



# PAIN CARE RESOURCE MANUAL

*A Practical Guide for Health Care Professionals*

**BERKSHIRE HEALTH SYSTEMS, INC.**



# **Pain Care Resource Manual**

## **A Practical Guide for Healthcare Professionals**



**Berkshire  
Health Systems**

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[www.berkshirehealthsystems.org](http://www.berkshirehealthsystems.org)

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**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 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 Department of Public Health 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 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 intended to be an evolving document, updated as needed, and the Community Pain Management Project welcomes comment and suggested improvements to the *Pain Care Resource Manual* from any of its users.

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 dispensed in Massachusetts (the Department is currently seeking to expand the data base to include other scheduled medications). 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. The Prescription Monitoring Program is working to make prescriber-specific data available at the request of or with the consent of the prescriber.

On at least a quarterly basis, the Community Pain Management Project 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 Community Pain Management Project 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 that important information to subsequent providers who may be considering a course of treatment that includes what would become additional controlled substances. 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 Community Pharmacists***

Community pharmacists have a special perspective that can contribute significantly to better management of pain care and control of medication abuse and diversion in Berkshire County. Pharmacists are often in a position to observe conduct (including by prescribers) that can lead to abuse and diversion as well as conduct that may be actual evidence of abuse and diversion. The Community Pain Management Project is adding community pharmacists to its Steering Committee and will be working with all community pharmacists to more efficiently coordinate the flow of information between pharmacists and prescribers around issues of pain management prescribing and potential prescription abuse. The Community Pain Management Project will also assist in improving the efficiency and coordination between community pharmacies and the Prescription Monitoring Program and, when appropriate and necessary between pharmacists and local law enforcement.

## **VIII. *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.

## **IX. *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 than the general populations. 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 Berkshire Health System and the medical staff of Berkshire Medical Center to develop and implement a comprehensive multidisciplinary pain clinic in order to better serve its patient population. This project has been under construction for some time and is finally coming to fruition. Though these effort, we now have , a true multidisciplinary pain clinic 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 avoiding stigmatizing and still 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 or stimulants.

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 aberrant behavior. Such precautions involve the consistent use of narcotic agreements, initial and random urine toxicology testing and should include a multidimensional set of assessments (Brief Pain Inventory and Screener and Opioid Assessment for Patient with Pain) and treatment modalities. In combination, these provide both a universal approach while still fostering individualized care.

By documenting with a patient that a multidisciplinary approach will be utilized to maximize the outcome and that standard assessments and 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 (documentation). The needs of the community are also served by preventing appropriately prescribed medications from being available for diversion. In addition, the patient is likely to feel he or she is comprehensive comprehensive 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 choose from any 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. Utilizing the tamper-resistant prescription pads made available by Berkshire Health System can further protect providers and minimize opportunities for prescription alteration and forgery.

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

**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](http://www.guidelines.gov))

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

### 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

# 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

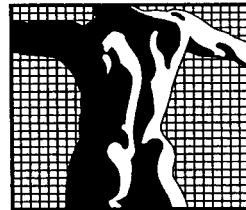
**History:** Pain history, History of treatment, Psychological history, Vocational and medical legal issues, General medical history, Pt's ideas about the cause of pain, Pt's goals for evaluation and treatment

## Diagnosis:

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

## 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

## 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

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

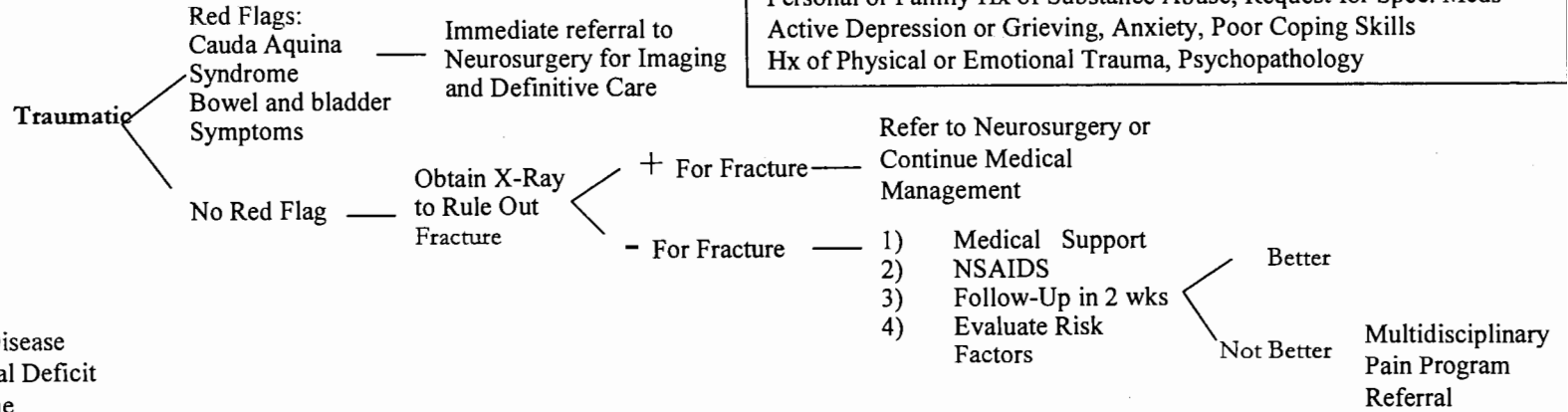
These guidelines are recommendations based upon best scientific evidence but are not intended to replace medical judgment.

## 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

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

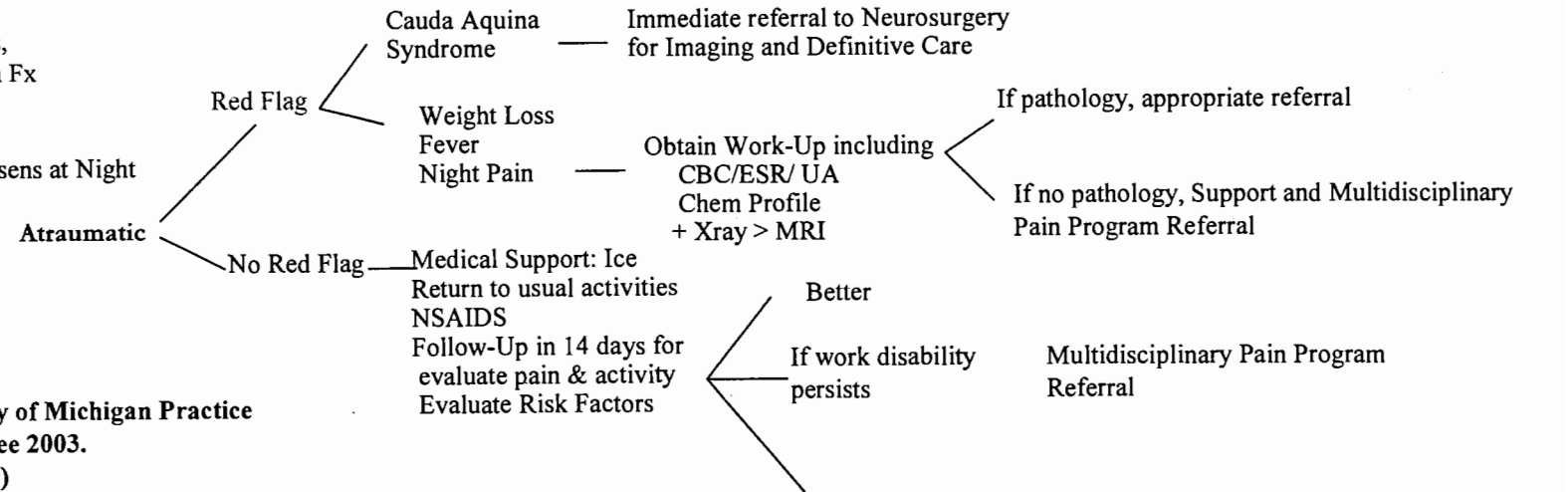
LBP occurs in 80% of people and within 6 weeks, 90% will resolve satisfactorily  
 Pts disabled more than 1yr., 90% will never work again.



**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

- 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,
- Atraumatic**
- Recent Surgery
  - IV Drug Use, HIV,
  - Immune Suppression



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.

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

# 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.



## Complex Regional 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 tender region. Decreased mobilization of extremity can lead to wasting of muscles

### 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

No Flag

Early referral to New England Pain Diagnosis and Treatment Center:

Reference:

### 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

Medical Management or Appropriate Specialty Referral

Negative Specialty Evaluation

Multi-Disciplinary Pain Clinic Referral

### 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

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

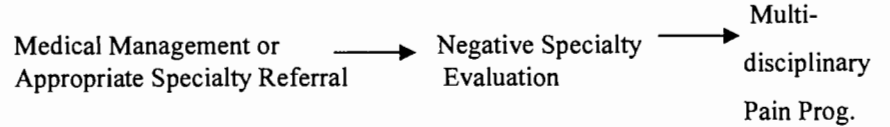


**Diffuse Musculoskeletal Pain**

**Red Flags**

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

**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



**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

Lack of Effectiveness. Consider Change in Therapy or Referral

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

No Obvious Primary Disorder

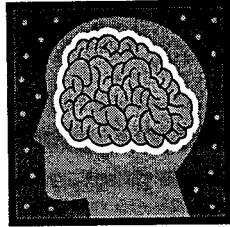
Initiate Medical Management This may include Tricyclic Antidepressants Consider Specialty or Multidisciplinary Pain Program Referral, may include referral for cognitive behavioral therapy

**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)

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

# 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

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

Severe: Chlorpromazine, Depacon, DHE  
 Ketorolac IM, Magnesium Sulfate IV, 5HT  
 agonists  
Status: > 72 Hr Duration > Call / Urgent Referral to Neurology/ ED

