Pain Management Resource Guide

Created by faculty committed to improving care for patients experiencing pain

Daniel Clauw, MD – University of Michigan: Professor of Anesthesiology, Medicine & Psychiatry; Director of Chronic Pain and Fatigue Research Center

Glenn Dregansky, DO – Western Michigan University: Program Director for WMU Homer Stryker School of Medicine's Family Medicine Residency Program

James Hudson, MD – Medical Director of the Pain Center at Mary Free Bed Rehabilitation Services

Eric Lake, MA, LLP, CADC – Mary Free Bed Rehabilitation Services: Psychologist, Pain Rehabilitation Program

Timothy Phillips, PT, DPT, MTC – Spectrum Health: Lead physical therapist, Grand Rapids, MI

Eva Quirion, FNP PhD – St. Joseph Healthcare: Nurse Practitioner specializing in treatment of pain and substance use disorder

David Williams, PhD – University of Michigan: Professor of Anesthesiology, Medicine, Psychiatry & Psychology; Associate Director of the Chronic Pain and Fatigue Research Center

Phillip Baty, MD – Michigan Center for Clinical Systems Improvement, (Mi-CCSI): Medical Director

Susan Vos, BSN – Michigan Center for Clinical Systems Improvement, (Mi-CCSI): Program Director

Amy Wales – Michigan Center for Clinical Systems Improvement, (Mi-CCSI): Administrative Coordinator

Steve Williams – Michigan Center for Clinical Systems Improvement, (Mi-CCSI): Executive Director

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Michigan Center for Clinical Systems Improvement

www.miccsi.org

Mi-CCSI Pain Management Resource Guide

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Risk Stratification Tools

- Guidance using the Michigan Automated Prescription System (MAPS)

https://www.michigan.gov/lara/0,4601,7-154-89334_72600_72603_55478---,00.html

Assessment and Screening tools

- ## PHQ Screening

Source: Pfizer, Inc.; online: US Preventive Service Task Force www.uspreventifveservicestaskforce.org

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
		add columns	+	+

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all _____ Somewhat difficult _____ Very difficult _____ Extremely difficult _____

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- **GAD 7**

Source: SAMSHA.gov https://www.integration.samhsa.gov/clinical-practice/gad708.19.08cartwright.pdf

Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column	+	+	+	
Total Score *(add your column scores)* =				

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all _____
Somewhat difficult _____
Very difficult _____
Extremely difficult _____

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Inern Med.* 2006;166:1092-1097.

Assessment and Screening tools

• Opioid Risk Tool

Source: NIH National Institute on Drug Abuse
https://www.drugabuse.gov/sites/default/files/files/OpioidRiskTool

Opioid Risk Tool

This tool should be administered to patients upon an initial visit prior to beginning opioid therapy for pain management. A score of 3 or lower indicates low risk for future opioid abuse, a score of 4 to 7 indicates moderate risk for opioid abuse, and a score of 8 or higher indicates a high risk for opioid abuse.

Mark each box that applies	Female	Male
Family history of substance abuse		
Alcohol	1	3
Illegal drugs	2	3
Rx drugs	4	4
Personal history of substance abuse		
Alcohol	3	3
Illegal drugs	4	4
Rx drugs	5	5
Age between 16—45 years	1	1
History of preadolescent sexual abuse	3	0
Psychological disease		
ADD, OCD, bipolar, schizophrenia	2	2
Depression	1	1
Scoring totals		

Questionnaire developed by Lynn R. Webster, MD to asses risk of opioid addiction.

Webster LR, Webster R. Predicting aberrant behaviors in Opioid-treated patients: preliminary validation of the Opioid risk too. Pain Med. 2005; 6 (6) : 432

Assessment and Screening tools

• Pain Catastrophizing Tool

Source: http://sullivan-painresearch.mcgill.ca/pdf/pcs/Measures_PCS_Adult_English.pdf

Pain Catastrophizing Scale (Copyright 1995, 2001, 2004, 2006, 2009 Michael JL Sullivan, PhD)
Everyone experiences painful situations at some point in their lives. Such experiences may include headaches, tooth pain, joint or muscle pain. People are often exposed to situations that may cause pain such as illness, injury, dental procedures or surgery.

We are interested in the types of thoughts and feeling that you have when you are in pain. Listed below are thirteen statements describing different thoughts and feelings that may be associated with pain. Using the scale, please indicate the degree to which you have these thoughts and feelings when you are experiencing pain.

