 mg/kg or 10 mg PR	Max pediatric dose of 200 mg/day
Ketoprofen (Orudis)	25-75 mg PO q 6-8 hrs	300 mg		12.5 mg comparable to Ibuprofen 200 mg; 25 mg comparable to Ibuprofen 400 and superior to 650 mg of aspirin; 50 mg superior to acetaminophen/ codeine combination
Ketorolac (Toradol)	Pts. < 65 yrs of age: 30-60 mg IM initially followed by 15-30 mg q 6 hr. Oral dose following IM dosage: 10 mg q 6-8 hr. IV Dosage: 30 mg IV q 6 hrs. Pts. > 65 yrs of age: 15 mg IV/IM q 6 hrs	Pts. < 65 yrs of age: 120 mg Pts > 65 yrs of age: 60 mg	0.5 mg/kg/dose max 100 mg/24 hrs	IV/IM comparable to 10 mg morphine with longer duration; use should be limited to 5 days
Meclofenamate sodium (Meclomen)	50-100 mg PO 4-6 hrs	400 mg		Comparable to aspirin; approved for dysmenorrhea
Mefenamic acid (Ponstel)	500 mg PO initially followed by 250 mg PO q 6 hr	1250 mg		Comparable to aspirin; approved for dysmenorrhea; duration of use not to exceed 1 week
Naproxen (Naprosyn)	500 mg PO initially followed by 250 mg PO q 6-8 hrs	1250 mg the first day, then 1000 mg	5-10 mg/kg PO q 12 hrs	250 mg probably comparable to 650 mg aspirin with longer duration; 500 mg superior to 650 mg aspirin
Naproxen sodium (Anaprox)	550 mg PO initially, followed by 275 mg PO q 6-8 hrs	1375 mg the first day, then 1100 mg	5-10 mg/kg PO q 12 hrs	275 mg comparable to 650 mg of aspirin with longer duration; 550 mg superior to 650 mg of aspirin with longer duration
Selective COX-2 Inhibitors				
Celecoxib (Celebrex)	100-200 mg twice daily	400 mg		Caution in patients with sulfa allergy

Caution: Recommended doses do not apply to patients with renal or hepatic insufficiency or other illness that may effect drug metabolism and kinetics.

*Contraindicated in presence of fever or other evidence of a viral illness.

This table completed using the following resources:

1) 2002 Mosby's Drug Consult: A Comprehensive Reference for Brand and Generic Prescription Drugs. Mosby Publishing Company, 2002.
2) American Pain Society. Principles of Analgesic Use in the Treatment of Acute Pain and Cancer Pain. 5th edition. American Pain Society, 2003.

Antidepressants and Antiepileptic Drugs Used in Chronic Pain Syndromes

Drug	Dosage	Side effects, contraindications, and comments
Antidepressants Tricyclic antidepressants	—	Side effects: dry mouth, constipation, urinary retention, sedation, weight gain Contraindications: cardiac conduction abnormalities, recent cardiac events, narrow-angle glaucoma
Amitriptyline (Elavil),* imipramine (Tofranil)*	10 to 25 mg at bedtime; increase by 10 to 25 mg per week up to 75 to 150 mg at bedtime or a therapeutic drug level.	Tertiary amines have greater anticholinergic side effects; therefore, these agents should not be used in elderly patients.
Desipramine (Norpramin),* nortriptyline (Pamelor)*	25 mg in the morning or at bedtime; increase by 25 mg per week up to 150 mg per day or a therapeutic drug level.	Secondary amines have fewer anticholinergic side effects.
Selective serotonin reuptake inhibitors Fluoxetine (Prozac),* paroxetine (Paxil)*	10 to 20 mg per day; up to 80 mg per day for fibromyalgia.	Side effects: nausea, sedation, decreased libido, sexual dysfunction, headache, weight gain. Efficacy in pain syndromes is relatively poor.
Novel antidepressants Bupropion (Wellbutrin)*	100 mg per day; increase by 100 mg per week up to 200 mg twice daily (400 mg per day).	Side effects: anxiety, insomnia or sedation, weight loss, seizures (at dosages above 450 mg per day)
Venlafaxine (Effexor)*	37.5 mg per day; increase by 37.5 mg per week up to 300 mg per day.	Side effects: headache, nausea, sweating, sedation, hypertension, seizures Serotoninergic properties in dosages below 150 mg per day; mixed serotoninergic and noradrenergic properties in dosages above 150 mg per day
Duloxetine (Cymbalta)*	20 to 60 mg per day taken once or twice daily in divided doses (for depression); 60 mg twice daily for fibromyalgia	Side effects: nausea, dry mouth, constipation, dizziness, insomnia
Antiepileptic drugs First-generation agents Carbamazepine (Tegretol)	200 mg per day; increase by 200 mg per week up to 400 mg three times daily (1,200 mg per day).	Side effects: dizziness, diplopia, nausea Treatment can result in aplastic anemia.
Phenytoin (Dilantin)*	100 mg at bedtime; increase weekly up to 500 mg at bedtime.	Side effects: dizziness, ataxia, slurred speech, confusion, nausea, rash. Treatment can result in blood dyscrasias and hepatotoxicity.
Second-generation agents Gabapentin (Neurontin)	100 to 300 mg at bedtime; increase by 100 mg every 3 days up to 1,800 to 3,600 mg per day taken in divided doses three times daily.	Side effects: drowsiness, dizziness, fatigue, nausea, sedation, weight gain
Pregabalin (Lyrica)	150 mg at bedtime for diabetic neuropathy; 300 mg twice daily for postherpetic neuralgia.	Side effects: drowsiness, dizziness, fatigue, nausea, sedation, weight gain
Lamotrigine (Lamictal)*	50 mg per day; increase by 50 mg every 2 weeks up to 400 mg per day.	Side effects: dizziness, constipation, nausea; rarely, life-threatening rashes

** Not approved by the U.S. Food and Drug Administration for treatment of neuropathic pain.*

Because doses for pain are lower than doses for depression, blood levels are not helpful.

Opioid Analgesics

Drug	Equianalgesic dose		Initial ADULT Parenteral Dose	Initial ADULT Oral Dose	Comments
	Oral	Parenteral			
Morphine	30 mg	10 mg	1 to 10 mg	10 to 30 mg	Long-acting forms may be given orally every 8 to 12 hours. Some long-acting dosage forms may be given rectally. Metabolites may cause myoclonus in patients with renal failure.
Hydromorphone	7.5 mg	1.5 mg	0.2 to 1 mg	1 to 4 mg	Potent opioid. Good agent for patients with renal dysfunction.
Oxycodone	20 mg	NA	NA	5-10 mg	Long-acting form may be given orally/rectally every 12 hours.
Hydrocodone	30 mg	NA	NA	5-10 mg	Often combined with nonopioid analgesics which limits the total dose per day.
Oxymorphone	NA	1 mg	1 mg	NA	Available as suppository.
Tramadol			NA	50 mg	Maximum dose 400 mg/day.
Methadone	5 mg	*	*	2.5-5 mg	Half-life > 24 hrs, so dosing adjustments should be made cautiously. Given every 6 to 8 hrs for pain management. May have role in management of neuropathic pain.
Fentanyl		100 mcg	25 to 100 mcg	NA	Short-acting. Available as transdermal patch (see conversion below)

Transdermal Fentanyl Conversion

Remember 1:2:3 This ratio represents the absolute number equivalent doses for the number of mgs daily intravenous morphine, to the number of hourly mcg of fentanyl, to the number of mgs of daily oral morphine respectively.

1 : 2 : 3

25 mg/daily IV morphine = Fentanyl 50 mcg/hr q 3 days = 75 mg/day PO morphine

* Methadone: Confer with pain specialist before parenteral use.

This table was completed using the following sources:
2002 Mosby's Drug Consult: A Comprehensive Reference for Brand and Generic Prescription Drugs. Mosby Publishing Company, 2002.
American Pain Society. Principles of analgesic use in the treatment of acute pain and cancer pain. 5th edition. American Pain Society, 2003.

Side Effects

Drug Category	Side Effect	Management	Adult Dose	Pediatric Dose	Comments
Opioids	Nausea & vomiting	Prochlorperazine (Compazine)	5-10mg PO/IV/IM q4h or 25mg PR q12h	> 10kg: PO/PR 0.4mg/kg/day in 3-4 divided doses; IM 0.1-0.15mg/kg/dose (usual 0.13mg/kg/dose) 2-12 years: 0.01-0.06 mg/kg/dose q 4-6 h	Consider changing opioid (i.e., to hydromorphone)
		Droperidol (Inapsine)	0.625 to 2.5mg IV/IM q2-4hr	20-75mcg/kg IV/IM max. dose 2.5 mg	
		Haloperidol (Haldol)	0.5mg PO/IV/IM q8h	Not recommended in <3yo 3-12yo: 50-75mcg/kg/ day in 2-3 divided doses	
		Metoclopramide (Reglan)	10-20mg PO /IV q6h	0.4-0.8mg/kg/day in 4 divided doses	
		Ondansetron (Zofran) Dolasetron (Anzemet), Granisetron (Kytril)	Ondansetron: 4mg IV Dolasetron: 12.5 IV Granisetron: 1 mg IV	Ondansetron: 2-12yo: 0.1mg/kg up to 4mg dose Dolasetron: 2-16yo: 0.35mg/kg up to 12.5mg Granisetron: 40 mcg/kg up to 1 mg	
		Non-drug	toast/crackers, sherbet, pretzels, oatmeal, soft & bland fruits and vegetables		
	Constipation	Senna/docusate (Senokot S)	Senna 1-2 tabls bid or higher; 1 senna tablet for each 10mg IV MS/day	1mo-1yo: 54.5-109mg qhs; 1-5yo: 109-218mg qhs; 5-15yo: 218-436mg qhs	
		Bisacodyl (Dulcolax)	10mg PO /PRqhs	Avoid in newborns; <2yo: 5 mg PO/PR; >2-11yo: 5-10mg PO/PR >11yo: 10mg PO/PR	
		Milk of Magnesia (MOM)	15-30ml PO qhs	<2yo: 0.5ml/kg/dose; 2-5yo: 5ml/day; 6-11yo: 15-30ml/day	
		Magnesium Citrate	150-300 ml PO qd	<6yo: 2-4ml/kg once or in divided doses; 6-12yo: 100-150ml; >12: 150-200ml	
		Lactulose (Cephulac)	15-30ml PO TID-QID	Infants: 1.7-16grams/day in 3-4 divided doses Older children: 40-90ml/day in divided doses	

Side Effects

Drug Category	Side Effect	Management	Adult Dose	Pediatric Dose	Comments
Opioids (cont.)	Constipation (cont.)	Sorbitol	15-30ml PO TID-QID	No recommendations	
		Non-drug	good hydration; if po intake: prunes, prune juice, Smooth Move Tea (1 tea bag=2.5 senna tablets); mobility		
	Pruritus	Diphenhydramine (Benadryl)	20-50mg q6h around the clock if opioid continues, then prn	5mg/kg/day divided in 3-4 doses	Consider changing opioid (i.e., to hydromorphone)
		Naloxone (Narcan)	50mcg/hr		For epidural and intrathecal morphine
		Propofol	10mg IV, may repeat in 5 min.		For epidural and intrathecal morphine
	Delirium	Appropriate management			Consider changing opioid (i.e., to hydromorphone)
	Myoclonus	Clonazepam (Klonopin)	0.5mg PO BID-TID	0.01-0.03mg/kg/day divided in 2-3 doses	Switch to another opioid (i.e., to hydromorphone)
		Lorazepam (Ativan)	0.5-1mg PO /IV	0.02-0.05mg/kg/dose (max 2mg) q4-8hr	
	Respiratory Depression.	Naloxone (Narcan)	Dilute 0.4mg (1ml.) Naloxone with 9ml of normal saline (total volume 10ml). Administer 0.02mg (0.5ml) boluses every minute until the patient's respiratory rate increases. Repeat as necessary.	<20kg: 0.1mg/kg/dose IV/IM/SC/ETT >20kg or >5yo: 2mg/dose	
Acetaminophen	Hepatotoxicity		Limit dose of acetaminophen to ≤4grams/day; consider lower total daily dose in patients with pre-existing liver disease	Infants and children: limit dose to 75mg/kg/day	
Corticosteroids	Hyperglycemia	Appropriate mgmt			May consider changing to NSAID

