

Practitioner Education: Pain Management



[kawahhealth.org](https://www.kawahhealth.org)



Goals and Objectives

Kaweah Health is committed to a standardize approach to the treatment of pain throughout our system. Our goal is to provide practitioners with tools and resources to manage the complex pain management needs of our patients.

1. Review the assessment, education, and discharge planning for patients with pain
2. Identify order sets available for mild, moderate, and severe pain control
3. Identify resources available at Kaweah Health
4. Describe Opioid Prescribing Guidelines and resources
5. Present MAT and buprenorphine resources for OUD
6. Execute CURES enrollment and requirements required for prescribing analgesic regimen



Pain Assessment

PQRSTAU for every patient reporting Moderate or Severe Pain

P: Palliative/Precipitating Factors and Prior Therapies

Q: Qualitative (dull, sharp, stabbing, electric, etc)

R: Radiation (localized or transmitted elsewhere?)

S: Severity (0-10, tailor scale to patient experiences)*

T: Temporal (When during the day is pain noted?)

A: Associated Symptoms with pain

U: YOU, what is the patient's perception of the problem and how does pain affect their livelihood?

See Policy PC.44 for additional information

Pain Assessment

Setting Expectations

- It is imperative to set realistic goals of pain management with your patient
- The goal of pain management should be to potentially decrease pain levels by 2-3 points and improve activities of daily living and functionality.
- Help patients recognize that a 0/10 pain score is often unattainable and typically associated with toxicity, including: over-sedation, respiratory depression, constipation, etc.

Pain Assessment

When is pain controlled

Some general guidelines include:

- When vital signs are within normal limits (not indicative of an acute pain crisis) and:
 - Pain rating of 4/10 or less
 - 4 or less rescue/breakthrough doses used in 24 hours
- In chronic pain: focus on/look for improvement in functionality (i.e. participation in PT, increased mobility or activity tolerance, etc.) in addition to the above criteria

Pain Assessment Scales

Patients Able to Self-Report Pain Level

Self-Reported Pain Scale

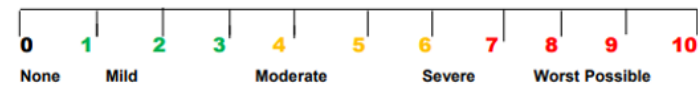
- Patients can report their own pain level

Scales Used:

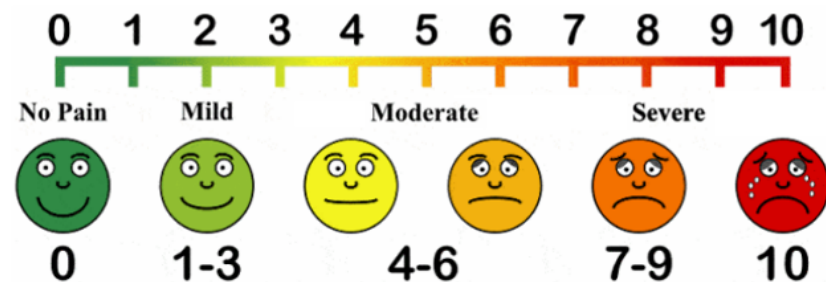
- Verbal: “0-10”
- FACES: Patient is able to point to a face which correlates with their pain level

Addendum A (Self-reporting Pain Scales)

Verbal Pain Assessment Scale



FACES



Adapted from Wong-Baker FACES Foundation (2018)

Pain Assessment Scales

Patients Unable to Self-Report Pain Level

Pain Assessment IN Advanced Dementia

PAINAD

	0	1	2	Score
Breathing Independent of vocalization	Normal	Occasional labored Breathing. Short period of hyperventilation	Noisy labored breathing. Long period of hyperventilation. Cheyne-stokes respirations	
Negative Vocalization	None	Occasional moan or groan. Low level speech with a negative or disapproving Quality	Repeated troubled calling out. Loud moaning or groaning. Crying	
Facial expression	Smiling, or inexpressive	Sad. Frightened. Frown	Facial grimacing	
Body Language	Relaxed	Tense. Distressed pacing. Fidgeting	Rigid. Fists clenched, Knees pulled up. Pulling or pushing away. Striking out	
Consolability	No need to console	Distracted or reassured by voice or touch	Unable to console, distract or reassure	
				TOTAL

Scale for Non-Critical Care Patients

Critical-Care Pain Observation Tool

(CPOT: Gélinas, C. et al., 2006, in press)

Policy adapted from the St. Vincent Hospitals and Health Services.