	Not at all	To a slight degree	To a moderate degree	To a great degree	All the time
I worry all the time about whether the pain will end	0	1	2	3	4
I feel I can't go on	0	1	2	3	4
It's terrible and I think it's never going to get any better	0	1	2	3	4
It's awful and I feel that it overwhelms me	0	1	2	3	4
I feel I can't stand it anymore	0	1	2	3	4
I become afraid that the pain will get worse	0	1	2	3	4
I keep thinking of other painful events	0	1	2	3	4
I anxiously want the pain to go away	0	1	2	3	4
I can't seem to keep it out of my mind	0	1	2	3	4
I keep thinking about how much it hurts	0	1	2	3	4
I keep thinking about how badly I want the pain to stop	0	1	2	3	4
There's nothing I can do to reduce the intensity of the pain	0	1	2	3	4
I wonder whether something serious may happen	0	1	2	3	4

Assessment and Screening tools

- **Substance Use disorder screening**
  - **Brief health screen -** Source: SBIRT Oregon: http://www.sbirtoregon.org/wp-content/uploads/Brief-screen-English-pdf.pdf
  - **Alcohol screening questionnaire (AUDIT) -** Source: SBIRT Oregon: http://www.sbirtoregon.org/wp-content/uploads/AUDIT-English-pdf.pdf
  - **Adult Drug screening questionnaire (DAST) -** Source: SBIRT Oregon: http://www.sbirtoregon.org/wp-content/uploads/DAST-English-pdf.pdf
  - **S2BI: Teen health screen (Ages 12-17)-** Source: SBIRT Oregon: http://www.sbirtoregon.org/wp-content/uploads/S2BI-English-pdf.pdf
  - **ASSIST-** The ASSIST is designed to be administered by a health professional as part of a verbal interview with an adult patient. Alternatively, it can be self-administered electronically, applying automatic skip patterns based on patient answers
    Source: SBIRT Oregon:
    http://www.sbirtoregon.org/wp-content/uploads/Modified-ASSIST-English-pdf.pdf

Assessment and Screening tools

- ## Clinical Opiate Withdrawal Scale

Source: NIH National Institute on Drug Abuse:
https://www.drugabuse.gov/sites/default/files/files/ClinicalOpiateWithdrawalScale.pdf

APPENDIX 1
Clinical Opiate Withdrawal Scale

For each item, circle the number that best describes the patient's signs or symptom. Rate on just the apparent relationship to opiate withdrawal. For example, if heart rate is increased because the patient was jogging just prior to assessment, the increase pulse rate would not add to the score.

Patient's Name:_____ Date and Time ____/____/____:_____

Reason for this assessment:_____

Resting Pulse Rate: _____beats/minute *Measured after patient is sitting or lying for one minute* 0 pulse rate 80 or below 1 pulse rate 81-100 2 pulse rate 101-120 4 pulse rate greater than 120	**GI Upset:** *over last 1/2 hour* 0 no GI symptoms 1 stomach cramps 2 nausea or loose stool 3 vomiting or diarrhea 5 multiple episodes of diarrhea or vomiting
Sweating: *over past 1/2 hour not accounted for by room temperature or patient activity.* 0 no report of chills or flushing 1 subjective report of chills or flushing 2 flushed or observable moistness on face 3 beads of sweat on brow or face 4 sweat streaming off face	**Tremor** *observation of outstretched hands* 0 no tremor 1 tremor can be felt, but not observed 2 slight tremor observable 4 gross tremor or muscle twitching
Restlessness *Observation during assessment* 0 able to sit still 1 reports difficulty sitting still, but is able to do so 3 frequent shifting or extraneous movements of legs/arms 5 unable to sit still for more than a few seconds	**Yawning** *Observation during assessment* 0 no yawning 1 yawning once or twice during assessment 2 yawning three or more times during assessment 4 yawning several times/minute
Pupil size 0 pupils pinned or normal size for room light 1 pupils possibly larger than normal for room light 2 pupils moderately dilated 5 pupils so dilated that only the rim of the iris is visible	**Anxiety or Irritability** 0 none 1 patient reports increasing irritability or anxiousness 2 patient obviously irritable or anxious 4 patient so irritable or anxious that participation in the assessment is difficult
Bone or Joint aches *If patient was having pain previously, only the additional component attributed to opiates withdrawal is scored* 0 not present 1 mild diffuse discomfort 2 patient reports severe diffuse aching of joints/muscles 4 patient is rubbing joints or muscles and is unable to sit still because of discomfort	**Gooseflesh skin** 0 skin is smooth 3 piloerrection of skin can be felt or hairs standing up on arms 5 prominent piloerrection
Runny nose or tearing *Not accounted for by cold symptoms or allergies* 0 not present 1 nasal stuffiness or unusually moist eyes 2 nose running or tearing 4 nose constantly running or tears streaming down cheeks	Total Score _____ The total score is the sum of all 11 items Initials of person completing assessment: _____

Score: 5-12 = mild; 13-24 = moderate; 25-36 = moderately severe; more than 36 = severe withdrawal

This version may be copied and used clinically.