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

**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<sup>o</sup> treatment: Beta-blocker or TCA or  
 2<sup>o</sup> drugs in combination  
 Antiepileptic drugs  
 Reinforce education and lifestyle management  
 Consider specialty consult

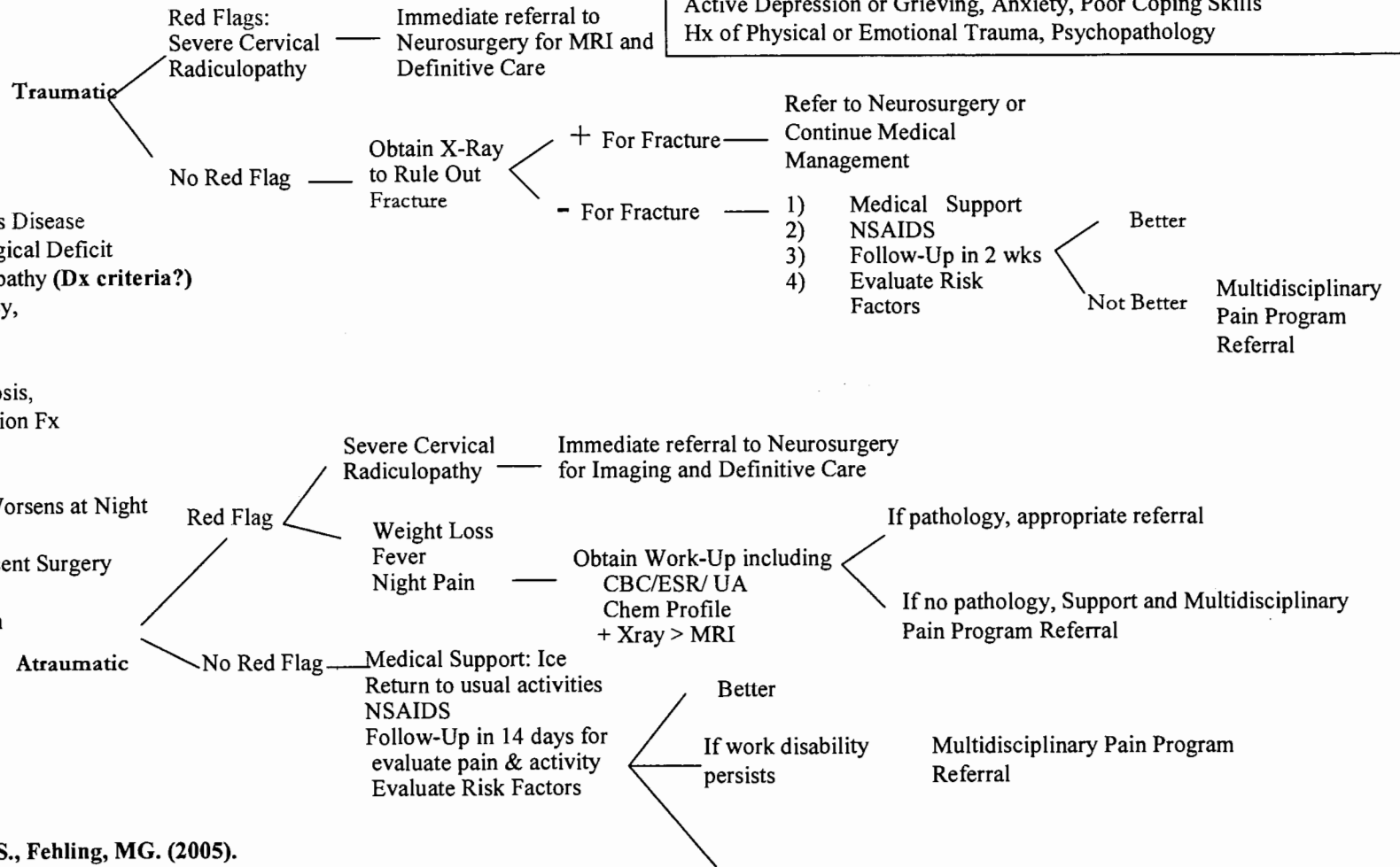
**These guidelines are recommendations based upon best scientific evidence but are not intended to replace medical judgment.**

# 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



- 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



Reference: Carrette, 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.

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

# 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



## 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.**

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

Symptom Management

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

**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

## **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

## Risks of Opioid Therapy

Chronic pain is a major public health problem in the US, and opioids, for better or worse, remain an essential tool in the armamentarium against acute and chronic pain. Owing to substantial efforts to improve awareness and treatment of chronic pain, the availability of opioids has increased dramatically in the past several decades. Although much more remains to be done to ensure appropriate access to opioids, opioid prescribing is currently at the highest level in decades, allowing patients with cancer and non-cancer pain unprecedented access to these analgesics. Opioids, like all medications, are associated with risks, and the prevalence of negative consequences of opioid use has risen concomitantly with their increased use. The risks of greatest concern have been abuse and addiction. Prescription opioid abuse is rising faster than any other type of drug abuse, and is now second only to marijuana in terms of prevalence of abuse and addiction, and ahead of cocaine and heroin by many measures. Current projections suggest that approximately 1.5 million Americans meet criteria for abuse or addiction to prescription opioids, which is nearly 1% of the population. While some clinicians have been comforted by a belief that addiction does not occur in “legitimate” pain patients, the reality is that there is significant overlap between patients with pain and those with addictive disorders; because the prevalence of chronic pain and of addiction are so high, no clinician is free of treating patients with co-morbid pain and addiction. This becomes clear when one considers that the background rate of active substance abuse is approximately 10% in the general US population; that substance abuse increases the risk for certain types of pain; that 20-40% of pain patients on opioids have substance abuse problems; and that pain is the number one reason patients see doctors. The presence of co-morbid addiction significantly complicates the treatment of pain, and the presence of co-morbid pain significantly complicates the treatment of addiction. A unique feature of prescription drug abuse as a complication of medical prescribing is that the problem occurs not only in patients but in their families and the community. Since one of the major sources of abused prescription opioids is the prescriptions of friends and family, it is clear that many of the patients to whom we prescribe are the source of medications that put their family and the community at risk, either from intentional diversion by the patient, or by theft or other unintentional pathways to diversion. The prescriber therefore has unique obligations to prescribe opioids in a manner that minimizes potential harm to non-patient collaterals. Side effects, such as nausea, vomiting, dizziness, sweating, and constipation, are commonly experienced risks of opioid therapy that can to a great extent be prevented or treated. Another risk of opioid therapy, which has not been widely publicized although observed for centuries, is endocrine disturbance, particularly testosterone deficiency.

Myth: Patients either have legitimate chronic pain or they have an addiction problem.

Reality: Many patients have both chronic pain and a substance abuse problem.

Myth: I can easily determine, without any screening tools, based on my clinical acumen who is a legitimate pain patient and who is merely “drug-seeking.”

Reality: You can only detect the most obvious of cases.

# Non-Opioid Analgesics

Medication	Usual Adult Dose	Maximum Adult Daily Dose	Usual Pediatric Dose	Comments
<b>Aminophenol Derivatives</b>				
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
<b>Salicylates</b>				
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			
<b>Other NSAIDs</b>				
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; contra indicated 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)	<u>Pts. &lt; 65 yrs of age:</u> 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. <u>Pts. &gt; 65 yrs of age:</u> 15 mg IV/IM q 6 hrs	<u>Pts. &lt; 65 yrs of age:</u> 120 mg <u>Pts &gt; 65 yrs of age:</u> 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
<b>Selective COX-2 Inhibitors</b>				
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. 5<sup>th</sup> edition. American Pain Society, 2003.

# Antidepressants and Antiepileptic Drugs Used in Chronic Pain Syndromes

Drug	Dosage	Side effects, contraindications, and comments
<b>Antidepressants</b> 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 (rozac),* 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 Serotonergic properties in dosages below 150 mg per day; mixed serotonergic 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
<b>Antiepileptic drugs</b> 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.**

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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 q4th or 25 mg 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 2.5 mg IV/ IM q2-4hr	20-75 mcg/kg IV/ IM max. dose 2.5mg	
		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: 2-12 yo: 0.1mg/kg up to 4mg dose Dolasetron: 2-16yo: 0.35mg/kg up to 12.5mg Ganisetron: 40mcg/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 tabs 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: 5mg 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	
		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 Effects	Management	Adult Dose	Pediatric Dose	Comments
<b>Opioids (cont.)</b>	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	
<b>Acetaminophen</b>	Hepatotoxicity		Limit dose of acetaminophen to $\leq$ 4grams/day; consider lower total daily dose in patients with pre-existing liver disease	Infants and children: limit dose to 75mg/kg/day	
<b>Corticosteroids</b>	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 <sub>2</sub> 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	++	++	+	

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**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 akathisia, 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

## 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 agreement 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. In some cases, long term use of pain medications can *increase* sensitivity to pain. 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

## El contrato y la informacion de terapia de sustancia controlada

Este contrato de tratamiento describe lo acuerdo que yo tengo con mi proveedor de asistencia medica (medico, asistente de medico, ou enfermero) sobre terapia de sustancia controlada. Este acuerdo cubre cualquier tratamiento que yo estoy teniendo que involucra opioids (medicina con narcotico para dolor), calmante, tranquilizantes, adhesivo en la piel y otras medicinas para el dolor.