Indicator	Description	Score
Facial expression	No muscular tension observed	Relaxed, neutral
	Presence of frowning, brow lowering, orbit tightening and levator contraction	Tense
	All previous facial movements plus eyelid tightly closed	Grimacing
Body movements	Does not move at all (doesn't necessarily mean absence of pain (Puntillo et al., 1997))	Absence of movements
	Slow, cautious movements, touching or rubbing the pain site, seeking attention through movements (Puntillo et al., 1997)	Protection
	Pulling tube, attempting to sit up, moving limbs/thrashing, not following commands, striking at staff, trying to climb out of bed (Devlin et al., 1999)	Restlessness
Muscular tension	No resistance to passive movements	Relaxed
	Resistance to passive movements	Tense, rigid
	Strong resistance to passive movements, incapacity to complete them	Very tense or rigid
Compliance with the ventilator (intubated patients)	Alarms not activated, easy ventilation	Tolerating ventilator or movement
	Alarms stop spontaneously	Coughing but tolerating
	Asynchrony: blocking ventilation, alarms frequently activated	Fighting ventilator
OR		
Vocalization (extubated patients)	Talking in normal tone or no sound	Talking in normal tone or no sound
	Sighing, moaning	Sighing, moaning
	Crying out, sobbing	Crying out, sobbing
TOTAL		___/8

Scale for Critical Care Patients

Pain Assessment Scales

Scales for Infants and Children

FLACC Scale

Categories	Scoring		
	0	1	2
Face	No particular expression or smile	Occasional grimace or frown, withdrawn, disinterested	Frequent to constant quivered chin, clenched jaw
Legs	Normal position or relaxed	Uneasy, restless, tense	Kicking, or legs drawn up
Activity	Lying quietly, normal position, moves easily	Squirming, shifting back and forth, tense	Arched, rigid or jerking
Cry	No cry (awake or asleep)	Moans or whimpers; occasional complaint	Crying steadily, screams or sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging or being talked to, distractible	Difficult to console or comfort

Each of the five categories (F) Face; (L) Legs; (A) Activity; (C) Cry; (C) Consolability is scored from 0-2, which results in a total score between zero and ten.

Scale for children 1 mo. – 7 yrs

















Assessment Criteria	Sedation		Normal	Pain / Agitation	
	-2	-1	0	1	2
Crying Irritability	No cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or crying at intervals Consolable	High-pitched or silent-continuous cry Inconsolable
Behavior State	No arousal to any stimuli No spontaneous movement	Arouses minimally to stimuli Little spontaneous movement	Appropriate for gestational age	Restless, squirming Awakens frequently	Arching, kicking Constantly awake or Arouses minimally / no movement (not sedated)
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual
Extremities Tone	No grasp reflex Flaccid tone	Weak grasp reflex ↓ muscle tone	Relaxed hands and feet Normal tone	Intermittent clenched toes, fists or finger splay Body is not tense	Continual clenched toes, fists, or finger splay Body is tense
Vital Signs HR, RR, BP, SaO₂	No variability with stimuli Hypoventilation or apnea	< 10% variability from baseline with stimuli	Within baseline or normal for gestational age	↑ 10-20% from baseline SaO ₂ 76-85% with stimulation - quick ↑	↑ > 20% from baseline SaO ₂ ≤ 75% with stimulation - slow ↑ Out of sync with vent

Premature Pain Assessment

+1 if < 30 weeks gestation/
corrected age

Admission Order set

To aid in the pharmacological treatment of the full range of assessed pain severity levels (mild, moderate, and severe), a PRN Pain order set has been added to the MED General Admission, with non-opioid options available.