Downloaded by [HSRL - Health Science Research Library] at 14:04 02 September 2015

Source: Wesson, D. R., & Ling, W. (2003). The Clinical Opiate Withdrawal Scale (COWS). *J Psychoactive Drugs*, 35(2), 253–9.

Office Based Addiction Treatment Resources
Office Based Addiction Treatment Clinical Guidelines

Source: OBAT TTA https://www.bmcobat.org/resources/?category=1

Guidelines and Tools include:

- DSM-5 Opioid Use Disorder
- DSM-5 Alcohol Use Disorder
- Telephone Screening
- Nursing Intake, Induction and Follow-Up Forms
- Intake Check-List
- Consents
- Agreements - Buprenorphine/Naloxone Treatment Agreements
- Patient Handouts
- Clinical Tools

Source: Case Management Society of America CMAG: Pain http://www.cmsa.org/cmag/

- Current definitions for pain and pain types
- The prevalence of pain in the U.S.
- The complications of pain
- The economic impact of pain
- Prevalent pain treatment modalities
- Other disease processes that might contribute to pain
- Adherence challenges
- CMAG assessment and intervention tools specific to the individual with pain
- Resources available for individuals with pain as well as for healthcare professionals

Morphine Equivalent Calculators

- **CDC Guideline for Prescribing Opioids for Chronic Pain**
  https://www.cdc.gov/drugoverdose/prescribing/guideline.html

- **Oregon Health Authority – Oregon Pain Guidance**
  https://www.oregonpainguidance.org/opioidmedcalculator/

- **AAFP Chronic Pain Management Toolkit – Conversion Table**
  https://www.aafp.org/dam/AAFP/documents/patient_care/pain_management/conversion-table.pdf

- **AMDG Agency Medical Directors' Group – Conversion Table**
  http://www.agencymeddirectors.wa.gov/calculator/dosecalculator.htm

Non-invasive provider

- ## Physical Therapy

  Source: Tim Phillips

  https://www.miccsi.org/resources/pain-management-resources/

Mi-CCSI Center for Clinical Systems Improvement

PHYSICAL THERAPY: REFERRAL & TREATMENT BARRIERS & TOOLKIT

Expectations/ Buy In

Are you interested in improving how you move and function?

How long do you think you need to work with PT to start seeing meaningful changes?

Are you willing to do exercises & stretching and a home program- or do you think that massage, Ultrasound or electrical stimulation is better for your condition? (active vs passive care)

Do you think that when you go to PT that every day will be better than the one before (pain and /or function)?

Access Examples

BCN: 60day window for the year

PH Medicaid: 90 day window

Flexibility with appts or rigid 3 x's a week?

Clinic Hours?

Childcare needs?

Finances

Copay?

Deductible?

Early in the year/ late in the year?

Distance or time away from work

Transportation costs?

Attendance

How many times have you attended?

Gaps in care?

Frequency?

Increased Pain

Overdosed exercise/ activity?

Is this the most activity you have done in a while?

Do you know what specifically made you worse?

How long did the increased in pain last?

What was the time to onset after PT?

Is there a pattern here? …or a 1 time fluke with no clear mechanism?

Are you willing to go back and try again?

Was this a new thing you tried? Eg. Treadmill, exercise, etc

Were you nervous uncomfortable when you tried it?

Does the pain feel like when you

Content

What are you doing in PT? (Active vs Passive treatment)

What have you learned?

What goals are you working on? (functional goals?)

What have you been taught to manage or decrease your pain on your own?

Are you working 1:1 with your therapist or are they managing multiple patients at a time?

Dosage

How much activity at each appointment? (vs passive?)

How intense is that activity? (in the clinic)

What are you expected to do at home?

How often are you doing it?

How intense is that activity? (at home)

What are your general activity levels?

Are co-morbidities preventing further participation or activity?

Interpersonal Conflict/ Rapport

Do you feel like your therapist is attentive to your needs?

Can you switch PT's or clinics?

Steps in Tapering Opiates in a Chronic Pain Patient

Start the discussion with the facts:
"Over the past 20 years in the United States we as a medical system have been attempting to control chronic pain with opioid medications when milder forms of pain relief have not been effective. We were led to believe that there would be a low risk of addiction, or serious side effects and that this treatment would be effective. We are the only country in the world to take this approach."