Side Effects

Drug Category	Side Effect	Management	Adult Dose	Pediatric Dose	Comments
NSAIDs	GI upset	Misoprostil (Cytotec)	200µg PO BID-TID		Consider taking with food, using antacids, H_2 blockers or proton pump inhibitors, or discontinuing NSAID and switching to a COX-2 inhibitor
	Bleeding tendency				Use Trilisate, Disalcid, or Celecoxib: no effect on platelet aggregation
	Nephrotoxicity				Alternatives: Sulindac or Celecoxib (celecoxib has shown no benefit in post-op surgical pain)
Selective Cox II inhibitors	GI upset	Consider using a proton pump inhibitor or discontinuation of medication			
	Liver dysfunction	Monitor closely or consider discontinuation of medication			
	Nephrotoxicity	Discontinuation of medication			
Anticonvulsant Drugs	Somnolence	Decrease dose			
	Cerebellar symptoms	Decrease dose			
Carbamzepine (Tegretol)	Myelosuppression	Change to another antiepileptic drug			
Tricyclic Antidepressants	Brand Names	Anticholinergic	Sedation	Orthostatic Hypotension	
Amitriptyline	Elavil	++++	+++	++	Consider switching drugs based on side effects
Doxepin	Adapin Sinequan	++	+++	++	
Imipramine	Tofranil	++	++	+++	
Desipramine	Norpramin	+	+	+	
Nortriptyline	Aventyl, Pamelor	++	++	+	

References:
Taketomo CK et al. Pediatric Dosage Handbook 5th edition. 1989-99. Lexi-Comp Inc., Canada
Wrede-Seaman, Linda. Symptom Management Algorithms for Palliative Care. Intellicard, 1996, Yakima, Washington
Johnson GA. Physicians Handbook of Symptom Relief in Terminal Care. 3rd edition. 1988. Home Hospice of Sonoma County.
AHCPR. Management of cancer pain. 1994.
"Building an institutional commitment to pain management." The Wisconsin Resource Manual for Improvement. 1996.
City of Hope: Standards of care: Pain management. Mayday Pain Resource Center, 1995.
Borgeat A, Wilder-Smith OH, Saiah M, Rifat K. "Subhypnotic doses of propofol relieve pruritus by epidural and intrathecal morphine." Anesthesiology 76:510-12, 1992.
Kendrich WD, Woods AM, Daly MY, et al. "Naloxone versus nalbuphine infusion for prophylaxis of epidural morphine-induced pruritus." Anesth Analg 82:641-47, 1996.
Mosby's Drug Consult: A Comprehensive Reference for Brand and Generic Prescription Drugs. Mosby Publishing Company, 2002.

BHS Department of Psychiatry
Prescribing Guidelines For Benzodiazepines*

- **Long-term use of benzodiazepines may be associated with neuro-adaptive changes and a dependence/discontinuation syndrome.** This syndrome is characterized by death, anxiety, pain, tachycardia, sweating, tremors and agitation.
- Misusers of other substances are at increased risk for a benzodiazepine use disorder.
- Benzodiazepines are not recommended for long-term use in patients with a history of a substance use disorder, unless alternative approaches (e.g. SSRI's, buspirone, psychotherapy), have been exhausted.
- Effective use of benzodiazepines requires an ability to weigh the potential risks of using these compounds with potential benefits, and to compare other therapeutic alternatives.

NEUROCHEMISTRY AND PHARMACOKINETICS: Benzodiazepines are a group of closely related compounds sharing the structure of a benzene ring fused to a seven- member diazepine ring. Benzodiazepines bind to a site on the GABA A receptor of neurons and act as positive allosteric modulators (enhance activity) of the neurotransmitter GABA. Benzodiazepines are categorized by potency, half-life, rate of onset, and route of metabolism.

THERAPEUTIC ACTIONS: Benzodiazepines have anxiolytic, sedative-hypnotic, central nervous system depressant, anticonvulsant and muscle relaxant properties, all with therapeutic applications. Benzodiazepines are widely prescribed in psychiatry for the treatment of anxiety spectrum disorders, insomnia, acute agitation and psychosis, alcohol and sedative-hypnotic withdrawal syndromes, neuroleptic-induced akathesia, and other less common disorders.

CHRONIC USE: **Long-term use of benzodiazepines may be associated with neuro-adaptive changes and a dependence/discontinuation syndrome.** This syndrome requires medical attention, as untreated individuals may suffer significant morbidity and potential mortality. Unwanted effects can best be avoided with low doses, short courses, and by patient pre-selection.

BENZODIAZEPINE USE DISORDER: Some individuals misuse benzodiazepines and exhibit cognitive, behavioral, affective and physiological signs of a substance use disorder (SUD). Substance misusers demonstrate associated compulsive use despite experiencing negative consequences. Individuals with a current or past history of substance misuse are at increased risk for a benzodiazepine use disorder. Patients with a personal or family history of SUD will more likely experience euphoria with benzodiazepines, with a greater risk for misuse.

DRUG INTERACTIONS: Benzodiazepines have additive or synergistic effects (depending on drug combination) when combined with other CNS depressants. Benzodiazepines mixed with other substances of abuse have been identified as a risk factor contributing to the elevated mortality rate (up to 14 times greater than the general population) among drug misusers. The odds ratio for mortality doubles for every additional drug of abuse misused. Refer to PDR for other specific drug interactions.

PRESCRIBING BENZODIAZEPINES: Effective use of benzodiazepines requires an ability to weigh the potential risks of using these compounds with potential benefits, and to compare other therapeutic alternatives. In general, safe, non-addictive alternatives exist and are preferred for the treatment of most non-acute psychiatric disorders. For example, the American Psychiatric Association Guidelines for Panic Disorder identify SSRI's as the first line in treatment due to the favorable balance of efficacy and adverse effects. Benzodiazepines, however, may be a treatment of choice for acute psychiatric emergencies such as the management of the severely agitated, panic disordered or psychotic patient.

BENZODIAZEPINES AND ACTIVE SUBSTANCE USERS: Alcohol and other drugs of abuse may cause psychiatric symptoms that mimic a non-substance induced psychiatric disorder. For example, patients withdrawing from benzodiazepines may experience anxiety, and may be misdiagnosed with generalized anxiety disorder. Drug induced effects must be considered before a non-substance related psychiatric diagnosis is made. Active substance use should be addressed before confirming the diagnosis of suspected dual diagnosis (patients with a substance use disorder and a coexisting other mental health disorder). Benzodiazepines are considered unsafe when combined with other drugs of abuse. Benzodiazepines are not indicated as a substitute for other substances of abuse (except during detoxification), as active users fail to demonstrate a decrease in substance use and are at increased risk to misuse benzodiazepines.

BENZODIAZEPINES AND SOBER SUBSTANCE USERS: Benzodiazepines are not recommended for the long-term use in sober (drug and alcohol free for a significant period of time) dual disordered individuals unless non-psychoactive approaches (medications with antipsychotic properties such as SSRI's, buspirone, etc.), including non-pharmacologic strategies (psychotherapy), have been exhausted. In such cases benzodiazepines with short half-lives and rapid onset (properties most closely associated with misuse) should be avoided. The prescriber should clearly review the potential risks with the patient, and beware of signs of benzodiazepine misuse (missed appointments, lost prescriptions, multiple prescribers, excessive dose escalation, early refill requests, overdose, etc.). A signed agreement may be indicated for high-risk patients. Releases of information to other treaters facilitate treatment coordination. Short prescriptions with limited or no refills, frequent patient monitoring and collaboration with addiction treatment team members may be indicated, especially when initiating treatment. Sober substance users entering treatment on a stable benzodiazepine dose without signs of misuse need not return to this stringent prescribing schedule. Medication treatment is most effective when combined with other therapeutic treatment modalities (individual, group, 12 step, etc.).

***This guideline was developed under the leadership of Jennifer Michaels, MD with a multi-disciplinary workgroup of clinicians at the Brien Center and Berkshire Medical Center during the fall and winter of 2003/2004.**

Tools

- Use the controlled substance contract early and often
- Urine toxicology screens and pill counts are another component of the universal precautions approach
- Fentanyl, buprenorphine, meperidine, tramadol, and propoxyphine are **not** detectable by the routine BHS urine toxicology screen
- Know how to handle contract breaks

BERKSHIRE MEDICAL CENTER, INC.
BERKSHIRE FACULTY SERVICES, INC.

Contract and Informed Consent For Controlled Substances Therapy

This treatment contract describes the agreement that I have with my Healthcare Provider (physician, physician's assistant, or nurse practitioner) about controlled substances therapy. This agreements covers any treatment I am having that involves opioids (narcotic pain medicine), sedatives, tranquilizers, skin patches and some other pain pills.

1. My Healthcare Provider and office staff are committed to treating me as a person entitled to dignified, sensitive care for a serious medical condition.

2. I have been told that this contract is needed because controlled substances can be **risky and even fatal**, unless I use them only as my Healthcare Provider has ordered.

3. **I know that if I do not comply with this contract my Healthcare Provider may end my controlled substances therapy for my own well-being.**

4. My Healthcare Provider has explained the therapy to me, including the likely benefits and the risks, side effects and other potential problems with the therapy.

5. My Healthcare Provider expects that I will have reduced pain and a better quality of life as a result of the therapy. Complete pain relief is not likely. I also know that my Healthcare Provider may suggest additional therapies, such as counseling or physical therapy. I agree to seriously consider taking advantage of those other therapies.

6. I understand there are risks and the potential for negative side effects from therapy involving controlled substances. These risks and side effects can include physical dependence and, in rare cases, addiction to the medication. These medicines can sometimes mask other serious conditions. They may cause nightmares, psychotic states, hallucinations or depressed moods. Sleepiness or slowing of reflexes, especially at the beginning of therapy, may occur and make it unwise for me to drive. Nausea, itching, sweating, dry mouth, retained urine, constipation, low testosterone, depressed breathing and muscle jerking at night are other possible side effects.

7. I have been told that a quick decrease or stopping of the drugs may lead to symptoms of withdrawal. The symptoms include pain, nausea, diarrhea, anxiety, sweating, and tremor seizures. I will inform my Healthcare Provider if I choose to stop any of my medicines. My Healthcare Provider may direct a slow taper to avoid the side effects.

8. I understand there are serious risks in mixing mind-altering drugs or substances when I am on controlled substances therapy. These include alcohol, marijuana, narcotics, sedatives and sleeping pills. Taking other drugs or substances while on therapy could result in over-sedation and could lead to serious injury or death. I will not use any

alcohol, sedating medicines or other prescribed narcotics during the course of my therapy without the written permission of my Healthcare Provider. I will not use any illegal drugs or substances.

9. If I take controlled substances while pregnant, my child may be born with a physical dependency on those substances or otherwise be physically harmed. I will immediately inform the Healthcare Provider managing my medicines if I believe that I may be pregnant. I will inform any provider of prenatal care that I am taking controlled substances therapy.

10. I understand that, because of the potential risks and side effects of my therapy, as well as the potential benefits, it is important that my controlled substances therapy be closely and carefully managed. For safe and effective management of my care, I agree that my Healthcare Provider may share the necessary information about my therapy with other healthcare providers. **I also agree that I will keep all follow-up appointments with my healthcare provider and any referral appointments. I will cooperate with any monitoring of my therapy that my Healthcare Provider believes to be necessary, including random urine screening, blood screening and pill counts.**

11. I understand that misuse or diversion of controlled substances creates serious risk of harm and is illegal. My Healthcare Provider closely manages controlled substances prescriptions. For that reason, during the course of my controlled substances therapy:

    - I will not attempt to get controlled substances from other healthcare providers. In case of an emergency, I shall tell the other healthcare provider that I am on a controlled substances therapy. I will also promptly notify my Healthcare Provider if I have gotten controlled substances from another provider.

    - I will use only one pharmacy to fill my prescriptions and have selected _____ for that purpose.

    - I will contact my Healthcare Provider's office 48 hours before running out of my prescribed medicine so that I can receive refills on schedule.

    - I agree that I will not seek early refills and that none will be provided. This includes if the medicine has been stolen, misplaced or lost.

    - I agree that I will not seek to have refills approved outside of regular office hours and understand that no such approval will be given.