Pain (Mild level 1-3)	
<input type="checkbox"/>	  acetaminophen (Tylenol) ▼ 650 mg, Oral, Tab, every 4 hours., PRN pain, mild (scale 1-3) May give PR if unable to take PO
<input type="checkbox"/>	  ibuprofen (Motrin) 400 mg, Oral, Tab, every 6 hours., PRN pain, mild (scale 1-3)
Pain (Moderate level 4-6)	
<input type="checkbox"/>	  hydrocodone-acetaminophen (Norco 5 mg-325 mg o... ▼ 1 tab, Oral, Tab, every 4 hours., PRN pain, moderate (scale 4-6)
<input type="checkbox"/>	  traMADol (Ultram) 50 mg, Oral, Tab, every 4 hours., PRN pain, moderate (scale 4-6)
<input type="checkbox"/>	  ketorolac (Toradol) 15 mg, IV Push, Injection, every 6 hours. for 5 days, PRN pain, moderate (scale 4-6) May be given concurrently with opioids
 Injectable opioids were removed due to a national shortage. Changes made under direction of Medical Executive Team and P&T Committee.	
Pain (Severe level 7-10)	
<input type="checkbox"/>	  hydrocodone-acetaminophen (Norco 10 mg-325 mg ... ▼ 1 tab, Oral, Tab, every 4 hours., PRN pain, severe (scale 7-10)
<input type="checkbox"/>	  traMADol (Ultram) 100 mg, Oral, Tab, every 4 hours., PRN pain, severe (scale 7-10)
 Injectable opioids were removed due to a national shortage. Changes made under direction of Medical Executive Team and P&T Committee.	

Please Note: A complete order must contain the name of the drug, dosage, route, frequency and indication for PRN orders.

Having orders available for each pain severity level may reduce phone calls for modified or additional orders

Breakthrough Pain Orders

Breakthrough pain orders must have clear parameters

Example: Dilaudid 0.5mg IVP every 2 hours
PRN breakthrough pain: May administer 60 minutes after last pain medication was administered if still having unacceptable pain and pain score is >5

Communicating with Patients and Families

Education provided to patients must include:

- Realistic pain expectations
- Measurable goals
 - i.e. *degree, duration, and reduction* of pain
- Treatment progress self-evaluation
 - i.e. relief of pain and improved physical and psychosocial function
- Treatment options –including non-pharmacologic
- Safe use of opioid and non- opioid medications
- Side effects of treatment
- Goals for progress including functional ability
 - i.e. ability to take a deep breath, turn in bed, walk with improved pain control
- Risk factors for adverse events

Discharge Planning for Patients with Pain Should Include:

- Pain management plan of care
- Side effects of pain management treatment
- Strategies to address activities of daily living, including the home environment, that might exacerbate pain or reduce effectiveness of the pain management plan of care
- Safe use, storage, and disposal of opioids when prescribed

Disposal of Medications

Information on the safe disposal of medications is available in the Patient Guide, provided to all patients on admit

Safe opioid disposal options:

Option 1:



Safely dispose of medication using these 5 steps:

1. Remove label
2. Add water to contents of Rx bottle
3. Tape lid
4. Place in a box
5. Place in trash receptacle

OR

Option 2:



Drop off medications at drop off locations like Walgreens



WHY SHOULD I KEEP MY MEDICINES SAFE AND GET RID OF THEM SAFELY?

7 OUT OF 10 PEOPLE WHO ABUSE MEDICINES GET THEM FROM FRIENDS OR FAMILY

ACCIDENTAL DRUG INTOXICATION IS ONE OF THE MOST COMMON REASONS KIDS GO TO THE EMERGENCY ROOM

1 OUT OF 4 PEOPLE THAT RECEIVE PRESCRIPTION OPIOIDS LONG TERM STRUGGLE WITH ADDICTION

EVERY 34 MINUTES, SOMEONE DIES FROM AN UNINTENTIONAL DRUG OVERDOSE IN THE USA

WERE YOU RECENTLY PRESCRIBED MEDICINE FOR PAIN?

Help prevent misuse and abuse of medicine! Learn the best way to safely keep and throw out medicine that was prescribed to you.

HOW TO KEEP YOUR MEDICINE SAFE:

- Keep in a safe place out of reach of others (children, friends, family, visitors)
- Throw out old or leftover medicine as soon as possible
- Do not leave medicine or pill bottles on countertops, tables, nightstands in open view
- Lock travel cases when traveling with prescription medicine

Are your medicines expired? Have no use for them anymore? Turn to the back page to learn how to get rid of leftover medicine!