"Extensive review by the Center for Disease Control has shown that this was incorrect. I'm sure you are aware of the epidemic of overdose deaths from these medications that has affected the entire nation but many people are not aware that many of these deaths have occurred in people who thought they were taking the medication as prescribed and only for legitimate medical purposes. Also studies have shown that instead of solving the chronic pain problem these drugs increase the pain experienced by patients when they are taken on a chronic daily basis. For this reason multiple states including Michigan have passed laws limiting the use of these drugs. Our office, after carefully reviewing all of this information has decided that the best treatment for our patients with chronic pain requires us to review all of our patients who are taking these medications on a regular basis and moving their treatment to safer and more effective therapies."

"We want you to know that we believe you are in chronic pain, we don't see you as an addict and we intend to move you to other treatments in a careful and gradual way. We are prepared to obtain consultations with whatever specialists are indicated to make sure that you are getting the best care possible."

"Stopping opioids suddenly, while not life threatening, can cause severe side effects like increased pain, nausea, vomiting, diarrhea, shaking, anxiety and sleeplessness. It is our intent to slowly reduce these medications so that these withdrawal symptoms are only mild. Most people who are withdrawn from opiates in this manner surprisingly find that their pain is not significantly worse and they actually feel better being off these strong medications. They report having more energy, alertness, better memory, better interactions with friends and family, better functioning at work and less depression. The problems with constipation, loss of libido and daytime drowsiness caused by opiates also resolve."

1. Complete a full evaluation for chronic pain:
   - Consider a 45 to 60-minute appointment or schedule multiple 15-30-minute appointments every 1-2 weeks.

Pain diagram (see template)	Review of systems	Urine drug screen (for Chronic Pain)
Informed consent	Pain contract	List of all past and current providers
MAPS	List of hospitalizations to include name, place	List of clinics current and past

   - Information to collect from the patient prior to the exam:
   - Complete history of pain from its' beginning. "When did you last feel well and healthy?
     - Some will have clear onset with accident, injury or surgery.

        - Some will say "I have never felt healthy." For some there will have been a gradual onset without injury.
    - Present level of functioning.
        - "Walk me through a usual day." Pay attention to how much time is spent working (and missed time from work, school etc.), resting, napping, exercising and amount and quality of sleep.
- Review prior treatments and response. (Obtain records if needed).

2. Go through Review of systems carefully with the patient, focusing on Pertinent Positives and Negatives. Consider including the following questions:

Do you experience the following:	YES	NO
Unusual fatigue or tiredness	_____	_____
Trouble making decisions	_____	_____
Loss of memory or concentration	_____	_____
A tendency to excessive worry	_____	_____
Attacks of anxiety	_____	_____
Feeling hopeless	_____	_____
Depression	_____	_____
Loss of temper	_____	_____
Frequent Crying	_____	_____
Work or Family Problems	_____	_____
Sexual difficulties	_____	_____
Suicidal thoughts	_____	_____
Have you ever sought psychological counselling?	_____	_____
Have you had any previous mental health hospitalizations?	_____	_____
Have you ever been the victim of abuse? (physical, sexual or emotional)	_____	_____
Do you have a history of alcohol or drug abuse?	_____	_____
Are you using Marijuana?	_____	_____
Do you have a medical marijuana card?	_____	_____

3. Those patients who respond by agreeing to go through a slow taper should be supplied with a copy of the **Clinical Opiate Withdrawal Scale** (Se example under Screening & Assessment Tools section) at the time of beginning a taper and explained how to use it. They should be instructed about what to do if withdrawal symptoms are worse than expected and regular appointments should be scheduled for follow up. Some offices may want to have nurses calling the patient on a weekly basis to encourage and help monitor the progress.

4. Patients with mental health issues or diagnoses are of special concern. For some of these patients the opiate may be acting as a mood stabilizer and they may become more unstable as they are withdrawn. If the patient has a

treating psychiatrist or a psychologist they should be made aware of the change in medication and visits coordinated if possible.

5. We have also seen patients who will threaten to kill themselves or even threaten the provider. These statements should be taken seriously and if the threats are felt to be credible mental health referral should be done prior to starting any taper.

6. Anxiety is almost universal in patients being tapered off of significant amounts of opiates and sometimes even in patients who seem to be taking almost placebo doses. Many of them can be reassured and managed with frequent visits and sometimes by the addition of antianxiety medications but caution must be observed with benzodiazepines and because of the risk of respiratory depression this is generally not recommended at all in the face of chronic opioid use.