1. Mi proveedor de asistencia medica y los empleados estan comprometidos de tartar-me como una persona intitulada digna, de sensible cuidado com grave condiciones medica.
2. Me fue hablado que este contrato es necesario porque las sustancias controladas pueden ser **muy arriesgado y incluso fatal**, a menos que yo use solamente como ordenou mi proveedor de asistencia medica.
3. **Yo sei que se yo no cumplir con este contrato mi proveedor de asistencia medica puede parar con la terapia de sustancia controlada para mi proprio bien-estar.**
4. Mi proveedor de asistencia medica me explicou como es la terapia, incluyendo los probables beneficios y los riesgos, los efectos secundarios y los otros potenciales problemas con la terapia.
5. Mi proveedor de asistencia medica espera que yo va reducir mi dolor y mejorar la calidad de vida con lo resultado de la terapia. Probablemente lo alivio de la dolor no es completo. Yo tambien sei que mi proveedor de asistencia medica puede sugerir terapias adicionales, como un asesor o una terapia fisica. Yo concuerdo seriamente en tomar en conta las vantagens de esas outras terapias.
6. Yo comprendo que hay riesgos y uno potencial de efecto secundario da terapia involviendo sustancias controladas. Estos riesgos y efectos secundarios puedem incluir dependencia fisica y, em raros casos, adiccion la medicacion. Estos medicamentos puedem en algun momento encubrir otras serias condiciones. Puedem causar pesadillas, estados psicoticos, alucinaciones, disposicione depressiva. Somnolencia o reflejos lentos, especialmente no principio de la terapia, puede ocurrer o ser imprudente para yo manejar. Mareos, picazon, sudor, boca seca, retencion de urina, estrenimiento, baja testosterona, respiracion depremida e muscular contraction la noche son otros posibles efectos secundarios.

7. Me fue hablado que la rapida disminucion o la parada do medicamento puede inducir que aparescan los sintomas. Los sintomas incluen dolor, mareos, diarrea, ansiedad, sudor, y ataque de tremor. Yo informare a mi proveedor de asistencia medica si yo decida parar cualquier una de mi medicaciones. Mi proveedor de asistencia medica puede direccionar una disminuicion lenta para evitar los efectos secundarios.
8. Yo comprendo que hay serios riesgos en mezclar medicinas con alteracion mental o sustancias cuando yo estoy sobre terapia controlada de sustancias. Estos incluen alcohol, marihuana, narcoticos, sedativos e pastillas para dormir. Tomar otros medicamentos o sustancias durante la terapia poderia resultar uno exceso de sedacion y poderia llevar seria lesion o muerte. Yo no tomare ninguna bebida alcoholica, medicamentos sedativos o outros narcoticos prescritos durante lo periodo de mi terapia sien la autorizacion por escrita de mi proveedor de asitencia medica. Yo no usare ninguna medicacion o sustancias ilegal.
9. Si yo tomo sustancias controladas durante el embarazo, mi bebe podera nacer con dependencia fisica de estas sustancias o de outra manera, ser fisicamente perjudicado. Yo informare inmediatamente al proveedor de asitencia medica gerenciando mi medicaciones si yo creo que yo puedo estar embarazada. Yo informarei cualquier proveedor de la area pre-natal que yo estoy teniendo terapia de sustancias controlada.
10. Yo comprendo que, por causa de los riesgos potenciales y efectos secundarios de mi terapia, y tambien de los beneficios potenciales, y es importante que mi terapia de sustancias controlada sea de cerca y cuidadosamente gerenciada. Por seguridad y eficaz manejo de mi cuidado, yo concuerdo que mi proveedor de asistencia medica podera dividir las informaciones necesarias sobre minha terapia con otros proveedores de asistencia medica. **Yo tambien concuerdo que yo ire a dar todos los seguimientos de las consultas con mi proveedor de asistencia medica y cualquier outra consulta solicitada. Yo ire a cooperar con cualquier monitoracion sobre mi terapia que o mi proveedor de asistencia medica crea que sea necesario, incluyendo aleatoriamente exame medico de urina, exame medico de sangre e pastillas contadas.**
11. Yo conpreendo que el mal uso o diversidad de sustacias controladas cria serios riesgos que hacem mal y es ilegal. Mi proveedor de asistencia medica ira controlar de cerca las sustancias de la receta medica. Por esta razon, durante el periodo de mi terapia de sustancia controlada:

- Yo no voy a tentar obtener sustancia controlada de otro proveedor de asistencia medica. En caso de emergencia, yo vendre a decir para lo otro proveedor de asistencia medica que yo estoy sobre terapia de sustancia controlada. Yo tambien notificare de inmediato a mi proveedor de asistencia medica caso yo tenga recibido sustancias controlada de otro medico.
- Yo usare solamente una farmacia para llenar mis prescripciones y tengo escogido \_\_\_\_\_ para este proposito.
- Yo ire a contactar la oficina de mi proveedor de asistencia 48 horas antes de lo termino de mi medicina prescritida entonse yo puedo recibir los respustos en fecha.
- Yo concuerdo que yo no pedire mas recetas anticipadas y que estas no seran llevadas en conta. Esto inclui si los remedios forem robados, extraviado ou perdidos.
- Yo concuerdo que yo no pedire para tener las receitas anticipadas aprovadas fuera de el horario regular de expediente y conpreendo que en semejante aprovacion no sera concedida.
- Yo concuerdo que ire recorer y firmar por todas las recetas personalmente, a menos que mi proveedor de asistencia medica concuerde con otros planos en el futuro.
- Yo entiendo que esto es crime en Massachusetts tentar obtener sustancias controlada con falsos engano, incluyendo distorsionando hecho o dejar de revelar importantes hechos.
- Yo concuerdo que es trastornador o inapropiado interacion con los funcionarios y no sera tolerado, y puede resultar que este contrato puede ser cancelado.

Si yo no sigo este contrato, mi proveedor de asistencia medica puede decidir que no es seguro continuar con la terapia de sustancias controlada y puede me remiter a una evaluacion adicional.

\_\_\_\_\_  
Firma de el paciente                      Fecha

\_\_\_\_\_  
Firma de el testigo                      Fecha

\_\_\_\_\_  
Firma de el proveedor de asistencia medica                      Fecha

## Контракт и Информированное Согласие на Терапию с Применением Учётных Препаратов

Этот контракт на лечение описывает договор между мной и моим врачом (терапевтом, ассистентом доктора или лицензированной профессиональной медсестрой) о лечении с применением учётных препаратов. Этот договор покрывает все виды лечений которые я прохожу с применением опиоида (наркотическое лекарство от боли), успокоительные, транквилизирующие средства, пластыри и другие виды болеутоляющих таблеток.

1. Мой врач и сотрудники офиса принимают активное участие в моём лечении как человека, заслуживающего внимательного и чувствительного подхода с серьёзным медицинским обстоятельством.
2. Меня проинформировали, что этот контракт необходим потому, что учётные препараты имеют **риск в применении и даже могут быть смертельными**, если я не буду использовать их так, как предписано моим врачом.
3. **Я знаю, что если я не буду выполнять данный контракт, то мой врач может остановить моё лечение с применением учётных препаратов для моего же блага.**
4. Мой врач объяснил мне лечение, включая возможные положительные факторы и риски, а также побочные эффекты и другие потенциальные проблемы, связанные с данным лечением.
5. Мой врач ожидает, что в результате данного лечения у меня уменьшится боль и это приведёт к улучшению качества жизни. Полное избавление от боли скорее всего не произойдёт. Я также знаю, что мой врач может предложить дополнительные виды лечения, такие как психотерапия или физическая терапия. Я согласен (-на) серьёзно рассматривать возможность получения пользы от таких видов лечения.
6. Я понимаю, что существует риски и потенциальные негативные побочные эффекты от лечения с применением учётных препаратов. Эти риски и побочные эффекты могут включать физическую зависимость и, в редких случаях, привыкание к медикаментам. Применение этих медикаментов иногда может приводить к другим серьёзным ситуациям. Они могут вызывать ночные кошмары, психотические состояния, галлюцинации или депрессивное настроение. Бессоница и ухудшение рефлексов, особенно в начале лечения, может возникнуть и может привести к ситуации, что мне будет лучше всего не управлять машиной. Среди других возможных побочных эффектов: тошнота, зуд, повышенная потливость, сухость во

7. рту, удержание мочи, запор, низкий уровень тестостерона, усложнённое дыхание и поддёргивание мышц ночью.
8. Мне объяснили, что быстрое понижение дозы или остановка приёма медикаментов может вызвать симптомы прекращения приёма учётных препаратов. Эти симптомы включают боль, тошноту, понос, чувство беспокойности, повышенные потовыделения и нервные приступы. Я сообщу своему врачу, если я решу прекратить приём своих медикаментов. Мой врач может назначить постепенное снижение дозы, во избежание побочных эффектов.
9. Я понимаю, что существуют серьёзные риски в смешивании препаратов или лекарств, воздействующими на мозг в то время, как я нахожусь на лечении с применением учётных препаратов. Это включает алкоголь, мариухану, наркотики, успокоительные и снотворные таблетки. Применение других лекарств или средств во время моего лечения может привести к чрезмерному угнетению центральной нервной системы и может вызвать серьёзные повреждения или смерть. Я не буду употреблять алкоголь, успокаивающие препараты или другие предписанные наркотики во время лечения без письменного разрешения моего врача. Я не буду использовать нелегальные медикаменты или препараты.
10. Если я буду принимать учётные препараты во время беременности, то мой ребёнок может быть рождён с физической зависимостью на эти препараты или может быть физически повреждён ими. Я немедленно сообщу своему врачу, контролирующему мои медикаменты, если я посчитаю, что есть возможность того, что я забеременела. Я проинформирую врача, занимающегося наблюдением за беременностью о том, что я нахожусь на лечении с применением учётных препаратов.
11. Я понимаю, что из-за потенциальных рисков и побочных эффектов моего лечения, так же как и потенциальных выгод, очень важно, чтобы лечение с применением учётных препаратов проходило под внимательным и детальным наблюдением. Для безопасности и эффективного управления моим лечением, я согласен (-на) с тем, что мой врач может делиться необходимой информацией по поводу моего лечения с другими врачами. **Я также согласен (-на), что я буду приходить на все назначенные приёмы к моему врачу и к другим специалистам, куда я буду направлен (-на). Я буду сотрудничать по поводу любого контроля моего лечения, которое мой врач посчитает необходимым, включая произвольные анализы мочи, крови и пересчёт таблеток.**
12. Я понимаю, что неправильное использование или отклонение в применении учётных препаратов несёт серьёзный риск потенциального вреда и является незаконным. Мой врач внимательно контролирует предписание препаратов. По этой причине во время моего лечения учётными препаратами:
  - Я не буду пытаться получить учётные препараты от других врачей. В случае экстренной ситуации я должен (-на) сказать другому врачу, что я нахожусь на лечении с применением учётных препаратов. Я также своевременно сообщу своему врачу, если я получил (-а) учётные препараты от другого врача.