    - I agree that I will pick up and sign for all prescriptions in person unless my Healthcare Provider has agreed to other plans in advance.

    - I understand that it is a crime in Massachusetts to attempt to obtain controlled substances by false pretenses, including by misrepresenting facts or by failing to disclose important facts.

- I agree that disruptive or inappropriate interaction with the office staff will not be tolerated and may result in this contract being terminated.

If I do not follow this contract, my Healthcare Provider may decide that it is unsafe to continue the controlled substances therapy and may refer me for addiction evaluation.

Patient Signature Date

Witness Signature Date

Healthcare Provider Signature Date

Berkshire Health Systems
Suggested Urine Toxicology Screening Procedures and Interpretation of Test Results

Urine toxicology screening is a useful tool when treating patients with controlled substances. The purpose of the urine drug screen is to provide objective documentation of compliance with the mutually agreed upon treatment plan. Patients who should be considered for testing include new patients to be started or already on a controlled substance, when making a major change in treatment, resistance to full evaluation, requests for a specific drug, display of aberrant behavior or to support a referral for a psychiatric or addiction counseling. One study found that using aberrant behavior alone to trigger a urine drug screen misses more than 50% of those using unprescribed/illicit drugs. For random testing 2-3 times a year may be adequate. It will provide valuable information about what substances the patient is, and is not, taking, though there may be variable results based on the patient's metabolism.

The table below describes the drug retention times:

Drug	Retention Time	Cutoff (ng/ml)	Notes
Amphetamines	48 hours	1000	Responds equally to amphetamine and methamphetamine and with lesser sensitivity to MDA (40%) and MDMA(20%).
Barbiturates	Short acting (secobarbital) 24 hours Long acting (phenobarbital) 2-3 wks	200	
Benzodiazepines	Up to3 days if therapeutic dose ingested, varies with drug and dosage. Up to 4-6 weeks after extended use or abuse quantities, particularly with long-acting congeners.	200	Assay is calibrated with oxazepam at 200 ng/ml. It is more sensitive to alprazolam, chlorazepate, diazepam, medazepam, prazepam and temazepam. It is less sensitive to chlordiazepoxide, clonazepam (15x less) flunitrazepam (4x less), and triazolam (1.5x less).
Cocaine metabolite Cocaine parent	2-3 days Few hours	300	Assay responds only to benzoylecgonine metabolite and not to parent cocaine.
Methadone	Approximately 3 days	300	Responds to parent methadone and methadol metabolite
Oxycodone	Approximately 1-2 days	100	Also detects oxymorphone metabolite
Opiates	2-3 days for morphine/codeine 6-acetyl morphine (metabolite of heroin) < 12 hrs 2-3 days for synthetic or semisynthetic opioids*	2000	Responds to morphine, codeine and hydromorphone. Less response to hydrocodone.
Propoxyphene	6 - 48 hours		
Cannabinoids	2-3 days - light smoker 5 days - moderate smoker (4 x's/wk) 10 days - heavy smoker (smokes daily)	50	
Phencyclidine (including Ketamine)	Approximately 8 days Up to 30 days in chronic users (mean value = 14 days)	25	

Note: Interpretation of retention time must take into account fluid intake, variability of urine specimens, variability of pH, drug metabolism & half-life, patient's physical condition and method and frequency of ingestions.
***Detected by Gas Chromatography/Mass Spectrometry or other high sensitive method.**
These are general guidelines only.

The current urine toxicology panel at Berkshire Medical Center includes:

Amphetamines	Benzodiazepines
Cocaine	Cannabinoids
Methadone	Opiates
Oxycodone	

Urine for testing should be between 90^0 F- 100^0 F. A lower temperature can indicate the urine was brought to the visit. Physicians should be aware that there are a variety of websites and other sources that sell "clean" urine and other products designed to prevent detection of substance abuse. When a concern exists, it may be beneficial to have the patient provide the urine sample in a location where there is no access to water which can be used to either dilute or adjust the temperature. A negative screen may not mean the absence of drug: the drug may be present at a concentration below the cutoff for positivity.

A list of how commonly used narcotics appear in our urine toxicology screen is shown below:

Berkshire Health Systems Laboratory Urine Tox Screen Analysis					
		Urine Tox Screen Gives a Positive Result for:			
Generic Name	**Trade Name**	**Opiates**	**Oxycodone**	**Methadone**	**Notes**
Buprenorphine					Not detected in routine screening
Codeine	Tylenol #3	X			
Fentanyl	Duragesic				Not detected in routine screening
Hydrocodone	Lorcet, Norco, Vicodin	X			May not be positive at low doses
Hydromorphone	Dilaudid	X			May not be positive at low dose
Levorphanol	Levo-Dromoran				Not detected in routine screening
Morphine sulfate	MS Contin, Kadian	X			
Meperidine	Demerol				Not detected in routine screening. Can be detected by TLC (order as UDRG, specify demerol).
Methadone				X	
Oxycodone	Oxycontin, Percocet		X		
Propoxyphene	Darvon, Darvocet				Not detected in routine screening. Can be detected by TLC (order as UDRG, specify propoxyphene).
Tramadol	Ultram				Not detected in routine screening. Can be detected by TLC (order as UDRG, specify tramadol).
Note: Some trade name drugs listed may include other substances					
A positive screen for oxycodone can cross to a positive opiate screen at a high enough doses					

BMC billed charges for a 7 drug panel for urine toxicology could be as much as $400-$500, since each immuno-assay is billed separately. Validated urine dipsticks for 7-9 drugs are available through several manufacturers at ~$25.00/stick, though it is important to understand this test is not CLIA-waived.

Don't Be Scammed By A Drug Abuser

Drug Enforcement Administration
Office of Diversion Control

Inside this Issue:

- Your Responsibilities
- Recognizing the Drug Abuser
- What You Should Do When Confronted by a Suspected Drug Abuser

The purpose of this guide is to inform and educate you, the healthcare practitioner, to ensure that controlled substances continue to be available for legitimate medical and scientific purposes while preventing their diversion into the illicit market. It is **not** the intent of this publication to reduce or deny the use of controlled substances where medically indicated. Nothing in this guide should be construed as authorizing or permitting any person to conduct any act that is not authorized or permitted under Federal or state laws.

Your Responsibilities:

The abuse of prescription drugs-- especially controlled substances--is a serious social and health problem in the United States today. As a healthcare professional, you share responsibility for solving the prescription drug abuse and diversion problem.

- You have a legal and ethical responsibility to uphold the law and to help protect society from drug abuse.

- You have a professional responsibility to prescribe controlled substances appropriately, guarding against abuse while ensuring that your patients have medication available when they need it.

- You have a personal responsibility to protect your practice from becoming an easy target for drug diversion. You must become aware of the potential situations where drug diversion can occur and safe- guards that can be enacted to prevent this diversion.

This guide will help you meet these responsibilities.

Recognizing the Drug Abuser

Telling the difference between a legitimate patient and a drug abuser isn't easy. The drug-seeking individual may be unfamiliar to you. They could be a person who claims to be from out-of-town and has lost or forgotten a prescription of medication. Or the drug seeker may actually be familiar to you such as another practitioner, co-worker, friend or relative. Drug abusers or "doctor-shoppers" often possess similar traits and modus operandi. Recognizing these characteristics and modus operandi is the first step to identifying the drug-seeking patient who may be attempting to manipulate you in order to obtain desired medications.

Common Characteristics of the Drug Abuser:

- Unusual behavior in the waiting room;
- Assertive personality, often demanding immediate action;
- Unusual appearance - extremes of either slovenliness or being over-dressed;
- May show unusual knowledge of controlled substances and/or gives medical history with textbook symptoms **OR** gives evasive or vague answers to questions regarding medical history;
- Reluctant or unwilling to provide reference information. Usually has no regular doctor and often no health insurance;
- Will often request a specific controlled drug and is reluctant to try a different drug;
- Generally has no interest in diagnosis - fails to keep appointments for further diagnostic tests or refuses to see another practitioner for consultation;
- May exaggerate medical problems and/or simulate symptoms;
- May exhibit mood disturbances, suicidal thoughts, lack of impulse control, thought disorders, and/or sexual dysfunction;
- Cutaneous signs of drug abuse - skin tracks and related scars on the neck, axilla, forearm, wrist, foot and ankle. Such marks are usually multiple, hyper-pigmented and linear. New lesions may be inflamed. Shows signs of "pop" scars from subcutaneous injections.

Modus Operandi Often Used by the Drug-Seeking Patient Include:

- Must be seen right away;
- Wants an appointment toward end of office hours;
- Calls or comes in after regular hours;
- States he/she's traveling through town, visiting friends or relatives (not a permanent resident);
- Feigns physical problems, such as abdominal or back pain, kidney stone, or migraine headache in an effort to obtain narcotic drugs;
- Feigns psychological problems, such as anxiety, insomnia, fatigue or depression in an effort to obtain stimulants or depressants;
- States that specific non-narcotic analgesics do not work or that he/she is allergic to them;
- Contends to be a patient of a practitioner who is currently unavailable or will not give the

name of a primary or reference physician;

- States that a prescription has been lost or stolen and needs replacing;
- Deceives the practitioner, such as by requesting refills more often than originally prescribed;
- Pressures the practitioner by eliciting sympathy or guilt or by direct threats;
- Utilizes a child or an elderly person when seeking methylphenidate or pain medication.

What You Should Do When Confronted by a Suspected Drug Abuser

DO:

- Perform a thorough examination appropriate to the condition.
- Document examination results and questions you asked the patient.
- Request picture I.D., other I.D. and Social Security number. Photocopy these documents and include in the patient's record.
- Call a previous practitioner, pharmacist or hospital to confirm patient's story.
- Confirm a telephone number, if provided by the patient.
- Confirm the current address at each visit.
- Write prescriptions for limited quantities.

DON'T:

- "Take their word for it" when you are suspicious.
- Dispense drugs just to get rid of drug-seeking patients.
- Prescribe, dispense or administer controlled substances outside the scope of your professional practice or in the absence of a formal practitioner-patient relationship.

Communication Strategies Regarding Prescribing and Discontinuing Controlled Substances

General Considerations

- New patients presents with records, on a regime with which the provider is uncomfortable. There is no obligation to continue the regime, however, there is a responsibility to continue good care and prevent withdrawal. Reasonably, one could taper the medication, switch the medications or refer to detox.

- The risk for a violent reaction is greatest when the pronouncement that the opioids will be "cut off" come too abruptly. This is especially true with dual diagnosis patients with a history of violence and when the patient feels he wasn't given adequate notice regarding the sticking points of the 'contract' and that current behaviors constitute a breach. The phase of the treatment when concern of abuse or diversion is aroused and before the decision is made to terminate treatment is a very sensitive treatment window when more time should be spent with patients. Managed optimally, some of these treatments will be successfully continued with a heightened appreciation for and awareness of potential addition issues, need for communication and trust with the prescriber.

- If not treatment contract exists; one can notify patients of the new BHS policy and how all practices are moving to the new model, Universal Precautions, to improve quality of care and safety. Give patients advance notice. "Our policy is changing and from this date forward, it will be ..." Have all patients sign their receipt of the new policy that will roll out in one month.

- Distribute responsibility to a practice guideline that all are adhering to, rather than making our limit-setting an individual matter.

- Talk about the problems of tolerance, dependency, sensitization to pain as opioid doses increase. Avoid use of personalized labeling and blaming language such as "You are an addict."

When there is a breach in the contract

- **The goal is to be respectful and to do the right thing medically.**
- Violence is a possibility because the patient may 1) feel powerless and disrespected by the physician; 2) fear the discomfort of withdrawal; 3) lose the needed income if he/she is diverting the medication and living off the proceeds.
- Given these issues, notification should address the following:
    - **Be seated, preferable with your eye on a level below the patient's**
    - If the situation warrants it, have security near by.
    - Do not be abrupt.
    - Give the patient time to accommodate to the changes.
    - Make sure there is space, a good way for you and the patient to leave the room if either feels agitated or afraid.