Kaweah Delta HEALTH CARE DISTRICT
400 W. Mineral King Avenue
Visalia, CA 93294
www.kaweahdelta.org

Option 3:

While drug take back locations are the preferred method for drug disposal, there is a Flush List from the FDA that dictates which medications would be ok to flush down the toilet given their abuse/misuse potential or overdose/death potential:
<https://www.fda.gov/drugs/disposal-unused-medicines-what-you-should-know/drug-disposal-fdas-flush-list-certain-medicines#1>

Resources available at Kaweah Health

Pharmacy Pain Management Service

- Consulted from the primary physician
- Follow up on audits for patients taking PRN medications
- Makes recommendations to the care team

Palliative Care Services

- Chronic pain management
- End of life care management

Pain Specialists & Anesthesiology available for consultation

Pain Management Committee

- Responsible for pain management and safe opioid prescribing and develops and monitors performance improvement activities. Ensure our pain management practices meet the highest standards. We strive to continually evaluate how pain is treated within our institution to ensure our procedures and protocols address the needs of our patients and empower our staff to provide excellent care.

Team Work: Practitioners, nursing, and pharmacy care providers can relieve patient anxiety and stress by presenting a united front

Pain Programs at Kaweah Health

Enhanced Recovery after Surgery

We use evidence-based interventions called ERAS – Enhanced Recovery After Surgery

This includes:

- Pre-admission discussion with patients regarding post-op pain expectations
- Using “blocks” to treat post-surgical pain
- Using non-opioid medications to treat pain
- Early mobilization
- Stimulation of gut motility

All of these interventions decrease post-op complications and allows patients to go home as expected, or even earlier than expected with less pain and less complications.

Resources available at Kaweah Health

Inpatient Pharmacy Pain Management

A practitioner may request consult from the pain management services to initiate / adjust pain medication therapy by doing the following:

- Place a “consult per pharmacy-Pain Management” order in the electronic medical record
- Order must include pain diagnosis and reason for consult

If questions, refer to policy RX 7.16.0
Pharmacist Pain Management Service
or Call extension: 4527



Resources available at Kaweah Health

Inpatient Pharmacy Pain Management

Available for complex pain management patients

- Acute pain crisis
- Cancer (new or pain crisis)
- Complex neuropathic pain not controlled on gabapentin or pregabalin
- PCA pain management
- New acute pain with diagnosed etiology for source of pain
- Chronic pain patient treated with methadone that has been restarted but the patient is still having severe pain
- Surgical patient who is currently treated with Buprenorphine products
- Patients who have been trialed on analgesic agents by the primary team with no success and the patient is still reporting severe pain
- Complex patients with severe psycho-social disorders who have been seen by psychiatry and after their evaluation are determined to have severe uncontrolled pain
- Complex OME (oral morphine equivalent) issues or opioid rotation related questions.
- After you meet with the patient and restart their home pain medications; and still have issues controlling pain

Outpatient Pharmacy Pain Management

Providers can refer pain patients to the Outpatient Pain Pharmacist at discharge

In Cerner: Referral for Kaweah Health OP Pharmacy Pain Management

Please provide detailed consult needs, specific pain diagnosis, and goals for patient

- Once pain control is stable and/or tapered to lowest effective dose(s), patients will be referred back to primary care practitioner for continued management
- For information on referral of patients from outpatient clinics and private practices call 624-6965

Please Note: Referrals can be made by hospitalists upon discharge, however it is best if the referral comes from the patient's primary care provider, as our service line refers patients back to the referring provider when stable or when all options have been exhausted.

Palliative Care Services

- ❖ Specialized medical care for people with serious illness. It focuses on providing relief from the symptoms and stress of a serious illness. The goal is to improve quality of life for both the patient and the family.
 - Center to Advance Palliative Care and the American Cancer Society
- ❖ Palliative care begins with a comprehensive assessment and emphasizes patient and family engagement, communication, care coordination and continuity of care across health care settings.
 - National Coalition for Hospice and Palliative Care