- Я буду использовать только одну аптеку при покупке лекарств по рецептам и выбрал (-а) \_\_\_\_\_ для этой цели.
- Я свяжусь с офисом своего врача в течение 48-ми часов перед тем, как у меня закончатся лекарства, таким образом я смогу получить необходимый рецепт вовремя.
- Я согласен (-на) с тем, что я не буду пытаться получить рецепт раньше времени и что мне рецепт не выдадут в такой ситуации. Это включает ситуации, когда лекарства были украдены, положены в неправильное место или утеряны.
- Я согласен (-на) с тем, что я не буду пытаться получить рецепт во внерабочее для офиса время и понимаю, что такого одобрения не будет.
- Я согласен (-на), что я забираю и расписываюсь за лекарства лично, за исключением случаев, когда мой врач дал своё согласие на иные планы заранее.
- Я понимаю, что в штате Массачусетс считается **преступлением** попытка получения учётных препаратов при помощи обмана, включая неправильное предоставление фактов или утаивание важных фактов.
- Я согласен (-на) с тем, что отвлекающие и неуместные действия с офисным персоналом не будут проходить незамеченными и могут быть причиной, по которой действие данного контракта будет прервано.

Если я не буду соблюдать условия данного контракта, то мой врач может посчитать, что продолжать лечение с применением учётных препаратов небезопасно и может направить меня на исследование по определению зависимости.

\_\_\_\_\_  
Подпись Пациента                      Дата

\_\_\_\_\_  
Подпись Свидетеля                      Дата

\_\_\_\_\_  
Подпись врача                              Дата

## **Contrato e consentimento de informacao de terapia de substancias controlada**

Este contrato de tratamento descreve o acordo que eu tenho com o meu provedor de assistencia medica (medicos, assistente de medico, ou enfermeiro) sobre terapia de substancias controlada. Este acordo cobre qualquer tratamento que eu estou tendo que envolve opioids (remedio com narcotico para dor), sedativos, tranquilizantes, adesivo na pele e outros remedios para dor.

1. Meu provedor de assistencia medica e os funcionarios estao comprometidos de tratar-me como uma pessoa intitulada digna, de sensivel cuidado com serias condicoes medica.
2. Me foi dito que este contrato e necessario porque substancias controladas podem ser **muito arriscado e ate mortal**, a menos que eu use-os somente como ordenou o meu provedor de assistencia medica.
3. **Eu sei que se eu nao agir em conformidade com este contrato meu provedor de assistencia medica pode parar com a terapia de substancia controlada para o meu proprio bem-estar.**
4. Meu provedor de assistencia medica explicou-me a terapia, incluindo os provaveis beneficios e os riscos, efeitos secundarios e outros potenciais problemas com a terapia.
5. Meu provedor de assistencia medica espera que eu va reduzir a dor e melhorar a qualidade de vida com o resultado da terapia. Provavelmente o alivio da dor nao e completo. Eu tambem sei que meu provedor de assistencia medica pode sugerir terapias adicionais, como um conselheiro ou terapia fisica. Eu concordo seriamente em tomar em conta as vantagens destas outras terapias.
6. Eu entendo que existem riscos e um potencial de efeitos secundarios da terapia envolvendo substancias controladas. Estes riscos e efeitos secundarios podem incluir dependencia fisica e, em raros casos, adicao a medicacao. Estes remedios podem algumas vezes incobrir outras serias condicoes. Podem causar pesadelos, estados psicoticos, alucinacoes, disposicao depressiva. Sonolencia ou reflexos lentos, especialmente no principio da terapia, pode ocorrer ou ser imprudente para eu dirigir. Nauseas, coceira, suor, boca seca, retencao de urina, prisao de ventre,

baixa testosterona, respiração deprimida e contração muscular a noite são outros possíveis efeitos secundários.

7. Me foi dito que a rápida diminuição ou a parada do medicamento pode levar os sintomas virem. Os sintomas incluem dor, náuseas, diarreia, ansiedade, suadeira, e ataque de tremor. Eu informarei o meu provedor de assistência médica caso eu decida parar qualquer uma das minhas medicações. Meu provedor de assistência médica pode direcionar uma diminuição devagar para evitar os efeitos secundários.
8. Eu entendo que existem sérios riscos em misturar remédios com alteração mental ou substâncias quando eu estou sobre terapia controlada de substâncias. Estes incluem álcool, maconha, narcóticos, sedativos e pilulas para dormir. Tomar outros medicamentos ou substâncias durante a terapia poderia resultar um excesso de sedação e poderia levar a lesão ou morte. Eu não tomarei nenhuma bebida alcoólica, medicamentos sedativos ou outros narcóticos prescritos durante o período da minha terapia sem a autorização por escrita do meu provedor de assistência médica. Eu não usarei nenhuma medicação ou substâncias ilegais.
9. Caso eu tome substâncias controladas durante a gravidez, meu bebê poderá nascer com dependência física destas substâncias ou de outro modo, ser fisicamente prejudicado. Eu informarei imediatamente ao provedor de assistência médica administrando minhas medicações se eu acredito que eu posso estar grávida. Eu informarei qualquer provedor da área pré-natal que eu estou tomando terapia de substâncias controlada.
10. Eu entendo que, por causa dos riscos potenciais e efeitos secundários da minha terapia, e também dos benefícios potenciais, é importante que minha terapia de substâncias controlada seja de perto e cuidadosamente dirigida. Por segurança e eficaz manejo dos meus cuidados, eu concordo que meu provedor de assistência médica poderá dividir as informações necessárias sobre minha terapia com outros provedores de assistência médica. **Eu também concordo que eu irei dar todos os seguimentos das consultas com meu provedor de assistência médica e qualquer outra consulta solicitada. Eu irei cooperar com qualquer monitoração sobre minha terapia que o meu provedor de assistência médica acredite que seja necessário, incluindo aleatoriamente exame médico de urina, exame médico de sangue e pilulas contadas.**
11. Eu entendo que o mau uso ou diversidade de substâncias controladas cria sérios riscos que fazem mal e é ilegal. Meu provedor de assistência médica vai controlar de perto as substâncias da receita médica. Por esta razão, durante o período da minha terapia de substância controlada:

- Eu não vou tentar adquirir substância controlada de outro provedor de assistência médica. Em caso de emergência, eu hei de dizer para o outro provedor de assistência médica que eu estou sob terapia de substância controlada. Eu também notificarei de imediato meu provedor de assistência médica caso eu tenha recebido substâncias controlada de outro médico.
- Eu usarei somente uma farmácia para preencher minhas prescrições e tenho escolhido \_\_\_\_\_ para este propósito.
- Eu entrarei em contato com o escritório do meu provedor de assistência 48 horas antes de terminar meus remédios e então eu poderei recebê-los a tempo.
- Eu concordo que eu não pedirei mais receitas antecipadas e que estas não serão levadas em conta. Isto inclui se os remédios forem roubados, extraviado ou perdidos.
- Eu concordo que eu não pedirei para ter as receitas antecipadas aprovadas fora do horário regular de expediente e entendo que semelhante aprovação não será concedida.
- Eu concordo que irei pegar e assinar por todas as receitas pessoalmente, ao menos que meu provedor de assistência médica concorde com outros planos no futuro.
- Eu entendo que isso é crime em Massachusetts tentar obter substâncias controlada com falso pretexto, incluindo desvirtuando fatos ou deixar de revelar importantes fatos.
- Eu concordo que é perturbador ou inapropriado integração com os funcionários e não será tolerado, e pode resultar deste contrato ser cancelado.

Caso eu não siga este contrato, meu provedor de assistência médica pode decidir que não é seguro continuar com a terapia de substâncias controlada e pode remeter-me a uma avaliação adicional.

\_\_\_\_\_  
Assinatura do paciente                      Data

\_\_\_\_\_  
Assinatura da testemunha                      Data

\_\_\_\_\_  
Assinatura do provedor de assistência médica                      Data

**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 to 3 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° F- 100° 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.

## Sample Office Policy for Urine Collection for Toxicology

**POLICY TITLE:** Collection of Urine Samples for Toxicology

**PURPOSE:** Safe and respectful collection of a unaltered human urine sample

**APPLICABILITY:** BFS practices prescribing chronic opiates, stimulants or benzodiazepines

**PROCESS:**

- 1) Have the patient provide picture ID; clinician can waive this step in the presence of long standing patient relationship. After verifying the picture ID, provide patient with the Urine Toxicology Testing information, if not already familiar.
- 2) Interview the patient to complete the Baseline Urine Testing Information Form (appendix A)
- 3) After explaining to patient reason for doing so, ask patient to prepare for urine sample collection by removing all but one layer of clothing, leaving outer layers and contents of pockets with bags, purses in the examination room. The patient should be encouraged to keep wallet. The clinician should look for any indicator that the patient is in possession of any unusual items that could contain a substance that could alter or dilute a urine specimen.
- 4) Have the patient wash hands vigorously with water but no soap and dry hands completely.
- 5) Prepare the toilet area by turning off the water if possible and spraying the toilet water with diluted blue food coloring.
- 6) Break the urine container's seal in the presence of the patient. Provide the patient with the outer urine container, keeping the 2 small specimen bottles.
- 7) Patient will take the collection bottle into the toilet area alone. Instruct the patient not to flush the toilet and return the specimen as quickly as possible. See "Shy Bladder Protocol" below if patient is unable to void.
- 8) Patient is always permitted to provide the specimen in privacy unless the physician has ordered a direct observed specimen.