   Anxiety regarding opioid tapering is considered normal. Reassurance that the patient is not being abandoned and then proceeding with the taper and following up as often as the patient feels necessary is the best way to deal with the anxiety. Far and away most patients find it easier than they thought it would be.

7. Some patients find that they are unable to control their use of the opiate and will run out of the medication early. Explain to them that the use of the opiate when we are withdrawing is for the purpose of avoiding withdrawal symptoms and that pain flare ups now need to be managed with non-opioid or non-pharmacologic measures. Encourage them to take hot baths, distract themselves with a good book or movie, involve friends or family in helping them through etc.

8. Medications for withdrawal can include clonidine 0.1mg at HS or bid (avoid in patients on beta-blockers or with low blood pressure) and hydroxyzine for anxiety or sleep. I have had family members dispense medications when the patient desires this. There are times when this is when it becomes clear that the problem is more addiction than dependence.

General Information

Online reference sites:

- Michigan Center for Clinical Systems Improvement Treating Pain & Addiction in Primary Care & Medication Assisted Treatment Training for providers: https://www.miccsi.org/training/pain-management-training/
- University of Michigan Medical School Pain Research: https://medicine.umich.edu/dept/pain-research
- Dan Clauw M.D. University of Michigan
  - Pain Body Map: https://medicine.umich.edu/dept/pain-research/clinical-research/michigan-body-map-mbm
  - YouTube videos:
    - Chronic Pain – Is it all in their head vs. 1 https://www.youtube.com/watch?v=B0EhNajqkdU
    - Chronic Pain – Is it all in their head https://www.youtube.com/watch?v=pgCfkA9RLrM
    - Pain and Depression https://www.youtube.com/watch?v=QLNPwivnmJo
    - Cannabinoids https://www.youtube.com/watch?v=97ff4jOMDaE
- Mary Free Bed Rehabilitation Hospital, Pain Rehabilitation Program: https://www.maryfreebed.com/rehabilitation/the-pain-center/
- Michigan Opioid Collaborative: https://medicine.umich.edu/dept/psychiatry/programs/michigan-opioid-collaborative-moc
- American Society of Addiction Medicine: https://www.asam.org/
- Providers Clinical Support System: https://pcssnow.org/
- Maine Quality Counts: https://www.mainequalitycounts.org/page/2-1401/controlled-medication-playbook
- What is addiction: https://www.youtube.com/watch?v=qRyeAL9tAVs
- Mindfulness Resources (for patients):
  - http://marc.ucla.edu/online-classes
  - https://palousemindfulness.com
  - https://health.ucsd.edu/specialities/mindfulness/programs/mbsr/pages/audio.aspx
- Recovery Strategies – Pain Guidebook: http://www.greglehman.ca/recovery-strategies-pain-guidebook

General Information

Patient Websites:

- Pain is Weird: https://www.painscience.com/articles/pain-is-weird.php
- www.retrainpain.org this website provides short slide show lessons on pain related topics for patients with chronic pain. Additional resources are provided by signing up to their newsletters.
- https://fibroguide.med.umich.edu A customizable self- management program available for fibromyalgia patients free of charge from the University of Michigan's Chronic Pain and Fatigue Research Center.
- https://www.tamethebeast.org/understanding "Tame the Beast" is another self-management program from the NOI group who are known for developing the Explain Pain approach to pain management
- Understanding pain in less than 5 minutes – Video/cartoon published by the Australian Government. https://youtu.be/C_3phB93rvI

Books (for patients):

- Kabat-Zinn, Jon. (2013). *Full catastrophe living: using the wisdom of your body and mind to face stress, pain, and illness.* New York: Bantam Books.
- Kabat-Zinn, J. (1994). *Wherever you go, there you are: Mindfulness meditation in everyday life*. New York: Hyperion.
- Gardner-Nix, Jackie. (2009). *The Mindfulness Solution to Pain: Step-by-Step Techniques for Chronic Pain Management*. Oakland: New Harbinger Publications.
- Burch, Vidyamala & Danny Penman You. (2015). *You Are Not Your Pain: Using Mindfulness to Relieve Pain, Reduce Stress, and Restore Well-Being – An Eight-Week Program*. New York: Flatiron Books.
- Gach, Michael Reed. (1990). *Acupressure's Potent Points: A Guide to Self-Care for Common Ailments.* New York: Bantam New Age Books.
- Turk, PhD, Dennis & Frits Winter, PhD. (2005). *The Pain Survival Guide: How to Reclaim Your Life*. APA Electronic Edition.