- Explain that the positive urine test (or other breach of contract) means that you will not be able to prescribe the narcotic indefinitely.
- Emphasize this happens to a number of people in treatment each day, and you have good, safe ways to help this patient and other patients with similar problems.
- Explain that you are not abandoning care and that you will do the right thing medically for the patient. You also have a treatment contract with him or her, and you will honor that.
- Explain that medical ethics and the standards of care do not allow you to endanger you overall health by not preventing an addiction or diversion problem.
- If the patient is angry or accusing you of ruining his/her life, keep your cool. That reaction is predictable. Validate the patient's experience by saying "I know this is upsetting." Don't amplify it by your own defensive reactions.
- You will taper the medication over a number of days.
- You demonstrate the utmost respect for your patient, and the difficulty he is having by helping with referral and maintaining continuity of care.
- You will notify all members of the treatment team, including the pharmacy.
- You will make a referral for substance abuse counseling.
- Clarify that although continued treatment with opiates is not an option, there are other alternatives to discuss.
- As your patient if he has any questions or issues he is concerned about?
- If you know other patients who have been through this difficult moment and have made it to a better life. Give an example. Dr. Jenny Michaels can supply success stories if need be.

Example; 40 yr old computer engineer with 20 years of opioid abuse. Multiple overdoses, much deception. Much deception of the ED, PCP, and pain specialist. Has lost his job, wife and family supports. Belief he can not function without heroin, methadone, Duragesic and Oxycontin. Finally addressed his substance abuse. Is now on Buprenorphine treatment, has clean urines, attends counseling and is back at work. Family have invited him back to family gatherings again. Self-respect and health are back.

Referral Options for Treatment of Substance Use Disorders

Outpatient Evaluation and Treatment: 413-499-0412

The Brien Center offers a weekly intake orientation group for patients seeking substance abuse treatment. The provider should contact the Brien Center at 499-0412 to request an evaluation. The initial group evaluation includes a needs assessment to determine the referral that is the best match for the patient needs. The Brien Center services include day treatment, buprenorphine program, individual, family or group therapy and referral for psychiatric evaluations or inpatient detoxification services. Please contact the Brien Center with any questions.

Alcoholic Anonymous	1-413-443-0212
Narcotics Anonymous	1-413-443-4377

Crisis Team:

The Crisis Team is a mobile countywide program for patients in crisis, a 24-hrs a day/ 7 days per week service to evaluate patients and the acuity of needs. Their services range from telephonic support and referral to home visits, if the patient is at risk of harming themselves or others. Please call 413-499-0227 with any questions or to access services.

The McGee Inpatient Chemical Detoxification Program:

Inpatient admission should be considered for patients with significant abuse of opioids, alcohol or benzodiazepines. Patients with unsafe or intolerable withdrawal symptoms or those that have failed a slow taper may be most appropriately provided care as an inpatient. Withdrawal from alcohol and benzodiazepines can be life threatening. Average length of stay may be 5-7 days.

To refer: 1) Either the patient or physician can simply call 413-442-1400. While they can call at any time, it is best if they call during the day. Intake screening staff will complete a telephone intake.

2) Payer financial eligibility is completed if pre-authorization is required.

3) All referrals for chronic pain patients will be reviewed by Donald Scherling, Ph.D. with Cindy Daniel PA-C or Jerry Carter, MD.

4) A preadmission phone consultation to review and coordinate treatment goals with the PCP or Pain Clinic is required to develop an inpatient and follow-up treatment plan for any patient on prescriptions for pain management.

5) Following the consultation and planning with the prescriber, the patient is notified of a scheduled admission. Admissions may be delayed by 24-48 hours due to bed availability. McGee asks the patient to stay in contact by telephone during this period.

6) Medical clearance in the Emergency Room at BMC is completed at the time of a scheduled admission.

Screening Forms

- Standardized Tools = Standardized Approach
- Monitor treatment objectively
- Document, document, document

Pain and Mental Health Screenings

Far too frequently the identification and treatment of the psychosocial impact of pain occurs after the condition has become chronic. The prevalence rates for chronic pain disorders have been estimated to range from 20% to 60% [8]. The prevalence of low back pain is estimated to be 30%[24], migraine, 15%[15,16] and chronic pain in community dwelling elders 25% to 40% of [5]. In a national survey, Bao, et al. [2] found that of those meeting criteria for major depression or dysthymia (N=1486), 63% had comorbid chronic pain conditions. These patients had 20% more primary care visits and were 20% less likely to see a mental health specialist than depressed, non-pain patients. Ohayon & Schatzberg [19] conducted telephone survey of 18,980 community dwelling people. Of this sample, 17% reported chronic pain and chronic pain was strongly and independently predictive of major depression. Untreated depression has been consistently linked to poor medical and surgical outcome for pain patients [4,19].

State of the art medical care is increasingly attentive to the importance of psychological factors in the etiology and perpetuation of disease and disability. This view is especially appropriate for pain conditions. The International Association for the Study of Pain defines pain as "An unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage." The IASP goes on to say that "Pain is always subjective. Each individual learns the application of the word through experiences related to injury in early life. ... It is unquestionably a sensation in a part or parts of the body, but it is also always unpleasant and therefore also an emotional experience [11]" Recent research has begun to prove the role of the limbic and higher cortical areas of the brain specifically thought processes as playing a significant role in the pain experience [13]. As Robert Coghill notes "Pain needs to be treated with more than just pills, ...The brain can powerfully shape pain, and we need to exploit its power."

While there are few medical providers who rigidly adhere to the Cartesian dualism between mind and body that originally guided the understanding of pain syndromes, many providers do not understand the ease and utility of gathering initial and ongoing data of psychological and behavioral functioning and the operationalization of findings for treatment planning. In an effort to assist area primary care providers to these ends, included here are assessment tools for the reliable identification of patients' pain experience, and its impact on activities of daily living and psychosocial functioning. Also provided are test descriptions, administration guidelines and appropriate referral indicators. Measures have been chosen for their reliability, validity and brevity. Length of testing runs from a maximum 10-20 minutes on initial testing and 5-10 minutes on follow-up.

Visual Analogue Scale (VAS):

Description: The VAS is a 10 cm scale anchored by the phrases "No Pain" to "Worst ever Pain." The line between the verbal anchors is not marked with intermediate points to avoid the clustering of responses by patients and to increase specificity. The lack of numeric rating also reflects the concept of pain as a subjective, continuous variable [18]. Since the Joint Commission pain standards of 2000 there has been somewhat of a bias toward using a numeric analogue scale. A numeric scale like the VAS is typically a 10cm line anchored by the phrases "No Pain and "Worst Pain Ever" but data points from 0 to 10 are marked along

the line. Research has shown that it has comparable reliability and validity to the VAS but is not as sensitive to change as the VAS because scores are not continuous [7, 18]. Visual analogue scales have been used for many years and have been found to be realiable and valid measurement method.

Time for Completion: 30 seconds
Age Range: 12+
Administration: Patients should be informed that the VAS is a measure designed to measure the intensity or severity of their pain right now. Inform patients to place a mark at the point on the line that best describes how much pain they are having right now. If patients are having pain in more than one area of their body, simply give them another VAS for that area.
Cautions: Avoid use of the VAS with elderly patients with significant cognitive limitations and patients with language barriers or other intellectual limitations. These patients may have difficulty understanding how to read the VAS. Print the VAS from a computer as making copies will enlarge the image [17, 18].
Scoring: Measure the scale by using a 100m ruler numbering where the mark falls.
Re-testing: the VAS is best given 2 to 4 weeks between testing and by providing the patient with a copy of their last test for reference [9, 21].

Brief Pain Inventory and Brief Pain Inventory - Short Form (BPI-SF):

Description: The BPI (Cleeland, 1982) was originally developed to assess the severity and intensity of cancer pain but has been a widely used and validated instrument in pain management for nonmalignant pain [22]. Factor analyses of the BPI have consistently produced 2 factors Pain Severity and Functional Impairment. Pain Severity includes the 4 items where pain is assessed on a 0 to 10 scale from "No Pain" to "Pain as bad as you can imagine." Functional deficits include 7 items and are also on a 0 to 10 scale from "Does not interfere" to " Completely interferes." These scales have shown good ability to detect response to pain management interventions. Additional items on the BPI enquire about social history, pain coping behaviors, pain location and quality, and medication taking behaviors, and response to pain management interventions to date. The BPI-SF drops several of these additional questions but maintains all of the Pain Severity and Functional Deficit items, response to treatment body location of pain and treatments for pain to date. The BPI-SF is useful for follow-up assessment but can also be used on initial testing.
Time for Completion: BPI – 10-15 minutes; BPI-SF 5 to 7 minutes
Age Range: 16+
Scoring: Scores above for the pain intensity items that are above 5 are considered to reflect "significant pain." The scores on the functional deficits items are averaged with scores above 5 reflecting "significant impact."

Mental Health Inventory-5 (MHI5):

Description: The 46-item Rand Mental Health Inventory was originally developed as part of the Rand Health Insurance Study [3, 26, 27]. This 46-item version assessed depression, anxiety and well-being. Various abbreviated versions of the MHI have been the developed.

The 5-tiem version assesses depression and anxiety. The MHI5 has undergone extensive study and has proved a valid and reliable indicator of the presence of anxiety and depressive disorders [1, 2, 3, 25, 29]. The MHI5 comprises the Mental Health subscale of the SF-36.
Time for Completion: 1 to 3 minutes
Age Range: 14 to 74+
Cautions: All items must be completed by the patient in order to score this test.
Scoring: The minimum score is 5 and maximum score is 25 with higher scores representing better emotional functioning. Items 1 and 2 are reverse scored. Items are then summed and transformed to a mean of 50 and standard deviation of 10 to allow comparison to national norms. (Transformed score = (Raw score – 5)/ 20 * 100) Transformed scores below 52 are clinically significant.
Referral Indicator: Transformed scores below 52 should trigger further evaluation and possible referral to a pain management psychotherapist. This psychotherapist should have specialization in cognitive behavioral therapy. The therapist typically refers the patient to a psychiatrist. Referral can also be made to a psychiatrist who has specialization in psychotherapy for a pain population.
Re-testing: 2 to 4 weeks. Patients should not be given their initial test for comparison.[25]

Two Item Conjoint Screening Test (TICS):

Description: The TICS is drawn from the conjoint screening questionnaires for alcohol and drug dependence (CAGE and CAGE-AID). It screens for alcohol and drug dependence disorders [5]. The TICS was found to have sensitivity in identifying drug and alcohol dependence disorders of those identified by the Composite International Diagnostic Interview – Substance Abuse Module [12].
Time for Completion: 5 seconds
Administration: The TICS has no special administration guidelines.
Cautions: The TICS validation study included only 18-59 year old subjects and therefore is not recommended for populations outside of this age range. Further the TICS is a better measure of alcohol and drug dependence and not current abuse status although this can be part of the physician inquiry.
Scoring: The TICS is a simple Yes or No answer format. A yes on either item should generate further discussion between physician and patient with serious consideration of referral for substance abuse evaluation by a mental health provider with specialization in the assessment and treatment addictive disorders.
Referral Indicator: A yes on either or both items should generate referral for substance abuse evaluation to a mental health provider with the appropriate addiction credentialing. Consultation with this provider will be necessary before consideration of administration of controlled substances[5].

Pain Assessment and Documentation Tool (PADT) (short version)

Descriptions: The PADT was developed by Janssen Pharmaceutica Products, L.P.. The second page of this two page document is included herein to assist physicians in triggering enquiring into Adverse Medication Events and Potential Aberrant Drug-related Behaviors. The items of the PADT administered by 27 physicians to 388 patients treated with opioids.

This tool was found useful by physicians in their care of patients. Items have not been established as reliable or valid and should not interpreted as such.

General Administration Instructions:

Administrators should carefully read the administration guidelines and test descriptions detailed below. These instructions reflect scientific standards of test administration known to protect against bias and other factors known to contaminate responses to test questions.[10] It is always a good idea that administrators take the tests they are giving patients and to score them as a way to familiarize them with the instruments. Patients can be administered questionnaires while waiting for their appointment. The administrator then scores the measures prior to the medical visit. In order to score the tests a 100 mm (10 cm) ruler and a calculator are needed.

Reading/ Cognitive/ Visual Ability: Patients be literate and fluent in English and be cognitively intact in order to understand questions and complete the tests. Usually this takes very little effort to determine. If a patient cannot see well or understand English they will tell you. If they cannot read they are not likely to tell you but may make an excuse like forgetting their glasses to avoid telling you they cannot read. Do not have friends or family members help the patient answer questionnaires as they are not trained to do this.