9) Wearing non-sterile gloves, receive the specimen from the patient, noting the volume (> 45 cc.) and temperature of the urine.

10) Within 4 minutes of urination, document the urine temperature on Baseline Urine Testing Information Form. The acceptable range is from 32-38 degree C or 90-100 degrees F. Include any comments on the condition of the urine: unusual color, odor or any signs of adulteration,

11) Complete laboratory forms and place the package into the shipping container.

**“Shy Bladder” Protocol**

1) Instruct patient not to drink anything except the water provided by the clinician.

2) The clinician will provide four 10 oz glasses of water

3) The patient has 3 hours to provide the urine specimen

4) Document in the medical record and inform the physician if the patient is unable to adequately in that period of time.

**Supplies:**

BMC Laboratory Request Form

Diluted blue food coloring (1 tsp / 2 cups of water) in spray bottle

Sealed sterile urine containers

Non-sterile gloves

**BASELINE URINE TESTING INFORMATION FORM**

Patient Name \_\_\_\_\_ Today's Date \_\_\_\_\_

Social Security Number \_\_\_\_\_ ID \_\_\_\_\_

Date of Birth \_\_\_\_\_ Telephone # \_\_\_\_\_

■ Alcohol in the last 24 hours      None      How Much \_\_\_\_\_

Medications	Time of last Dose	Prescribing MD
Antianxiety Meds _____	_____	_____
Pain Medications _____	_____	_____
_____	_____	_____
_____	_____	_____

Illicit drugs in the last 30 days      If Yes, When

Marijuana      \_\_\_\_\_

Cocaine      \_\_\_\_\_

Nonprescribed narcotics      What \_\_\_\_\_

Others      What \_\_\_\_\_

Urine Temperature: \_\_\_\_\_ Checked with 4 min

Urine Comments: \_\_\_\_\_ > 45 cc    Y    N

Patient Signature \_\_\_\_\_

Clinical Staff Signature \_\_\_\_\_

REMINDER: One layer  
of clothing, no bags, no purses or coats in the bathroom

## **BASELINE URINE COLLECTION CHECK LIST**

### **PRIOR TO COLLECTION:**

- 1) **Fill out Baseline Urine Testing Information Form**
- 2) **Inspect collection site for being clean and safe**
- 3) **Spray colored dye in the toilet**
- 4) **Turn off the water to the toilet area if possible**
- 5) **Remove unnecessary out garments and bulky items from pockets**
- 6) **Have donor wash and dry hands without soap**
- 7) **Give donor sealed container**
- 8) **Patient remains in the presence of clinician until he/she enters the toilet area**
- 9) **Have the patient keep their wallet**
- 10) **Note urine temperature and characteristics of urine within 4 minutes of urination**

## **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 your 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.
- Ask 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.

## **Electronic Medical Record Integration Alert Submission Process**

### **Purpose of the Berkshire County Community Pain Project**

The Community Pain Project has been organized to help improve the quality of pain management provided throughout Berkshire County while working to reduce the abuse, misuse, and diversion of prescription medication. As is the case when any other patient care issue is co-managed or serially managed by multiple providers, documentation of pain patient assessments, behavior and progress is critical to share across the care team members. As in the case of other coordinated patient care, the EMR is the strongest tool for sharing this information.

### **Who Can Participate**

Any prescriber can add information that may be significant in developing and implementing a patient treatment plan to the patient's EMR at Berkshire Health Systems.

### **How to Participate**

Complete the System Alert Submission Form, Appendix A. Submit in a confidential envelop to the Pain Project Steering Committee via John Rogers' office in the Bishop Clapp Building. After the information is reviewed by the Steering Committee for completeness it will be forwarded to Medical Records Dept for entry into the EMR.

All patients on chronic opioids should, at minimum, have a controlled substance contract (including informed consent provisions) completed by the prescriber and signed by the patient. A patient contract can also be used for patients chronically using other controlled substances after customizing the side effects. If a prescriber reasonably believes that information about a patient's tolerance for or history with controlled substances may be important in future treatment decisions for the patient, those concerns should be communicated to other providers by way of the EMR, along with any behavioral expectations that have been discussed with the patient. Please note that a controlled substance contract should be used and note of its existence entered into the EMR even if there is no concern of abuse or misuse. The existence of a controlled substance contract should be viewed as neutral information and should be considered part of the standard of care when prescribing controlled substances.

### **Controlled Substance Agreement / Pain Management Indicators**

The summary screen is the default screen when the EMR is opened unless there are new results within the last 24 hours. In that case, the **Summary Screen** is accessed by selecting it from the right hand column.

Two distinct types of pain management information will be available from the Summary Screen within the EMR; (1) the existence of a controlled substance agreement and the name of practitioner initiating the agreement, (2) indication of concern, if any, regarding controlled substance use/misuse (substance use / substance abuse; exact system wording to be determined.) The existence of a controlled substance contract will be noted under

Risk/Legal. A history of **Substance Use** creating concern along with the related treatment plan will be seen directly on the summary screen under “Pain Management Plan in the Substance Use section.

**Problem List, Patient**  
 DOB: 1/1/76 31 M M00000012799 / M... 9729 / BHSTV0001098  
 Ht: 66.2 in / Wt: 66.14 lb 5 West 522-1 ADM IN  
 Allergy/ADR: Abacavir, Penicillins, Rabbit Meat, Racepinephrine, p...  
 Summary

Summary List	Substance Use	Indicators	Risk/Legal	Demographics
Providers	Visit	Contacts	Insurance	Abstract
Office 2/22/07 Inpatient 7/28/06	BFS Neighb 522/1	Toomajian, Elizabeth Np Meditech, Doctor		Meditech Test
<b>Current Problems</b> : Mblackman Is My Doctor				
<b>Problem List</b> : Intestinal Infection due to Clostridium Difficile, Mblackman Is My Doctor				
<b>Medications</b>				
Active	Abacavir Sulfate (Ziagen) Ampicillin Sodium 1 gm/Sodium Chloride Aspirin (Aspirin™) Clopidogrel Bisulfate (Plavix) Insulin Human Regular (Regular Insulin (Human)) Nitroglycerin (Nitrol) Simvastatin (Zocor)			
Ambulatory	Acetaminophen (Tylenol) (0 Po q4hprn #10)Active Agalsidase Beta (Fabrazyme) (1mg Iv q2weeks #20)Active Sulfurated Lim500 Ml (500ml Mc 3xw #30)Active Lisinopril (Prinivil) (2.5mg Po daily #30 x5)Active Digoxin (Digoxin) (1tab Po daily #20)Active Acetaminophen (Tylenol) (0 Po q4hprn #30)Active			
<b>Health Maintenance</b>				
Hepatitis B Vaccinat : Yes 04 Sep 19, 2006				
Influenzae Vaccination : No 05 Sep 21, 2006				
Pneumococcal Vaccination : No Nov 14, 2006				
<b>Substance Use</b>				
Positive History:				
Alcohol Use : Yes PCS Comment Mar 27, 2007				
Substance Use : Yes non opiate protocol 3/27/... Mar 27, 2007				
Tobacco Use : Yes PCS Comment Nov 16, 2006				
<b>Procedures</b>				

Record List  
Other Visit  
Special Panels  
24 Hour  
Allergies  
Vital Signs  
I & O  
Notes  
Medications  
Order History  
Laboratory  
Microbiology  
Blood Bank  
Pathology  
Imaging  
Other Rep  
Care Trer  
Care Act  
History  
Summary  
Encounters  
Referrals  
Graph  
Orders  
Document  
Sign  
Other Menu

When the “Pain Management Plan” header is viewable in the **Substance Use** section, an attached note will briefly indicate the reason(s) for the alert and show where to go for further information. This will be contained in a comment directly attached to the alert. The full comment can be viewed by clicking on the callout bubble on the same line. In an effort to keep creation of an alert as objective as possible, the note will include the reason for the alert. Possible criteria are listed below:

- Compliant/No Note Problems
- Overdose History
- Prescription Alteration
- Multiple Lost / Stolen Prescriptions
- Inappropriately Positive / Negative Toxicology Screen
- Frequent Early Renewal Requests
- Dose Escalation Without Authorization
- Multiple Prescribers
- History of Drug Abuse
- Methadone Program
- Buprenorphine Program

# Berkshire Health Systems Community Pain Initiative System Alert Submission Form

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Submitted by: \_\_\_\_\_

Date: \_\_\_\_\_

Signature \_\_\_\_\_

Contact # or Email \_\_\_\_\_

Please check all that apply. Note; a Controlled Substance Agreement **must** be present to submit an alert for a restricted protocol.