Palliative Care Services

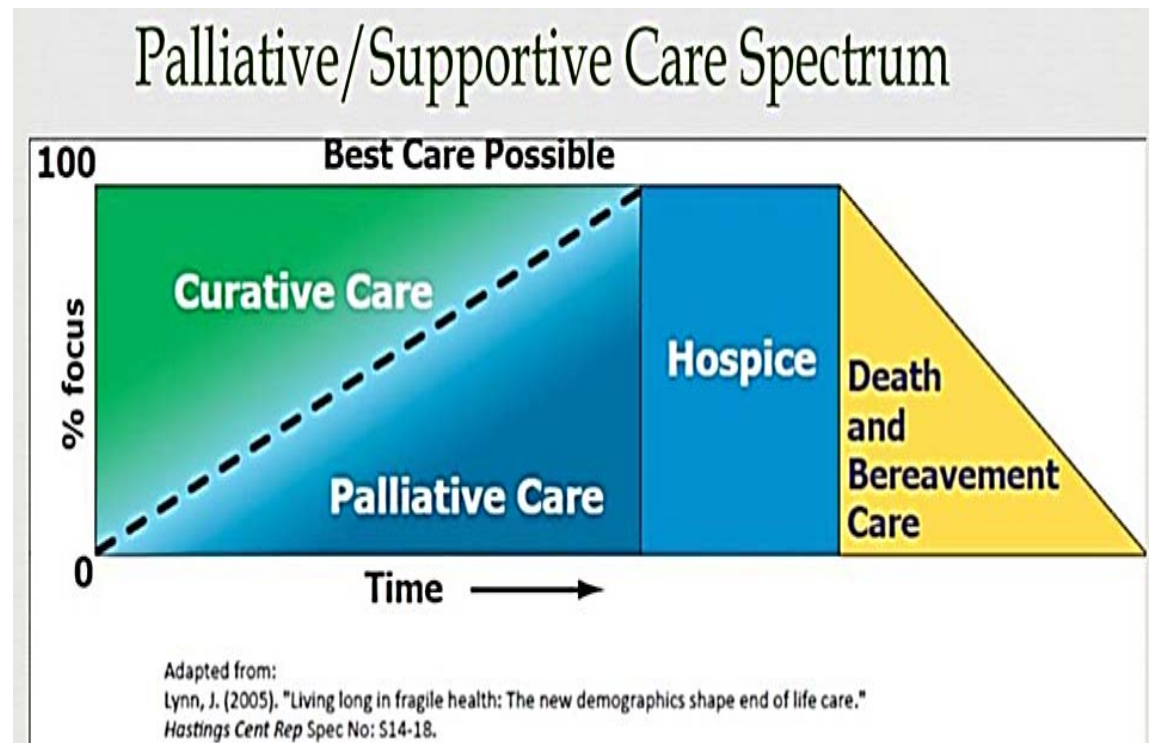
The Interdisciplinary team approach is used to address the following:

- Pain management
- Support and education to patient and family
- Collaboration within the continuum of care providers
- Improving the quality of life through symptom management and psychological support
- Realistic goals of care for long term or end stage condition management
- Symptom management to meet goals of care for patients and their families

Palliative Care Services

Implementation of Palliative and Supportive Care early in the progression of a serious or chronic illness has been shown to give patients and their families the best care possible

Palliative Care is NOT Hospice Care. Palliative care offers support and symptom management, a hospice plan is not a requirement for receiving palliative care.



Opioid Prescribing Guidelines

Kaweah Health is committed to ensuring best practice guidelines are followed related to safe prescribing of opioids.

The following slides provide information and resources from the Centers for Disease Control and Prevention regarding safe prescribing of opioids for Chronic and Post-Surgical Pain

Opioid Prescribing Guidelines

<https://www.cdc.gov/acute-pain/postsurgical-pain/index.html>

Postsurgical Pain

Pain Following Surgery May Vary Quite Widely in Severity

Postsurgical undertreatment of pain has been linked to reduced quality of life, surgical complications, prolonged rehabilitation, and development of chronic pain.^[1] Thus, in certain situations, the benefits of a limited course of opioids may outweigh the risks if pain management is inadequate with nonopioid therapies.

Patients of All Ages Frequently Take Fewer Opioids Than the Amount Prescribed Postsurgically

However, multiple studies have found that patients of all ages frequently take fewer opioids than the amount prescribed postsurgically and in some cases do not take any prescribed opioids at all, ^{[2]-[7]} resulting in excess opioid pills that are accessible to others, raising risks of misuse and overdose.

Perioperative Opioid Prescribing has been Associated with Persistent Opioid Use

Also, perioperative opioid prescribing has been associated with persistent opioid use after surgery,^{[8]-[10]} particularly with a larger prescription amount, highlighting that risks associated with opioids may extend well beyond the immediate postoperative period. Of note, one institution found that decreased opioid prescribing in the postsurgical setting was not associated with a decrease in clinician satisfaction ratings.^[11]

**Patients of all ages frequently take fewer opioids
than the amount prescribed after surgery.**

Opioid Prescribing Guidelines

<https://michigan-open.org/prescribing-recommendations>

“For patients discharged from surgical department with an opioid prescription:

Non-opioid therapies should be encouraged as a primary treatment for pain management (e.g., acetaminophen, ibuprofen).