Instructing Patients: It is important that the administrator verbally instruct patients on how to take the questionnaires and not rely on the patient reading instructions. Tell the patient that the following when asking them to fill out questionnaires. "Please fill out these questionnaires. They ask about your pain and how you are coping with it. Be sure to read the instructions and answer all questions. There are no right or wrong answers and you should fill questions out by yourself."

Handling patient questions: While verbal instructions usually eliminates the need for patients to ask questions, the administrator must be prepared to respond to questions. Again there are scientific limitations on how to answer patient questions. Responses to questions should be simple and focused on having the client determine the meaning of an item. For instance, a client may ask for the Visual Analogue Scale "what does 'worst ever pain' mean?" A proper response would be "the worst pain you have ever experienced in your life. Whatever that was for you." Answering by saying something like "the kind of pain you'd feel if a car ran over you" supplies them with your understanding of the worst ever pain but not the patient's.

Handling missing items: Questionnaires should be reviewed to ensure that all items are answered. If there are missing items ask the patient to complete them. If the patient expresses confusion about how to answer the question, encourage her or him to answer to the best of his or her ability and reinforce that there are no right or wrong answers.

Handling items with multiple or nonspecific answers: Patients may want to provide more than one answer to a question or give a response that is not included on a questionnaire. They should be instructed to finish items accurately. For instance, if a patient marks a point on a

10-point scale on the Brief Pain Inventory between two possible choices, say between 5 and 6, encourage them to pick the best choice for them. If a patient simply refuses to fill out an item, note this on the test but do not include that item in scoring. Patients can be told that they can talk to the physician should they wish to provide more explanation than their answer on a test suggests.

Information provided to Berkshire Health Systems, Inc by Ann Jorn, Ph.D., 2006

TEST FLOW CHART FOR ADMINISTRATORS

"Please fill out these questionnaires. They ask about your pain and how you are coping with it. Be sure to read the instructions and answer all questions. There are no right or wrong answers and you should fill questions out by yourself."

↓

ANSWER PATIENTS' QUESTIONS IN A LIMITED WAY.

↓

REVIEW TEST FOR MISSING ITEMS OR INCORRECTLY COMPLETED ITEMS. HAVE PATIENT FILL OUT THESE ITEMS.

↓

SCORING INSTRUCTIONS

1.) DETERMINE WHAT PAIN SCORES FLOW SHEET YOU NEED, LONG OR SHORT.

2.) Mental Health Test: **Step One:** Write down the reverse score for Items 1 and 2 (namely answer 1 should be 5 and 5 should be 1) like the following:

All the time	1 = 5
Most of the tme	2 = 4
Some of the time	3 = 3
A little of the time	4 = 2
None of the time	5 = 1

Step Two: Total all items #'s 1 thru 5 on the test. Take this score and subtract 5, divide by 20 and multiply by 100 to get the Transformed score.

$$\text{Transformed score} = \frac{\text{Total score} - 5}{20} \times 100$$

Step Three: Transfer the Transformed Score to the Pain Scores Flow Sheet

3.) Two Substance Abuse Questions: Transfer any "Y" from items 6 and 7

4.) Visual Analogue Scale: Measure the line using a 10cm ruler write down the number where the mark was made by the patient and transfer this number

5.) Brief Pain Inventory: **Step One:** transfer scores for items #'s 3-6 on Short Form or #'s 12-15 on Long Form.

Step Two: Transfer % score for item #8 for Short Form only

Step Three: Total answers in item #9 for Short Form or #23 for Long Form and divide by 7

PRIMARY CARE SCREENING TOOL FOR ADULT PATIENTS WITH PAIN

1. During the past month, how much of the time were you a happy person?	**[r]**
All the time	1
Most of the time	2
Some of the time	3
A little of the time	4
None of the time	5
2. How much of the time during the past month, have you felt calm and peaceful?	**[r]**
All the time	1
Most of the time	2
Some of the time	3
A little of the time	4
None of the time	5
3. How much of the time, during the past month, have you been a very nervous person?	
All of the time	1
Most of the time	2
Some of the time	3
A little of the time	4
None of the time	5
4. How much of the time, during the past month, have you felt downhearted and blue?	
All of the time	1
Most of the time	2
Some of the time	3
A little of the time	4
None of the time	5
5. How much of the time, during the past month, did you feel so down in the dumps that nothing could cheer you up?	
All of the time	1
Most of the time	2
Some of the time	3
A little of the time	4
None of the time	5
6. In the past year, have you ever drunk or used drugs more than you meant to?	Y N
7. Have you felt you wanted or needed to cut down on your drinking or drug use in the past year?	Y N

Place a vertical mark on the line below that best describes your pain right now.

No Pain — **Worst Ever Pain**

|——————————————————|

PROGRESS NOTE
Pain Assessment and Documentation Tool (PADT™)

Patient Stamp Here

Patient Name: _____ Record #: _____

Assessment Date: _____

Current Analgesic Regimen

Drug name	Strength (eg, mg)	Frequency	Maximum Total Daily Dose

The PADT is a clinician-directed interview; that is, the clinician asks the questions, and the clinician records the responses. The Analgesia, Activities of Daily Living, and Adverse Events sections may be completed by the physician, nurse practitioner, physician assistant, or nurse. The Potential Aberrant Drug-Related Behavior and Assessment sections must be completed by the physician. Ask the patient the questions below, except as noted.

Analgesia

If zero indicates "no pain" and ten indicates "pain as bad as it can be," on a scale of 0 to 10, what is your level of pain for the following questions?

1. What was your pain level on average during the past week? (Please circle the appropriate number)

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as it can be

2. What was your pain level at its worst during the past week?

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as it can be

3. What percentage of your pain has been relieved during the past week? (Write in a percentage between 0% and 100%.) _____

4. Is the amount of pain relief you are now obtaining from your current pain reliever(s) enough to make a real difference in your life?
☐ Yes ☐ No

5. Query to clinician: Is the patient's pain relief clinically significant?
☐ Yes ☐ No ☐ Unsure

Activities of Daily Living

Please indicate whether the patient's functioning with the current pain reliever(s) is Better, the Same, or Worse since the patient's last assessment with the PADT.* (Please check the box for Better, Same, or Worse for each item below.)

	Better	Same	Worse
1. Physical functioning	☐	☐	☐
2. Family relationships	☐	☐	☐
3. Social relationships	☐	☐	☐
4. Mood	☐	☐	☐
5. Sleep patterns	☐	☐	☐
6. Overall functioning	☐	☐	☐

* If the patient is receiving his or her first PADT assessment, the clinician should compare the patient's functional status with other reports from the last office visit.

PROGRESS NOTE
Pain Assessment and Documentation Tool (PADT™)

Adverse Events

1. Is patient experiencing any side effects from current pain reliever(s)? ☐ Yes ☐ No

Ask patient about potential side effects:

	None	Mild	Moderate	Severe
a. Nausea	☐	☐	☐	☐
b. Vomiting	☐	☐	☐	☐
c. Constipation	☐	☐	☐	☐
d. Itching	☐	☐	☐	☐
e. Mental cloudiness	☐	☐	☐	☐
f. Sweating	☐	☐	☐	☐
g. Fatigue	☐	☐	☐	☐
h. Drowsiness	☐	☐	☐	☐
i. Other _____	☐	☐	☐	☐
j. Other _____	☐	☐	☐	☐

2. Patient's overall severity of side effects?
☐ None ☐ Mild ☐ Moderate ☐ Severe

Potential Aberrant Drug-Related Behavior
This section must be completed by the physician.

Please check any of the following items that you discovered during your interactions with the patient. Please note that some of these are directly observable (eg, appears intoxicated), while others may require more active listening and/or probing. Use the "Assessment" section below to note additional details.

- ☐ Purposeful over-sedation
- ☐ Negative mood change
- ☐ Appears intoxicated
- ☐ Increasingly unkempt or impaired
- ☐ Involvement in car or other accident
- ☐ Requests frequent early renewals
- ☐ Increased dose without authorization
- ☐ Reports lost or stolen prescriptions
- ☐ Attempts to obtain prescriptions from other doctors
- ☐ Changes route of administration
- ☐ Uses pain medication in response to situational stressor
- ☐ Insists on certain medications by name
- ☐ Contact with street drug culture
- ☐ Abusing alcohol or illicit drugs
- ☐ Hoarding (ie, stockpiling) of medications
- ☐ Arrested by police
- ☐ Victim of abuse

Other: _____

Assessment: (This section must be completed by the physician.)

Is your overall impression that this patient is benefiting (eg, benefits, such as pain relief, outweigh side effects) from opioid therapy? ☐ Yes ☐ No ☐ Unsure

Comments: _____

Specific Analgesic Plan:

- ☐ Continue present regimen
- ☐ Adjust dose of present analgesic
- ☐ Switch analgesics
- ☐ Add/Adjust concomitant therapy
- ☐ Discontinue/taper off opioid therapy

Comments: _____

Date: _____ Physician's signature: _____

Multidisciplinary Pain Program

- Seek assistance when needed
- Multidisciplinary approach leads to the best outcomes
- Use the program

Multidisciplinary Pain Assessment and Treatment Program

Complaints of ineffectively treated pain are a common problem in our patient community. Acute pain that progresses to chronic pain can overwhelm patients, their families, and their physicians. Severe chronic pain can be one of the most devastating maladies that exist. According to some patients, it can be more difficult to deal with than a terminal illness.

Unfortunately, there is no miraculous medication or procedure that will be helpful for all patients with chronic pain. Many patients will be disappointed by this fact. This is understandable. After all, modern medicine has packaged itself as a purveyor of pharmaceutical and technological miracles.

The foundation of treatment for patients with chronic pain requires the most difficult, and perhaps the most effective medicine of all; teaching patients how they can help themselves. By utilizing a single telephone number, a multidisciplinary team of professionals will assess patients and will engage patients to adopt behaviors that will transform pain and suffering on every level: the biochemical level, the structural level, the psychological level, and the spiritual level. A comprehensive approach is crucial because chronic pain invades every aspect of our patient's lives. A physiatrist, a psychologist, an occupational therapist, and a social worker will evaluate every patient referred to our multidisciplinary program. Immediately after these evaluations occur, the team will construct a unique program individualized for each patient. If referral to a specialist outside the program is required, then that referral and evaluation will be arranged expeditiously. These referrals could include consultations with any physician within the Berkshire medical community as well as with other professionals or programs deemed necessary, e.g. weight loss, smoking cessation or physical therapy. A case conference will be held for particularly complex patients.

Once the appropriate team of professionals is determined, each patient will participate in concurrent specialty care and a program that includes biweekly cognitive-behavioral group sessions, which will address pain and pain management holistically. Each patient will also participate in biweekly restorative movement classes that will help patients overcome their fear of movement, recondition them, and teach them how to exercise safely. Each patient's support system will also participate in two educational meetings regarding the pain program. Appropriate medications will be evaluated, initiated and monitored during the program. Program goals for each patient will be measurable and related to mood, health, function or behavior. Care and communication will be coordinated across the treatment team by the pain clinic staff. During treatment and upon completion of the program, each patient's response to the program will be evaluated using the goals that were set for that individual patient. Upon completion, recommendations regarding further care with the specialists within the program will be shared with the referring provider.

It is understand the extent of the challenge the program is undertaking. This is the challenge that care givers accept each day when caring for patients with pain. Referrals for the 7 week program are currently being accepted. The team looks forward to working with you to improve the health of each individual patient as well as the health of our community. Please contact us by calling (413) 447-2242.

Regulatory Requirements

- State and federal regulations apply
- Know legal obligations
- Consult BHS counsel if needed

Frequently Asked Questions
Concerning Legal Implications of Berkshire Health Systems
Community Pain Management Project

Q. ***Doesn't the duty to preserve patient confidentiality prevent the sharing of information about a patient's pain medication with other healthcare providers?***

A. With few exceptions, such as the somewhat narrower rules that apply to a federally assisted alcohol and drug treatment program, a provider's duty to honor patient confidentiality does not prohibit the sharing of *necessary* information (clinical or otherwise) between providers who are jointly involved treating the patient. Effective and safe care, including pain management, involving multiple providers could not otherwise be delivered. The consent by the patient to such sharing of information is generally implied by law and ordinarily need not be separately given. The fact that the patient chooses to keep the providers unaware that they are each ostensibly treating the same condition does not serve to defeat the general rule permitting exchange of necessary information; at least when failure to share that information could result in the provider's unwittingly causing harm to the patient.