Controlled Substance Agreement  
Responsible Physician / NP / PA -- \_\_\_\_\_  
Date of Agreement -- \_\_\_\_\_

- Pain Management Note
- Compliant/No Noted Problems
  - Overdose History
  - Prescription Alteration
  - Multiple Lost / Stolen Prescriptions
  - Inappropriately Positive / Negative Toxicology Screening
  - Frequent Early Renewal Requests
  - Dose Escalation without Authorization
  - Multiple Prescribers
  - History of Substance Abuse
  - Methadone Program
  - Buprenorphine Program
  - Restricted Opiate Protocol
  - Other (please explain)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Steering Committee Review

Date \_\_\_\_\_

Name \_\_\_\_\_

Signature \_\_\_\_\_

Entered by Medical Records

Date \_\_\_\_\_

Name \_\_\_\_\_

Signature \_\_\_\_\_

## **Screening Forms**

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

## PRIMARY CARE SCREENING TOOL FOR ADULT PATIENTS WITH PAIN

<b>1. During the past month, how much of the time were you a happy person?</b> [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
<b>2. How much of the time during the past month, have you felt calm and peaceful?</b> [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
<b>3. How much of the time, during the past month, have you been a very nervous person?</b>	
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
<b>4. How much of the time, during the past month, have you felt downhearted and blue?</b>	
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
<b>5. How much of the time, during the past month, did you feel so down in the dumps that nothing could cheer you up?</b>	
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
<b>6. In the past year, have you ever drunk or used drugs more than you meant to?</b>	Y    N
<b>7. Have you felt you wanted or needed to cut down on your drinking or drug use in the past year?</b>	Y    N

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

No  
Pain

Worst Ever  
Pain

|-----|

PROTOCOL # \_\_\_\_\_

INSTITUTION \_\_\_\_\_

PATIENT SEQUENCE # \_\_\_\_\_

HOSPITAL CHART # \_\_\_\_\_

DO NOT WRITE ABOVE THIS LINE

# Brief Pain Inventory

Date: \_\_\_/\_\_\_/\_\_\_

Name: \_\_\_\_\_  
Last First Middle Initial

Phone: (\_\_\_\_) \_\_\_\_\_ Sex:  Female  Male

Date of Birth: \_\_\_/\_\_\_/\_\_\_

### 1) Marital Status (at present)

- 1.  Single
- 2.  Married
- 3.  Widowed
- 4.  Separated/Divorced

### 2) Education (Circle only the highest grade or degree completed)

Grade	0	1	2	3	4	5	6	7	8	9
	10	11	12	13	14	15	16	M.A./M.S.		

Professional degree (please specify) \_\_\_\_\_

### 3) Current occupation

(specify titles; if you are not working, tell us your previous occupation)

### 4) Spouse's occupation

### 5) Which of the following best describes your current job status?

- 1.  Employed outside the home, full-time
- 2.  Employed outside the home, part-time
- 3.  Homemaker
- 4.  Retired
- 5.  Unemployed
- 6.  Other

6) How long has it been since you first learned your diagnosis? \_\_\_\_\_ months

### 7) Have you ever had pain due to your present disease?

- 1.  Yes
- 2.  No
- 3.  Uncertain

8) When you first received your diagnosis, was pain one of your symptoms?

1.  Yes                      2.  No                      3.  Uncertain

9) Have you had surgery in the past month?                      1.  Yes                      2.  No

If YES, what kind? \_\_\_\_\_

10) Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, toothaches). Have you had pain **other** than these everyday kinds of pain during the **last week**?

1.  Yes    2.  No

10a) Did you take pain medications in the last 7 days?

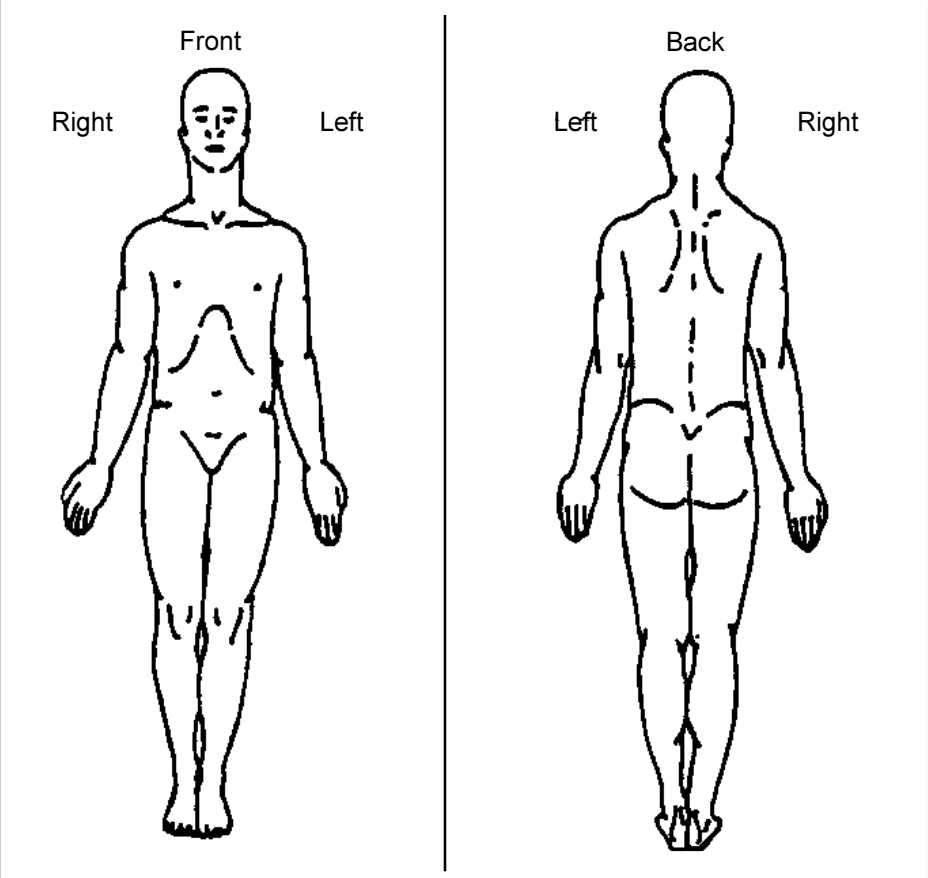
1.  Yes    2.  No

10b) I feel I have some form of pain now that requires medication each and every day.

1.  Yes    2.  No

IF YOUR ANSWERS TO 10, 10a, AND 10b WERE **ALL NO**, PLEASE STOP HERE AND GO TO THE LAST PAGE OF THE QUESTIONNAIRE AND SIGN WHERE INDICATED ON THE BOTTOM OF THE PAGE.  
IF ANY OF YOUR ANSWERS TO 10, 10a, AND 10b WERE **YES**, PLEASE CONTINUE.

11) On the diagram, shade in the areas where you feel pain. Put an X on the area that hurts the most.





20) If you take pain medication, how many hours does it take before the pain returns?

- |   |   |
|---|---|
| 1. <input type="checkbox"/> Pain medication doesn't help at all | 5. <input type="checkbox"/> Four hours                    |
| 2. <input type="checkbox"/> One hour                            | 6. <input type="checkbox"/> Five to twelve hours          |
| 3. <input type="checkbox"/> Two hours                           | 7. <input type="checkbox"/> More than twelve hours        |
| 4. <input type="checkbox"/> Three hours                         | 8. <input type="checkbox"/> I do not take pain medication |

21) Check the appropriate answer for each item.

I believe my pain is due to:

- |                              |                             |  |
|------------------------------|-----------------------------|--|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | 1. The effects of treatment (for example, medication, surgery, radiation, prosthetic device).                        |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | 2. My primary disease (meaning the disease currently being treated and evaluated).                                   |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | 3. A medical condition unrelated to my primary disease (for example, arthritis).<br>Please describe condition: _____ |

22) For each of the following words, check Yes or No if that adjective applies to your pain.

- |             |                              |                             |
|-------------|------------------------------|-----------------------------|
| Aching      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Throbbing   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Shooting    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Stabbing    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Gnawing     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Sharp       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Tender      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Burning     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Exhausting  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Tiring      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Penetrating | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Nagging     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Numb        | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Miserable   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Unbearable  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

23) Circle the one number that describes how, during the past week, **pain** has interfered with your:

**A. General Activity**

0 1 2 3 4 5 6 7 8 9 10  
Does not interfere Completely interferes

**B. Mood**

0 1 2 3 4 5 6 7 8 9 10  
Does not interfere Completely interferes

**C. Walking Ability**

0 1 2 3 4 5 6 7 8 9 10  
Does not interfere Completely interferes

**D. Normal Work (includes both work outside the home and housework)**

0 1 2 3 4 5 6 7 8 9 10  
Does not interfere Completely interferes

**E. Relations with other people**

0 1 2 3 4 5 6 7 8 9 10  
Does not interfere Completely interferes

**F. Sleep**

0 1 2 3 4 5 6 7 8 9 10  
Does not interfere Completely interferes

**G. Enjoyment of life**

0 1 2 3 4 5 6 7 8 9 10  
Does not interfere Completely interferes

24) I prefer to take my pain medicine:

- 1.  On a regular basis
- 2.  Only when necessary
- 3.  Do not take pain medicine

25) I take my pain medicine (in a 24 hour period):

- 1.  Not every day
- 2.  1 to 2 times per day
- 3.  3 to 4 times per day
- 4.  5 to 6 times per day
- 5.  More than 6 times per day

26) Do you feel you need a stronger type of pain medication?

- 1.  Yes
- 2.  No
- 3.  Uncertain

27) Do you feel you need to take more of the pain medication than your doctor has prescribed?

- 1.  Yes
- 2.  No
- 3.  Uncertain

28) Are you concerned that you use too much pain medication?

- 1.  Yes
- 2.  No
- 3.  Uncertain

If Yes, why?

---

---

29) Are you having problems with side effects from your pain medication?

- 1.  Yes
- 2.  No

Which side effects?

---

30) Do you feel you need to receive further information about your pain medication?

- 1.  Yes
- 2.  No

31) Other methods I use to relieve my pain include: (Please check all that apply)

- Warm compresses
- Cold compresses
- Relaxation techniques
- Distraction
- Biofeedback
- Hypnosis
- Other  Please specify \_\_\_\_\_

32) Medications not prescribed by my doctor that I take for pain are:

---

---

Please sign the back of this questionnaire.