Non-pharmacologic therapies should be encouraged (e.g., ice, elevation, physical therapy).

Do NOT prescribe opioids with other sedative medications (e.g., benzodiazepines).

Short-acting opioids should be prescribed for no more than 3-5-day courses (e.g., hydrocodone, oxycodone).

Fentanyl or long-acting opioids such as methadone [and] OxyContin ... should NOT be prescribed to opioid naïve patients.”


Michigan OPEN surgery-specific opioid prescribing recommendations are regularly updated based on clinical data on opioid use.

Opioid Prescribing Guidelines


<https://www.agencymeddirectors.wa.gov/Files/FinalSupBreeAMDGPostopPain091318wcover.pdf>

"Evidence-Based Duration of Opioid Prescriptions on Discharge Following Surgery (*select guidance; please refer to the guideline for its complete recommendations*)


Type I – Expected rapid recovery (procedures such as laparoscopic appendectomy, inguinal hernia repair, carpal tunnel release, thyroidectomy, among other surgeries)

- Prescribe non-opioid analgesics (e.g., [NSAIDs](#) ) and/or acetaminophen) and non-pharmacologic therapies as first-line therapy.
- If opioids are necessary, prescribe ≤3 days (e.g., 8 to 12 pills) of short-acting opioids in combination with an NSAID or acetaminophen for severe pain. Prescribe the lowest effective dose strength.

Type II – Expected medium term recovery (procedures such as anterior cruciate ligament [ACL] repair, rotator cuff repair, discectomy, laminectomy, open or laparoscopic colectomy, among other surgeries)

- Prescribe non-opioid analgesics (e.g., [NSAIDs](#) ) and/or acetaminophen) and non-pharmacologic therapies as first-line therapy.
- Prescribe ≤7 days (e.g., up to 42 pills) of short-acting opioids for severe pain. Prescribe the lowest effective dose strength.
- For those exceptional cases that warrant more than 7 days of opioid treatment, the surgeon should re-evaluate the patient before a third prescription and taper off opioids within 6 weeks after surgery.

Type III – Expected longer term recovery (procedures such as lumbar fusion, knee replacement, hip replacement, abdominal hysterectomy, axillary lymph node resection, among other surgeries)

- Prescribe non-opioid analgesics (e.g., [NSAIDs](#) ) and/or acetaminophen) and non-pharmacologic therapies as first-line therapy.
- Prescribe ≤14 days of short-acting opioids for severe pain. Prescribe the lowest effective dose strength.
- For those exceptional cases that warrant more than 14 days of opioid treatment, the surgeon should re-evaluate the patient before refilling opioids and taper off opioids within 6 weeks after surgery."

Opioid Prescribing Guidelines

Treatment of Acute Post Surgical Pain

The CDC offers a free CME regarding the Treatment of Acute Post Surgical Pain. <https://www.cdc.gov/acute-pain/training/acute-postsurgical-pain.html>

PROGRAM DESCRIPTION: The treatment of acute pain in the postsurgical setting must strike the best balance of adequate management of symptoms with risks of persistent opioid use in the long-term. Postsurgical patients who experience undertreated acute pain could develop postsurgical complications, reduced quality of life, prolonged rehabilitation, and chronic pain development. After taking this module, learners will understand the effects of persistent opioid use in postsurgical patients and will have an increased awareness of treatment strategies in postsurgical settings to help providers treat pain safely and effectively.

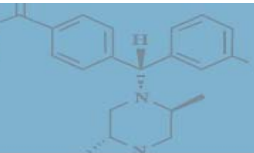
OBJECTIVES:

At the conclusion of the session, the participant will be able to:

1. Identify risks of opioid therapy in postsurgical patients
2. Identify risks associated with undertreatment of postsurgical pain.
3. List examples of nonopioid and nonpharmacologic options for treatment of postsurgical pain.
4. Describe the benefits of shared decision-making between patient and provider in managing acute pain.
5. Describe the importance of interprofessional collaboration in postsurgical settings

Opioid Prescribing Guidelines

GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN



IMPROVING PRACTICE THROUGH RECOMMENDATIONS

CDC's *Guideline for Prescribing Opioids for Chronic Pain* is intended to improve communication between providers and patients about the risks and benefits of opioid therapy for chronic pain, improve the safety and effectiveness of pain treatment, and reduce the risks associated with long-term opioid therapy, including opioid use disorder and overdose. The Guideline is not intended for patients who are in active cancer treatment, palliative care, or end-of-life care.