Q. ***Does the HIPAA Privacy Rule permit the sharing of pain medication information with other healthcare providers?***

A. The HIPAA Privacy Rule allows the sharing of necessary patient information for "treatment, payment or operations" purposes within a "Covered Entity", such as Berkshire Health Systems and its affiliated entities and services (including the emergency department, pain clinic, primary care practices and behavioral health services) and within an "Organized Health Care Arrangement", such as Berkshire Health Systems entities and the members of the medical staffs of the two Berkshire Health Systems hospitals. The Privacy Rule also permits disclosure of protected health information to another health care provider for treatment purposes, payment activities or operations involving quality assurance activities, fraud and abuse detection and compliance activities, provided that both the disclosing and the receiving provider have or have had a relationship with the patient and the disclosed information is relevant to that relationship. *Office of Civil Rights, "Treatment, Payment, Health Care Operations" Guidance.* Berkshire Health Systems' "Notice of Privacy Practices", required by HIPAA to be given to patients, informs them that necessary patient information will be shared in this fashion. Such a sharing of information is, in fact, often required—in order, for example, to assure appropriate continuity of care; to prevent conflict between treatment regimens (including conflicting or duplicative medication); to assure that a patient is receiving the correct array of healthcare services (e.g., physiatry services or behavioral health services as well as or instead of medication); or, in the case of suspected prescription drug abuse, to minimize the risk of patient harm by reason of "office shopping".

Q. *What if I have reason to believe that a patient is seeking pain medication for purposes of misuse or diversion, can I report that to anyone?*

A. Neither traditional confidentiality principles nor the HIPAA Privacy Rule prohibit a provider from alerting law enforcement agencies of a suspected crime occurring on the provider's premises and providing the information necessary to assist the police in proving the case. Massachusetts General Laws, Chapter 94C, §33 makes it a crime, punishable by imprisonment for 4 years and/or a fine of $20,000 to "knowingly or intentionally acquire or obtain possession of a controlled substance by means of forgery, fraud, deception or subterfuge, including but not limited to the forgery or falsification of a prescription or the nondisclosure of a material fact in order to obtain a controlled substance from a practitioner." The crime expressly includes *both* affirmative deception to obtain drugs and also the failure to disclose a material fact in order to obtain drugs, such as the fact that the patient has already been to the Emergency Department or to another physician for the same purpose. An unsuccessful attempt to commit this crime is itself a crime under Massachusetts General Laws, Chapter 274, § 6. Under traditional confidentiality rules, a provider is permitted to report such a crime, disclosing the necessary patient information in the process. A similar exception is included in the HIPAA Privacy Rule, §164.512 (f)(5).

Q. *How certain to I have to be that a patient is seeking pain medication for purposes of misuse or diversion before I can report the incident to the police?*

A. The law permits disclosure to law enforcement agencies when the provider has a "good faith belief" that a crime has been committed on the premises. What constitutes a "good faith belief" that criminal activity has occurred may vary somewhat with each case. "Good faith belief" generally requires only that the provider have some reasonable basis for believing that criminal activity occurred.

Q. *Would my malpractice insurance cover my decision to report to the police a good faith belief that my patient is seeking drugs from me for purposes of diversion?*

A. Because the reporting of a patient crime involves some level of disclosure of what otherwise would be confidential information, there is some risk that a reported patient will bring a breach a confidentiality claim against the provider. Breach of confidentiality claims are generally covered claims under most professional liability policies, including those issued by the Berkshire Insurance Company SPC, Ltd., and the ProMutual, so long as the claim does not involve an intentional violation of a patient's legitimate expectation of privacy. A patient does not have a legitimate expectation of confidentiality concerning an attempt to commit the crime of obtaining controlled substances by false pretenses.

Q. *Would there be any liability risk to me if I chose not to report to the police a good faith belief that my patient is seeking drugs from me for purposes of diversion?*

A. Deciding not to report a suspected effort to obtained controlled substances by false pretenses also carries some risk for the provider (as well as the patient and community), at least in those cases where the patient moves on to another provider and is successful in obtaining the controlled substance. Moreover, acquiescing to the suspected patient's request for controlled substances in the face of a "good faith belief" that the patient is seeking them under false pretenses exposes the provider to potentially very serious consequences, both in civil liability and in federal and state regulatory sanction for negligent (or reckless) prescribing practices.

Q. *So, if I have a good faith belief that a patient of mine is seeking controlled substances by false pretenses (including by forging my prescriptions), where can I get advice about how to proceed?*

A. Practitioners employed by Berkshire Health Systems-affiliated entities should contact the Berkshire Health Systems Legal Department (413-445-9529) or jrogers@bhs1.org. The Berkshire County Controlled Substances Collaborative is arranging for a panel of four community lawyers from which community providers may select for assistance in resolving these issues. Although the Berkshire Health Systems Legal Department cannot give legal advice to community providers not employed by Berkshire Health Systems entities, the Legal Department can make referrals.

Q. *Any other advice about how to proceed?*

A. Review "Communication Strategies Around Prescribing and Discontinuing Controlled Substances" in the *Pain Care Resource Manual* and talk with colleagues about strategies to follow (Michael Blackman, M.D., Andrew DeMaggio, M.D., Gordan Kuhar, M.D., Alex Sabo, M.D. and Jennifer Michaels, M.D. may be of assistance). Allow the patient to leave your office and call local police immediately if you are concerned that the patient may become violent or otherwise harmful.

Commonwealth of Massachusetts
Board of Registration in Medicine
560 Harrison Avenue
Boston, Massachusetts 02118

Guidelines for the Use of Controlled Substances for the Treatment of Pain

Federation of State Medical Boards of the United States, Inc.

The recommendations contained herein were adopted as policy by the House of Delegates of the Federation of State Medical Boards of the United States, Inc., May 1998.

Adopted by the Massachusetts Board of Registration in Medicine December 15, 2004

Section I: Preamble

The Massachusetts Board of Registration in Medicine recognizes that principles of quality medical practice dictate that the people of the Commonwealth of Massachusetts have access to appropriate and effective pain relief. The appropriate application of up-to-date knowledge and treatment modalities can serve to improve the quality of life for those patients who suffer from pain as well as reduce the morbidity and costs associated with untreated or inappropriately treated pain. The Board encourages physicians to view effective pain management as a part of quality medical practice for all patients with pain, acute or chronic, and it is especially important for patients who experience pain as a result of terminal illness. All physicians should become knowledgeable about effective methods of pain treatment as well as statutory requirements for prescribing controlled substances.

Inadequate pain control may result from physicians' lack of knowledge about pain management or an inadequate understanding of addiction. Fears of investigation or sanction by federal, state

and local regulatory agencies may also result in inappropriate or inadequate treatment of chronic pain patients. Accordingly, these guidelines have been developed to clarify the Board's position on pain control, specifically as related to the use of controlled substances, to alleviate physician uncertainty and to encourage better pain management.

The Board recognizes that controlled substances, including opioid analgesics, may be essential in the treatment of acute pain due to trauma or surgery and chronic pain, whether due to cancer or non-cancer origins. Physicians are referred to the *U.S. Agency for Health Care and Research Clinical Practice Guidelines* for a sound approach to the management of acute[1] and cancer-related pain.[2] The medical management of pain should be based on current knowledge and research and include the use of both pharmacologic and non-pharmacologic modalities. Pain should be assessed and treated promptly, and the quantity and frequency of doses should be adjusted according to the intensity and duration of the pain. Physicians should recognize that tolerance and physical dependence are normal consequences of sustained use of opioid analgesics and are not synonymous with addiction.

The Massachusetts Board of Registration in Medicine is obligated under the laws of the Commonwealth of Massachusetts to protect the public health and safety. The Board recognizes that inappropriate prescribing of controlled substances, including opioid analgesics, may lead to drug diversion and abuse by individuals who seek them for other than legitimate medical use. Physicians should be diligent in preventing the diversion of drugs for illegitimate purposes.

1. Acute Pain Management Guideline Panel. Acute Pain Management: Operative or Medical Procedures and Trauma. *Clinical Practice Guideline.* AHCPR Publication No. 92-0032. Rockville, Md. Agency for Health Care Policy and Research. U.S. Department of Health and Human Resources, Public Health Service. February 1992.
2. Jacox A, Carr DB, Payne R, et al. Management of Cancer Pain. *Clinical Practice Guideline No. 9.* AHCPR Publication No. 94-0592. Rockville, Md. Agency for Health Care Policy and Research. U.S. Department of Health and Human Resources, Public Health Service. March 1994.

Physicians should not fear disciplinary action from the Board or other state regulatory or enforcement agency for prescribing, dispensing or administering controlled substances, including opioid analgesics, for a legitimate medical purpose and in the usual course of professional practice. The Board will consider prescribing, ordering, administering or dispensing controlled substances for pain to be for a legitimate medical purpose if based on accepted scientific knowledge of the treatment of pain or if based on sound clinical grounds. All such prescribing must be based on clear documentation of unrelieved pain and in compliance with applicable state or federal law.

Each case of prescribing for pain will be evaluated on an individual basis. The board will not take disciplinary action against a physician for failing to adhere strictly to the provisions of these guidelines, if good cause is shown for such deviation. The physician's conduct will be evaluated to a great extent by the treatment outcome, taking into account whether the drug used is medically and/or pharmacologically recognized to be appropriate for the diagnosis, the patient's

individual needs—including any improvement in functioning—and recognizing that some types of pain cannot be completely relieved.

The Board will judge the validity of prescribing based on the physician's treatment of the patient and on available documentation, rather than on the quantity and chronicity of prescribing. The goal is to control the patient's pain for its duration while effectively addressing other aspects of the patient's functioning, including physical, psychological, social and work-related factors. The following guidelines are not intended to define complete or best practice, but rather to communicate what the Board considers to be within the boundaries of professional practice.

Section II: Guidelines

The Board has adopted the following guidelines when evaluating the use of controlled substances for pain control:

1. Evaluation of the Patient

A complete medical history and physical examination must be conducted and documented in the medical record. The medical record should document the nature and intensity of the pain, current and past treatments for pain, underlying or coexisting diseases or conditions, the effect of the pain on physical and psychological function, and history of substance abuse. The medical record also should document the presence of one or more recognized medical indications for the use of a controlled substance.

2. Treatment Plan

The written treatment plan should state objectives that will be used to determine treatment success, such as pain relief and improved physical and psychosocial function, and should indicate if any further diagnostic evaluations or other treatments are planned. After treatment begins, the physician should adjust drug therapy to the individual medical needs of each patient. Other treatment modalities or a rehabilitation program may be necessary depending on the etiology of the pain and the extent to which the pain is associated with physical and psychosocial impairment.

3. Informed Consent and Agreement for Treatment

The physician should discuss the risks and benefits of the use of controlled substances with the patient, persons designated by the patient or with the patient's surrogate or guardian if the patient is incompetent. The patient should receive prescriptions from one physician and one pharmacy where possible. If the patient is determined to be at high risk for medication abuse or have a history of substance abuse, the physician may employ the use of a written agreement between physician and patient outlining patient responsibilities, including

- urine/serum medication levels screening when requested;
- number and frequency of all prescription refills; and
- reasons for which drug therapy may be discontinued (i.e., violation of agreement).

4. Periodic Review

At reasonable intervals based on the individual circumstances of the patient, the physician should review the course of treatment and any new information about the etiology of the pain. Continuation or modification of therapy should depend on the physician's evaluation of progress toward stated treatment objectives, such as improvement in patient's pain intensity and improved physical and/or psychosocial function, i.e., ability to work, need of health care resources, activities of daily living and quality of social life. If treatment goals are not being achieved, despite medication adjustments, the physician should reevaluate the appropriateness of continued treatment. The physician should monitor patient compliance in medication usage and related treatment plans.

5. Consultation

The physician should be willing to refer the patient as necessary for additional evaluation and treatment in order to achieve treatment objectives. Special attention should be given to those pain patients who are at risk for misusing their medications and those whose living arrangement pose a risk for medication misuse or diversion. The management of pain in patients with a history of substance abuse or with a comorbid psychiatric disorder may require extra care, monitoring, documentation and consultation with or referral to an expert in the management of such patients.