1903

Date:  /  /   
(month) (day) (year)

Study Name: \_\_\_\_\_

Subject's Initials : \_\_\_\_\_

Protocol #: \_\_\_\_\_

Study Subject #:

PI: \_\_\_\_\_

Revision: 07/01/05

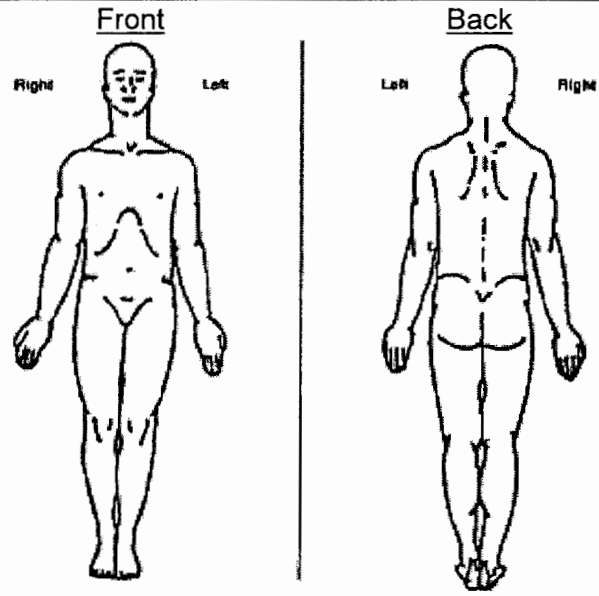
PLEASE USE  
BLACK INK PEN

### Brief Pain Inventory (Short Form)

1. Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain other than these everyday kinds of pain today?

Yes  No

2. On the diagram, shade in the areas where you feel pain. Put an X on the area that hurts the most.



3. Please rate your pain by marking the box beside the number that best describes your pain at its **worst** in the last 24 hours.

0  1  2  3  4  5  6  7  8  9  10  
 No Pain Pain As Bad As You Can Imagine

4. Please rate your pain by marking the box beside the number that best describes your pain at its **least** in the last 24 hours.

0  1  2  3  4  5  6  7  8  9  10  
 No Pain Pain As Bad As You Can Imagine

5. Please rate your pain by marking the box beside the number that best describes your pain on the **average**.

0  1  2  3  4  5  6  7  8  9  10  
 No Pain Pain As Bad As You Can Imagine

6. Please rate your pain by marking the box beside the number that tells how much pain you have **right now**.

0  1  2  3  4  5  6  7  8  9  10  
 No Pain Pain As Bad As You Can Imagine



## The Pain Assessment & Documentation Tool:

### Fulfilling the Critical Task of Documenting Provider Decisions Concerning Patients on Chronic Controlled Substances

Although complete and timely documentation of clinical decision making is a critical element of all patient care, proper documentation has added importance in chronic pain management and prescription of controlled substance.

Effective management of patients over time and across providers cannot meaningfully occur without effective documentation. In addition, that documentation is an essential tool in the provider's effort to find the right clinical intervention for the vast majority of patients who legitimately require treatment for chronic pain and to detect those individuals who are seeking prescription pain medication for non-medical purposes.

Although there are occasional news reports of physicians being prosecuted over their prescribing practices, the DEA and other law enforcement agencies have made it clear that their intent is pursue only those providers whose prescribing of drugs is disconnected from medical decision-making and patient care. Effective documentation of clinical decision making is, therefore, also an essential protective tool for providers who prescribe pain medication.

The response to the challenges of managing patients complaining of chronic pain—properly assessing the patient's needs, identifying those seeking drugs for non-medical purposes, avoiding issues with law enforcement—should not, of course, be to decline to accept such patients but rather to have available the tools necessary to manage them well.

One valuable aid is the **Pain Assessment & Diagnostic Tool** ("PADT"). Four domains have been proposed as most important for surveillance of chronic pain patients on opioid therapy:

- Relief from pain;
- Side effects;
- Physical and psychosocial functioning; and
- Occurrence of any potentially aberrant (or non-compliant) drug-related behaviors.

These four domains have been summarized as the "4 A's" (analgesia, activities of daily living, adverse side effects, and aberrant drug-taking behaviors). Changes in any of these domains over time should affect ongoing treatment decisions and be part of the documentation for the clinical use of prescribed controlled drugs.

The **PADT** is a simple, reliable way to meet these requirements and should be included in the patient's permanent record. Russell Portenoy and others have validated the tool and its components in previous studies.

After using the Brief Pain Inventory-long form to set goals (the critical first step in planning), the **PADT** will be helpful in evaluating patient progress over time. Open-ended prescription writing of opioid medication *without* documentation of some clear *functional improvement* (including specific examples) in the patient's day to day life may be construed as inadequate justification of opioid usage. On the other hand, pain scores or functional activities that meet goals and the absence of the adverse side effects and aberrant behavior—also as documented through the use of the **PADT**—will generally substantiate ongoing prescribing.

# 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Family relationships	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Social relationships	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Mood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Sleep patterns	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Overall functioning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

\* 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.

(Continued on reverse side)

# 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Mental cloudiness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Sweating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Drowsiness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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 medication
- 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                      Comments: \_\_\_\_\_
- Adjust dose of present analgesic                      \_\_\_\_\_
- Switch analgesics                      \_\_\_\_\_
- Add/Adjust concomitant therapy                      \_\_\_\_\_
- Discontinue/taper off opioid therapy                      \_\_\_\_\_

Date: \_\_\_\_\_ Physician's signature: \_\_\_\_\_

## **The Screener and Opioid Assessment for Patients in Pain Being Considered for Long-Term Opioid Therapy**

The SOAPP is designed to be a quick and easy-to-use questionnaire designed to help providers evaluate a pain patient's relative risk for developing problems when placed on long-term opioid therapy. The SOAPP is **NOT** intended to be the single determining tool to rule out patients for chronic or long-term opioid therapy. Along with other clinical information, the SOAPP data can help the provider make a risk-benefit assessment with regard to the use of opioid therapy and therefore, should be administered prior to initiating therapy. If opioid therapy is being considered as an option, the SOAPP can help the provider determine the level of monitoring that may be necessary to safely prescribe long-term opioid therapy for a given patient. In addition, clinicians are recommended to have conversations with their patients about the risks associated with a narcotic or opioid pain management regimen and the answers to the SOAPP tool can be used to highlight concerns and guide the discussion.

Both a long form (24Q) and a short form (5Q) SOAPP are provided. An individual who scores an 8 on the SOAPP 24Q or a 5 on the SOAPP-5Q is considered in the high-risk category for aberrant opioid use behaviors. The SOAPP may have false positives, so some patients with scores at 7 or above on the 24Q or 4 or above 5Q SOAPP will turn out to not exhibit aberrant behaviors. Likewise, the low, but present, false negative rate means that even some who score below the cutoff will later demonstrate problems.

The 24Q SOAPP is a sensitive test. A cutoff score of 7 has a sensitivity of .91% meaning that it correctly classified 91% of the patients who actually went on to exhibit aberrant behaviors. Its specificity is only 69%. 31% of the people, who scored a 7 or higher on the SOAPP, did not go on to show detectable aberrant behavior (N. Katz).

A score of 4 or higher for the SOAPP 5Q has a specificity of 86% in predicting aberrant behaviors in the use of opioids. The Negative Predictive Values for a cutoff score of 4 is 85%, which means that most people who have a SOAPP score of 4 or below are likely to be at low-risk. Finally, the positive likelihood ratio suggests that a positive SOAPP score (at a cutoff of 4) is more than two and half times (2.59 times) as likely to come from someone who is actually at high risk (compare with 2.94 for the score above 7 on the 24Q SOAPP). This implies a cutoff score of 4 will ensure that the provider is least likely to miss someone who is really at high risk.

### **Recommendations for Patient Care Based on Risk Status:**

#### **High Risk Patients:**

- Past medical records should be obtained and contact with previous and current providers should be established and maintained.
- Clinic visits should be on a frequent and regular 4-8 week schedule
- Patients should also be told that they would be expected to give a urine sample for a toxicology screen during every clinic visit. They should initially be given limited prescriptions without refills (e.g., every 1-2-week supply)
- In cooperation with the patient, family members should be interviewed and involvement with an addiction medicine specialist and/or mental health professional

should be sought. The consent for family involvement could be incorporated into the contract and informed consent.

- Although all forms of narcotics are subject to abuse, less abusable formulations or chemical entities should be considered (e.g., long-acting versus short-acting opioids, transdermal versus oral preparation).
- Early signs of aberrant behavior and a violation of the opioid agreement should result in a change in treatment plan. Depending on the degree of violation, one might consider more restricted monitoring, or if resources are limited, referring the patient to a program where opioids can be prescribed under stricter conditions. If violations or aberrant behaviors persist, it may be necessary to discontinue opioid therapy.

#### **Moderate Risk Patients:(near cut-off)**

- These patients are probably best treated by concomitant psychological interventions in which they can learn to increase their pain-coping skills, decrease depression and anxiety, and have more frequent monitoring of their compliance.
- Periodic urine screens are recommended.
- After a period in which no signs of aberrant behavior are observed, less frequent clinic visits may be indicated. If there are any violations of the opioid agreement, then regular urine screens and frequent clinic visits would be recommended.
- With two or more violations of the opioid agreement, an assessment by an addiction medicine specialist and/or mental health professional should be mandated.
- After repeat violations referral to a substance abuse program would be recommended. A recurrent history of violations would also be grounds for tapering and discontinuing opioid therapy

#### **Low Risk Patients:**

- Review of SOAPP questions is likely not indicated, unless the provider is aware of inconsistencies or other anomaly in patient history/report.
- Frequent urine screens are not indicated.
- Worry less about the type of opioid to be prescribed and the frequency of clinic visits.
- Efficacy of opioid therapy should be re-assessed every six months, and urine toxicology screens and update of the opioid therapy agreement would be recommended annually.

#### **All Patients:**

Regardless of a patient's SOAPP score, these recommendations should be considered:

- Patients should read and sign an opioid therapy agreement that outlines the patient's responsibilities and clinic policies.
- Patients should be advised of their risks for addiction, dependence and drug side effects
- Remember, the SOAPP is NOT a lie detector. Particularly if the SOAPP score suggests low risk, the provider should be alert to inconsistencies in the patient report or with a collateral report. As the provider gains experience with a particular patient, the provider's view of how vulnerable the patient is to aberrant behavior will be continually revised and refined. Experience with the patient will provide the most important data that you can get.