6. Medical Records

The physician should keep accurate and complete records to include

- the medical history and physical examination;
- diagnostic, therapeutic and laboratory results;
- evaluations and consultations;
- treatment objectives;
- discussion of risks and benefits;
- treatments;
- medications (including date, type, dosage and quantity prescribed);
- instructions and agreements; and
- periodic reviews.

Records should remain current and be maintained in an accessible manner and readily available for review.

7. Compliance With Controlled Substances Laws and Regulations

To prescribe, dispense or administer controlled substances, the physician must be licensed in the state and comply with applicable federal and state regulations. Physicians are referred to *the Physicians Manual of the U.S. Drug Enforcement Administration* and (any relevant documents issued by the state medical board) for specific rules governing controlled substances as well as applicable state regulations.

Section III: Definitions

For the purposes of these guidelines, the following terms are defined as follows:

Acute Pain

Acute pain is the normal, predicted physiological response to an adverse chemical, thermal or mechanical stimulus and is associated with surgery, trauma and acute illness. It is generally time-limited and is responsive to opioid therapy, among other therapies.

Addiction

Addiction is a neurobehavioral syndrome with genetic and environmental influences that results in psychological dependence on the use of substances for their psychic effects and is characterized by compulsive use despite harm. Addiction may also be referred to by terms such as "drug dependence" and "psychological dependence." Physical dependence and tolerance are normal physiological consequences of extended opioid therapy for pain and should not be considered addiction.

Analgesic Tolerance

Analgesic tolerance is the need to increase the dose of opioid to achieve the same level of analgesia. Analgesic tolerance may or may not be evident during opioid treatment and does not equate with addiction.

Chronic Pain

A pain state which is persistent and in which the cause of the pain cannot be removed or otherwise treated. Chronic pain may be associated with a long-term incurable or intractable medical condition or disease.

Pain

An unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage.

Physical Dependence

Physical dependence on a controlled substance is a physiologic state of neuro-adaptation which is characterized by the emergence of a withdrawal syndrome if drug use is stopped or decreased abruptly, or if an antagonist is administered. Physical dependence is an expected result of opioid use. Physical dependence, by itself, does not equate with addiction.

Pseudoaddiction

Pattern of drug-seeking behavior of pain patients who are receiving inadequate pain management that can be mistaken for addiction.

Substance Abuse

Substance abuse is the use of any substance(s) for non-therapeutic purposes or use of medication for purposes other than those for which it is prescribed.

Tolerance

Tolerance is a physiologic state resulting from regular use of a drug in which an increased dosage is needed to produce the same effect, or a reduced effect is observed with a constant dose.

244 CMR 4.00: MASSACHUSETTS REGULATIONS GOVERNING THE PRACTICE OF NURSING IN THE EXPANDED ROLE

Section

4.11 Categories of Nurses Practicing in Expanded Roles

A nurse practicing in an expanded role includes nurses whose professional activities fall within the following categories:

(1) Nurse Midwife

(2) Nurse Practitioner

(3) Psychiatric Nurse Mental Health Clinical Specialist

(4) Nurse Anesthetist

(5) Other categories as the Board and the Board of Registration in Medicine determine from time to time.

4.22: Development, Approval and Review of Guidelines for Nurse Midwives, Nurse Practitioners and Nurse Anesthetists

(1) All nurses practicing in an expanded role (physician's office, institution or private practice) shall practice in accordance with written guidelines developed in collaboration with and mutually acceptable to the nurse and to:

(a) a physician expert by virtue of training or experience in the nurse's area of practice in the case of the nurse in the physician's office and the nurse in private practice; or

(b) the appropriate medical staff and nursing administration staff of the institution employing the nurse.

(2) In all cases the written guidelines shall designate a physician who shall provide medical direction as is customarily accepted in the specialty area. Guidelines may authorize the nurse's performance of any professional activities included within her area of practice. The guidelines shall:

(a) specifically describe the nature and scope of the nurse's practice;

(b) describe the circumstances in which physician consultation or referral is required;

(c) describe the use of established procedures for the treatment of common medical conditions which the nurse may encounter; and

(d) include provisions for managing emergencies.

(3) In addition to the requirements of 244 CMR 4.22(2), the guidelines pertaining to prescriptive practice shall:

(a) include a defined mechanism to monitor prescribing practices, including documentation of review with a supervising physician at least every three months;

(b) include protocols for the initiation of intravenous therapies and Schedule II drugs;

(c) specify the frequency of review of initial prescription of controlled substances; the initial prescription of Schedule II drugs must be reviewed within 96 hours; and
(d) conform to M.G.L. c. 94C, the regulations of the Department of Public Health at 105 CMR 700.000 *et seq.*, and M.G.L. c. 112, §§ 80E or 80G, as applicable.

(5) The Board may request at any time an opportunity to review the guidelines under which a nurse is practicing or proposes to practice in an expanded role. Failure to provide guidelines to the Board is basis for and may result in disciplinary action. The Board may require changes in the guidelines if it determines that they authorize a nurse to perform professional activities without adequate supervision or collaboration or to perform professional activities which exceed the bounds of the nurse's area of practice or her education or experience. The Board may also disapprove guidelines in their entirety if it determines that the institution which approved them is incapable of assuring that professional activities performed under them will be in accordance with the Board's standards of professional nursing.

4.23: Development, Approval and Review of Guidelines for Psychiatric Nurse Mental Health Specialists

(1) A psychiatric nurse practicing in the expanded role shall practice in accordance with written guidelines which will be available upon request to the Board of Registration in Nursing. The guidelines shall specifically describe the nature and scope of the nurse's practice, as well as the circumstances in which physician collaboration, consultation, or referral is required.

(2) In all cases the written guidelines shall designate a physician who shall provide medical direction as is customarily accepted in the specialty area. Guidelines may authorize the nurse's performance of any professional activities included in her area of practice. The guidelines shall:
(a) specifically describe the nature and scope of the nurse's practice;
(b) describe the circumstances in which physician consultation or referral is required; and
(c) describe the use of established procedures for the treatment of common medical conditions which the nurse may encounter.

(3) Guidelines pertaining to prescriptive practice shall:
(a) include a defined mechanism to monitor prescribing practices, including documentation of review with a supervising psychiatrist at least every three months;
(b) include protocols for the initiation of intravenous therapies and Schedule II drugs;
(c) specify the frequency of review of initial prescription of controlled substances: the initial prescription of Schedule II drugs shall be reviewed within 96 hours; and
(d) conform to M.G.L. c. 94C, the regulations of the Department of Public Health at 105 CMR 700.000 *et seq.*, and M.G.L. c. 112, § 80E;

4.27: Self-Prescribing and Prescribing for Family Members

A nurse authorized to prescribe medication is prohibited from prescribing drugs in Schedules II, III, and IV for personal use. Except in an emergency, such nurse is prohibited from prescribing Schedule II drugs to a member of her immediate family, including spouse or equivalent, a parent, child, sibling, parent-in-law, son/daughter-in-law, brother/sister-in-law, step-parent, step-child, step-sibling, and any other relative residing in the same household.

263 CMR 5.00: SCOPE OF PRACTICE AND EMPLOYMENT OF PHYSICIAN ASSISTANTS

Section

5.04: Scope of Services Which May Be Performed

(1) A physician assistant may, under the supervision of a licensed physician, perform any and all services which are:

(a) Within the competence of the physician assistant in question, as determined by the supervising physician's assessment of his or her training and experience; and

(b) Within the scope of services for which the supervising physician can provide adequate supervision to ensure that accepted standards of medical practice are followed.

(2) A physician assistant may approach patients of all ages and with all types of conditions; elicit histories; perform examinations; order, perform and interpret diagnostic studies; order and perform therapeutic procedures; instruct and counsel patients regarding physical and mental health issues; respond to life-threatening situations; and facilitate the appropriate referral of patients; consistent with his or her supervising physician's scope of expertise and responsibility and the level of authority and responsibility delegated to him or her by the supervising physician.

(3) Nothing contained herein shall be construed to allow a physician assistant to:

(a) Give general anesthesia;

(b) Perform any procedure involving ionizing radiation, except in an emergency situation where the procedure is performed under the direction and control of a licensed physician; or

(c) Render a formal medical opinion on procedures involving ionizing radiation.

(4) Where a physician assistant is involved in the performance of major invasive procedures, such procedures shall be undertaken under specific written protocols, available to the Board upon request, which have been developed between the supervising physician and the physician assistant and which specify, *inter alia*, the level of supervision the service requires, e.g., direct (physician in room), personal (physician in building), or general (physician available by telephone).

5.05 Scope of Supervision Required

(1) All professional activities of a physician assistant must be supervised by a supervising physician approved by the Massachusetts Board of Registration in Medicine pursuant to 243 CMR 2.08(7). A "supervising physician", for purposes of this subchapter, shall mean a physician who is a "full licensee" of the Massachusetts Board of Registration in Medicine.

(2) A supervising physician shall not supervise more than two physician assistants at any one time.

(3) A supervising physician may use a physician assistant to assist him or her in the process

of gathering data necessary to make decisions and institute patient care plans. A physician assistant shall not, however, supplant a licensed physician as the principal medical decision-maker.

(4) A supervising physician shall afford supervision adequate to ensure all of the following:
(a) The physician assistant practices medicine in accordance with accepted standards of medical practice. 263 CMR 5.05(4)(a) does not require the physical presence of the supervising physician in every situation in which a physician assistant renders medical services.
(b) The physician assistant, except in life threatening emergencies where no licensed physician is available, informs each patient that he or she is a physician assistant and that he or she renders medical services only under the supervision of a licensed physician.
(c) The physician assistant wears a name tag which identifies him or her as a physician assistant.
(d) The supervising physician reviews diagnostic and treatment information, as agreed upon by the supervising physician and the physician assistant, in a timely manner consistent with the patient's medical condition.
(e) On follow-up care, hospital visits, nursing home visits, attending the chronically ill at home, and in similar circumstances in which the supervising physician has established a therapeutic regimén or other written protocol, the physician assistant checks and records a patient's progress and reports the patient's progress to the supervising physician. Supervision is adequate under this subparagraph if it permits a physician assistant who encounters a new problem not covered by a written protocol or which exceeds established parameters to initiate a new patient care plan and consult with the supervising physician.
(f) In an emergency, the physician assistant renders emergency medical services necessary to avoid disability or death of an injured person until a licensed physician arrives.
(g) When a supervising physician is unable or unavailable to be the principal medical decision-maker, another licensed physician must he designated to assume temporary supervisory responsibilities with respect to the physician assistant. The name and scope of responsibility of the physician providing such temporary supervision must be readily ascertainable from records kept in the ordinary course of business which are available to patients. The supervising physician(s) of record is ultimately responsible for ensuring that each task performed by a physician assistant is properly supervised.

5.07: Prescription Practices of a Physician Assistant

(1) Any physician assistant who holds a full certificate of registration, issued by the Board pursuant to 263 CMR 3.02, may issue written or oral prescriptions or medication orders for a patient, provided that he or she does so in accordance with all applicable state and federal laws and regulations, including but not limited to M.G.L. c. 112 § 9E; M.G.L. c. 94C, §§ 7, 9 and 20; 105 CMR 700.000 and 263 CMR 5.07(1).

(2) A physician assistant who holds a temporary certificate of registration, issued by the Board Pursuant to 263 CMR 3.04, may prepare a written or oral prescription or medication order for a patient, Provided that:
(a) Any such written prescription or medication order is signed by his or her supervising physician, or by another licensed physician who has been designated to assume temporary supervisory responsibilities with respect to that physician assistant pursuant to 263 CMR 5.05(4)(g), prior to the issuance of said prescription or medication order to the patient;
(b) Any such oral prescription or medication order is approved, in writing, by his or her supervising physician, or by another licensed physician who has been designated to assume temporary supervisory responsibilities with respect to that physician assistant pursuant to 263 CMR 5.05(4)(g), prior to the issuance of that oral prescription or

medication order; and

(c) All such oral or written prescriptions or medication orders are issued in the name of the supervising physician, and are otherwise issued in accordance with all applicable state and federal laws and regulations, including but not limited to M.G.L. c. 112, § 9E; M.G.L. c. 94C, §§ 7, 9 and 20; 105 CMR 700.000; and 263 CMR 5.07(2).

(3) Any prescription or medication order issued by a physician assistant for a Schedule II controlled substance, as defined in 105 CMR 700.002, shall be reviewed by his or her supervising physician, or by a temporary supervising physician designated pursuant to 263 CMR 5.05(4)(g), within 96 hours after its issuance.

(4) All physician assistants shall issue prescriptions or medication orders in accordance with written guidelines governing the prescription of medication which are mutually developed and agreed upon by the physician assistant and his or her supervising physician(s).

(a) Such guidelines shall address, but need not be limited to, the following issues:

1. Identification of the supervising physician(s) for that work setting;
2. Frequency of medication reviews by the physician assistant and his or her supervising physician;
3. Types and classes of medications to be prescribed by the physician assistant;
4. The initiation and/or renewal of prescriptions for medications which are not within the ordinary scope of practice for the specific work setting in question, but which may be needed to provide appropriate medical care;
5. The quantity of any medication to be prescribed by a physician assistant, including initial dosage limits and refills;
6. The types and quantities of Schedule VI medications which may be ordered by the physician assistant from a drug wholesaler, manufacturer, laboratory or distributor for use in the practice setting in question;
7. Review of initial prescriptions or changes in medication; and
8. Procedures for initiating intravenous solutions.

(b) Such guidelines shall be available for review by any duly authorized representative of the Board, the Massachusetts Board of Registration in Medicine, the Massachusetts Department of Public Health, and such other state or federal government agencies as may be reasonably necessary and appropriate to ensure compliance with all applicable state or federal laws and regulations. Copies of such guidelines, however, need not be filed with those agencies.

(c) All such guidelines must be in writing and must be signed by both the supervising physician and the physician assistant. Such guidelines shall be reviewed annually and dated and initialed by both the supervising physician and the physician assistant at the time of each such review. The physician assistant and his/her supervising physician may alter such guidelines at any time and any such changes shall be initialed by both parties and dated.

(5) All prescriptions or medication orders issued by a physician assistant shall be issued in a manner which is consistent with the scope of practice of the physician assistant, the guidelines developed pursuant to 263 CMR 5.07(4), and accepted standards of good medical practice for licensed physicians with respect to prescription practices.

(6) At least four hours of the continuing medical education which a physician assistant is required to obtain pursuant to 263 CMR 3.05(3) as a condition for license renewal shall be in the field of pharmacology and/or pharmacokinetics.

(7) All prescriptions written by a physician assistant shall he written in accordance with the regulations of the Massachusetts Department of Public Health at 105 CMR 721.000.

(8) A physician assistant may order only Schedule VI controlled substances from a drug wholesaler, manufacturer, distributor or laboratory, and only in accordance with the written guidelines developed with his/her supervising physician pursuant to 263 CMR 5.07(4). A physician assistant may sign only for sample Schedule VI controlled substances received by or

sent to the practice setting by a pharmaceutical representative.

(9) The use of pre-signed prescription blanks or forms is prohibited.

(10) A physician assistant shall not prescribe controlled substances in Schedules II, III and IV for his or her own use. Except in an emergency, a physician assistant shall not prescribe Schedule II controlled substances for a member of his or her immediate family, including a parent, spouse or equivalent, child, sibling, parent-in-law, son/daughter-in-law, brother/sister-in-law, step-parent, step-child, step-sibling, or other relative permanently residing in the same residence as the physician assistant.

(11) The physician assistant and the supervising physician for that work setting shall be jointly responsible for all prescriptions or medication orders issued by the physician assistant in that work setting.

5.08 Legal Responsibility for Actions of Physician Assistant

(1) Where a physician assistant is employed by a physician or group of physicians, the employing physician or physicians shall remain legally responsible for the acts or omissions of said physician assistant at all times, including those occasions where said physician assistant, under the direction and supervision of said employing physician or physicians, aids in the care and treatment of patients in a health care facility.

(2) Where a physician assistant is employed by a health care facility, the employing health care facility shall be legally responsible for the acts or omissions of said physician assistant at all times. Physician assistants who are employed by health care facilities shall nevertheless be supervised by licensed physicians, as required by 263 CMR 5.05. Physician assistants employed by health care facilities shall not be utilized as the sole medical personnel in charge of emergency services, outpatient services, or any other clinical service where a licensed physician is not regularly available.

Contacts

BHS and Community Resources

Alcoholic Anonymous	1-413-443-0212
Addiction Evaluation and Treatment	
Brien Center – Dr. Jennifer Michaels, Med. Dir.–Adult & Family Serv.	
Pittsfield	1-413-496-9671
Gt. Barrington	1-413-528-9156
North Adams	1-413-664-4541
BMC & Hillcrest Campus - McGee Unit	1-413-442-1400
Fairview Pain Management	1-413-854-9828
Multidisciplinary Chronic Pain Program	1-413-447-2242
Physical Medicine	
Psychology	
Occupational Therapy	
Narcotics Anonymous	1-413-443-4377
New England Pain Diagnosis & Treatment Ctr	1-413-445-7246
Nutrition / Counseling	1-413-447-2671
Psychological Services	
Primary Care Outreach Team	1-413-447-2169
John Harrington, Ph.D. *	1-413-447-2352
Carolyn Killian, LMHC	1-413-447-2145
Psychiatric Crisis Team–Avail. 24/7	1-413-499-0227
	1-800-252-0412
Smoking Cessation Counseling	1-413-499-2602
Urine Toxicology Screening - BMC	1-413-447-2592
Larry Spatz, PhD.	
Legal Counsel -John Rogers, VP / BHS	1-413-445-9529

For questions or suggestions regarding Pain Manual, contact Denise Rose (413-395-7980) or email painmanual@bhs1.org.

* Has specific training and expertise in the treatment of patients with chronic pain.

Algorithm References and Websites

Pain Management Algorithms: Guidelines.gov

Guidelines for the Assessment and Management of Chronic Pain (2004). Wisconsin Medical Journal, Vol 103: 3.

Algorithm for Complex Regional Pain Syndrome. Reflex Sympathetic Dystrophy Syndrome Assn. (2002). Clinical Practice Guidelines (2nd ed.) for the diagnosis, treatment and management of reflex sympathetic dystrophy/complex regional pain syndrome.

Algorithm for Neuropathic Pain. Dworkin, RH, et al. (2003) Advances in neuropathic pain: diagnosis, mechanisms and treatment recommendations. Arch Neurology Nov; 60 (11) 1524-34.

Algorithm for Primary Care of Back Pain, University of Michigan Back Pain Practice Guideline Committee, 2003.

Diagnosis and classification of primary headache disorders (2004). Martin V, Elkind A. Diagnosis and classification of primary headache disorders. In: Standards of care for headache diagnosis and treatment. Chicago (IL): National Headache Foundation; 2004. p. 4-18. [35 ref]

Mathew N, Ward T. Treatment of primary headache: chronic daily headache. In: Standards of care for headache diagnosis and treatment. Chicago (IL): National Headache Foundation; 2004. p. 73-80. [4 references]

VHA/Dept of Defense clinical practice guideline for the management of medically unexplained symptoms: chronic pain and fatigue. Management of Medically Unexplained Symptoms: Chronic Pain and Fatigue Working Group. Washington (DC): Veterans Health Administration, Department of Defense; 2001 Jul. Various p. [148 references]

Websites

Agency for Health Care Research and Quality	www.guidelines.gov
American Pain Society	www.ampainsoc.org
American Academy of Physical Medicine & Rehabilitation	www.aapmr.org
American College of Rheumatology	www.rheumatology.org
American Academy of Family Physicians	www.aafp.org
American Academy of Pain Medicine	www.painmed.org
American Pain Foundation	www.painfoundation.org
American Academy of Pain Management	www.aapainmanage.org
American Society for Pain Management Nursing	www.aspmn.org
American Society of Addiction Medicine	www.asam.org
Chronic Pain Foundation	www.chronicpainfoundation.org
Institute for Clinical Systems Improvements	www.icsi.org
International Association for the Study of Pain	www.iasp-pain.org
Massachusetts Board of Registration in Medicine	www.massmedboard.org
National Foundation for the Treatment of Pain	www.paincare.org
National Pain Foundation	www.nationalpainfoundation.org
North American Spine Society	www.spine.org
Wisconsin Medical Society	www.wisconsinmedicalsociety.org

Pain and Mental Health Screening References

1. Elliott AM, Smith BH, Penny KI, Smith WC, Chambers WA. The epidemiology of chronic pain in the community. Lancet. 1999;354:1248–52.y
2. van Tulder M, Koes B, Bombardier C. Low back pain. Best Pract Res Clin Rheumatol. 2002;16:761–75.
3. Mannix LK. Epidemiology and impact of primary headache disorders. Med Clin North Am. 2001;85:887–95.
4. Lipton RB, Stewart WF, Diamond S, Diamond ML, Reed M. Prevalence and burden of migraine in the United States: data from the American Migraine Study II. Headache. 2001;41:646–57.
5. Chodosh, Bruce A. Ferrell, Paul G. Shekelle, Neil S. Wenger RAND, 2004).
6. Bao, Sturm & Croghan (Psychiatric Services, (2003). Psychiatric Services. Vol. 54(5):693-97
7. Ohayon & Schatzberg (2003), Archives of General Psychiatry)
8. Ohayon & Schatzberg, 2003 Psychiatric Services
9. Block, Gatchel, Deardorff & Guyer, 2003)
10. iasp- http://www.iasp-pain.org/terms-p.html#top. Pain Terms. (Original source: Classification of Chronic Pain, Second Edition, IASP Task Force on Taxonomy, edited by H. Merskey and N. Bogduk, IASP Press, Seattle, © 1994, pp. 209-214.)
11. (Koyama, McHaffil, Laurienti, & Coghill, 2005 as noted in (Jones-London, 2006 nih.org).
12. Groth-Marnat, G. (1990). Handbook of Psychological Assessment 2nd Edition. John Wiley & Sons: New York, NY.

Coll A.M., Ameen J.R.M. & Mead D. (2004) Postoperative pain assessment tools in day surgery: literature review. Journal of Advanced Nursing. 46(2), 124–133)

Berwick, Murray, Goldman, Ware, Barsky & Weinstein, 1991

Brown RL, Leonard T, Saunders, LA, Papasouliotis O. (1997). A two-item screening test for alcohol and other drug problems. The Journal of Family Practice. 1997;44(2):151-160.

Scott J & Huskisson E. (1979). Accuracy of subjective measurement made with or without previous scores: an important source of error in serial measurement of subjective states. *Annals of Rheumatic Disease*. 38:558-59.

Guyatt G, Berman L, Townsend M & Taylor D. Should study subjects see their previous responses? *J Chron Dis*, 1985;18 (12):1003-07.

Jones-London, M.D. Expectations of Pain: I Think, Therefore I Am. February 15, 2006, www.nih.gov. (Original source: Koyama T, McHaffie JG, Laurienti PJ, Coghill RC. "The subjective experience of pain: Where expectations become reality." Proceedings of the National Academy of Sciences, September 6, 2005, Vol.102, pp.12950-12955.)

Andresen, E.M., Bowley, N., Rothenberg, B.M., Panzer, R., Katz,P. (1996). *Test-Retest Performance of a Mailed Version of the Medical Outcomes Study 36-Item Short-Form Health Survey Among Older Adults.* Medical Care. 34(12):1165-1170.

McDowell, I. & Newell, C. (1996). Measuring Health: A Guide to Rating Scales and Questionnaires, Oxford University Press, New York, NY.

Ware, J.E. (Nov 16 2005). SF-36 Health Survey Update. www.sf-36.org.

Ware, Johnson, & Davies-Avery, 1979

Ware, Kosinski & Keller 1994

Tan, G. Jensen,M.P., Thornby, J.I. Shanti, B.F. Validation of the Brief Pain Inventory for chronic nonmalignant pain. Journal of Pain. Mar.; 5(2): 133-7.

Thalji, L., Haggerty, C.C., Rubin, R., Berckmans, T.R., & Pardee, B.L. (1991). 1990 National Survey of Functional Health Status: Final report. Chicago, IL: National Opinion Research Center.

References provided to Berkshire Health Systems, Inc. by Ann Jorn, Ph.D., 2006