## SOAPP- SF ®

Name: \_\_\_\_\_ Date: \_\_\_\_\_

The following are some questions given to all patients in our practice who are on or being considered for opioids for their pain. Please answer each question as honestly as possible. This information is for our records and will remain confidential.

Your answers alone will not determine your treatment. Thank you.

Please answer the questions below using the following scale: 0 = Never, 1 = Seldom, 2 = Sometimes, 3 = Often, 4 = Very Often

1. How often do you have mood swings?

0 1 2 3 4

2. How often do you smoke a cigarette within an hour after you wake up?

0 1 2 3 4

3. How often have you taken medication other than the way that it was prescribed?

0 1 2 3 4

4. How often have you used illegal drugs (for example, marijuana, cocaine, etc.) in the past five years?

0 1 2 3 4

5. How often, in your lifetime, have you had legal problems or been arrested?

0 1 2 3 4

Please include any additional information you wish about the above answers. Thank you.

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## SOAPP ® Version 1.0

Name: \_\_\_\_\_ Date: \_\_\_\_\_

The following are some questions given to all patients in our practice who are on or being considered for opioids for their pain. Please answer each question as honestly as possible.

This information is for our records and will remain confidential.

Your answers alone will not determine your treatment. Thank you.

Please answer the questions below using the following scale: 0 = Never, 1 = Seldom, 2 = Sometimes, 3 = Often, 4 = Very Often

1. How often do you feel that your pain is “out of control?” 0 1 2 3 4
2. How often do you have mood swings? 0 1 2 3 4
3. How often do you do things that you later regret? 0 1 2 3 4
4. How often has your family been supportive and encouraging? 0 1 2 3 4
5. How often have others told you that you have a bad temper? 0 1 2 3 4
6. Compared with other people, how often have you been in a car accident? 0 1 2 3 4
7. How often do you smoke a cigarette within an hour after you wake up? 0 1 2 3 4
8. How often have you felt a need for higher doses of medication to treat your pain?  
0 1 2 3 4
9. How often do you take more medication than you are supposed to? 0 1 2 3 4
10. How often have any of your family members, including parents and grandparents, had a problem with alcohol or drugs? 0 1 2 3 4
11. How often have any of your close friends had a problem with alcohol or drugs?  
0 1 2 3 4
12. How often have others suggested that you have a drug or alcohol problem? 0 1 2 3 4
13. How often have you attended an AA or NA meeting? 0 1 2 3 4
14. How often have you had a problem getting along with the doctors who prescribed your medicines? 0 1 2 3 4

## **Multidisciplinary Pain Program**

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

## **Integrative Pain Treatment Program**

Chronic pain is one of the most pervasive and intractable medical conditions in the United States; affects 10% of Americans.<sup>1</sup> Berkshire County experience reflects this rate of affliction. Chronic pain can be devastating, impacting the lives of patients and their families at many levels.

Although frequently helpful in providing relief, medications and interventional procedures have not proved *curative* for most patients with the disease of chronic pain. Moreover, in the absence of other interventions, medications alone help fewer than one third of patients, can be associated with adverse side effects and lead to the development of aberrant behaviors in some.<sup>2</sup>

The foundation of treatment for patients with chronic pain is a multidisciplinary approach carried out by specialists who are trained in pain medicine.<sup>3</sup> Teaching patients to manage their own nervous systems through behavioral transformation and the rational use of medications is of proven benefit for patients with chronic pain.<sup>4</sup> Through a process that includes detailed evaluation, setting measurable goals and collecting outcome data, the benefit of these behavioral interventions and medications can be accurately assessed.

Now, through the use of a single telephone number, your patient may be referred to a team of pain, behavioral and functional specialists who will perform an in-depth medical, psychological and functional assessment. They will determine if a multidisciplinary approach is appropriate for your patient and if so, the patient will be offered the opportunity to participate in a six-week multidisciplinary program. This program will engage the patient to adopt behaviors that will mitigate pain and suffering on several levels: the biochemical level, the structural level, the psychological level, the behavioral level and the level. The team will also evaluate whether prescribed medications are having a positive influence on your patient's life or having a detrimental effect.

A multidisciplinary approach is crucial since the disease of chronic pain affects many aspects of your patient's life. Each patient will be evaluated by a psychologist, an occupational therapist and a pain medicine specialist, certified by the American Board of Medical Specialties. This team will construct a program of measurable goals unique to each participating 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 another physician within the Berkshire medical community, or other professionals or program as deemed necessary (e.g. nutrition counseling, smoking cessation or physical therapy).

Once the appropriate goals are determined, each patient will participate in concurrent specialty care and a program that includes twice-weekly cognitive-behavioral group sessions, which will address pain and pain management holistically. Each patient will also participate in twice-weekly restorative movement classes that will help patients overcome their fear of movement, recondition them and teach them to exercise safely.

## **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., psychiatry 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?***

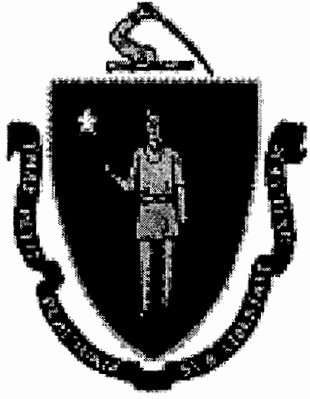
A. Deciding not to report a suspected effort to obtain controlled substances by false pretenses also carries some risk for the provider (as well as the patient and community), at least in those cases where the patient moves on to another provider and is successful in obtaining the controlled substance. 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](mailto: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**  
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**Boston, Massachusetts 02118**

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**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

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**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<sup>1</sup> and cancer-related pain.<sup>2</sup> 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: BOARD OF REGISTRATION IN NURSING

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

#### Section

- 4.11: Categories of Nurses Practicing in Expanded Role
- 4.22: Development, Approval and Review of Guidelines for Nurse Midwives, Nurse Practitioners and Nurse Anesthetists (Excerpts)
- 4.23 :Development, Approval and Review of Guidelines for Psychiatric Nurse Mental Health Specialists
- 4.27: Self-Prescribing and Prescribing for Family Members

#### 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: BOARD OF REGISTRATION OF PHYSICIAN ASSISTANTS

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

#### Section

- 5.04: Scope of Services Which May be Performed
- 5.05: Scope of Supervision Required
- 5.07: Prescription Practices of a Physician Assistant
- 5.08: Legal Responsibility for Actions of Physician Assistant

#### 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 regimen 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 be 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 be 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.

## **BHS and Community Resources**

<b>Alcoholic Anonymous</b>	1-413-443-0212
<b>Addiction Evaluation and Treatment</b>	
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
<b>Multidisciplinary Chronic Pain Program</b>	1-413-447-2242
Physical Medicine	
Psychology	
Occupational Therapy	
<b>Narcotics Anonymous</b>	1-413-443-4377
<b>New England Pain Diagnosis &amp; Treatment Ctr</b>	1-413-445-7246
<b>Nutrition / Counseling</b>	1-413-447-2671
<b>Psychological Services</b>	
Primary Care Outreach Team	1-413-447-2169
John Harrington, Ph.D. *	1-413-447-2352
Carolyn Killian, LMHC	1-413-447-2145
<b>Psychiatric Crisis Team–Avail. 24/7</b>	1-413-499-0227
	1-800-252-0412
<b>Smoking Cessation Counseling</b>	1-413-499-2602
<b>Urine Toxicology Screening - BMC</b>	1-413-447-2592
Larry Spatz, PhD.	
<b>Legal Counsel -John Rogers, VP / BHS</b>	1-413-445-9529

For questions or suggestions regarding Pain Manual, contact Denise Rose (413-395-7980)  
or email [painmanual@bhs1.org](mailto: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 (2<sup>nd</sup> 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	<a href="http://www.guidelines.gov">www.guidelines.gov</a>
American Pain Society	<a href="http://www.ampainsoc.org">www.ampainsoc.org</a>
American Academy of Physical Medicine & Rehabilitation	<a href="http://www.aapmr.org">www.aapmr.org</a>
American College of Rheumatology	<a href="http://www.rheumatology.org">www.rheumatology.org</a>
American Academy of Family Physicians	<a href="http://www.aafp.org">www.aafp.org</a>
American Academy of Pain Medicine	<a href="http://www.painmed.org">www.painmed.org</a>
American Pain Foundation	<a href="http://www.painfoundation.org">www.painfoundation.org</a>
American Academy of Pain Management	<a href="http://www.aapainmanage.org">www.aapainmanage.org</a>
American Society for Pain Management Nursing	<a href="http://www.aspmn.org">www.aspmn.org</a>
American Society of Addiction Medicine	<a href="http://www.asam.org">www.asam.org</a>
Chronic Pain Foundation	<a href="http://www.chronicpainfoundation.org">www.chronicpainfoundation.org</a>
Institute for Clinical Systems Improvements	<a href="http://www.icsi.org">www.icsi.org</a>
International Association for the Study of Pain	<a href="http://www.iasp-pain.org">www.iasp-pain.org</a>
Massachusetts Board of Registration in Medicine	<a href="http://www.massmedboard.org">www.massmedboard.org</a>
National Foundation for the Treatment of Pain	<a href="http://www.paincare.org">www.paincare.org</a>
National Pain Foundation	<a href="http://www.nationalpainfoundation.org">www.nationalpainfoundation.org</a>
North American Spine Society	<a href="http://www.spine.org">www.spine.org</a>
Wisconsin Medical Society	<a href="http://www.wisconsinmedicalsociety.org">www.wisconsinmedicalsociety.org</a>