DETERMINING WHEN TO INITIATE OR CONTINUE OPIOIDS FOR CHRONIC PAIN

- 1 Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate.
- 2 Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how opioid therapy will be discontinued if benefits do not outweigh risks. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.
- 3 Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy.

CLINICAL REMINDERS

- Opioids are not first-line or routine therapy for chronic pain
- Establish and measure goals for pain and function
- Discuss benefits and risks and availability of nonopioid therapies with patient



Opioid Prescribing Guidelines

OPIOID SELECTION, DOSAGE, DURATION, FOLLOW-UP, AND DISCONTINUATION

CLINICAL REMINDERS

- Use immediate-release opioids when starting
- Start low and go slow
- When opioids are needed for acute pain, prescribe no more than needed
- Do not prescribe ER/LA opioids for acute pain
- Follow-up and re-evaluate risk of harm; reduce dose or taper and discontinue if needed

4

When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids.

5

When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when considering increasing dosage to ≥ 50 morphine milligram equivalents (MME)/day, and should avoid increasing dosage to ≥ 90 MME/day or carefully justify a decision to titrate dosage to ≥ 90 MME/day.

6

Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed.

7

Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently. If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.

ASSESSING RISK AND ADDRESSING HARMS OF OPIOID USE

8

Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (≥ 50 MME/day), or concurrent benzodiazepine use, are present.

9

Clinicians should review the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months.

10

When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs.

11

Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.

12

Clinicians should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder.

CLINICAL REMINDERS

- Evaluate risk factors for opioid-related harms
- Check PDMP for high dosages and prescriptions from other providers
- Use urine drug testing to identify prescribed substances and undisclosed use
- Avoid concurrent benzodiazepine and opioid prescribing
- Arrange treatment for opioid use disorder if needed

CURES

Practitioners are required to consult CURES (10.2.2018)

- Prior to prescribing controlled substances II-IV
- Practitioners with a DEA number must be enrolled in CURES

Exclusions (no CURES required):

- While patients are admitted
- Hospice Care enrolled patients
- ED patients receiving < 7 day supply
- Surgical patients receiving < 5 day supply

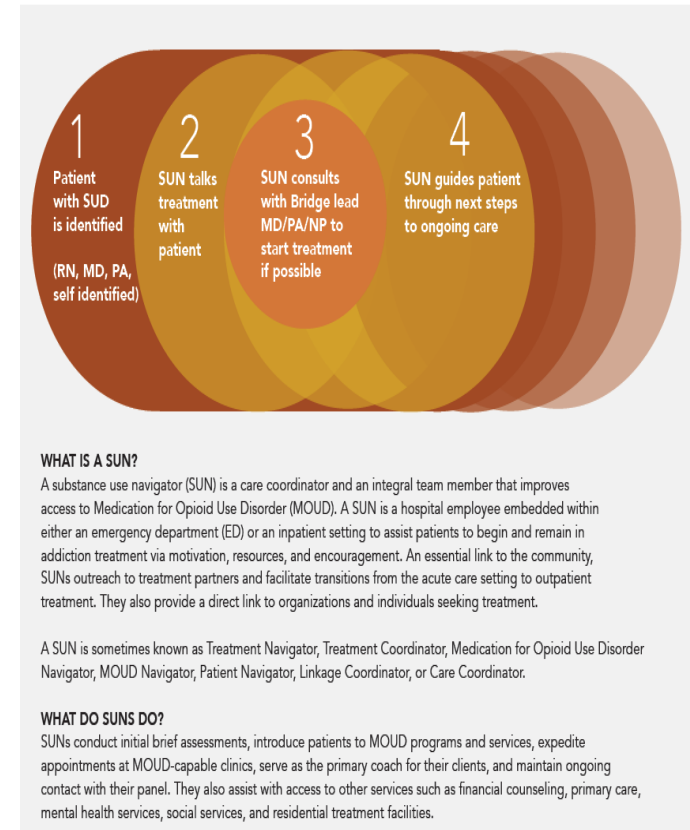
MAT, SUD, and SUN

Medication Assisted Treatment (MAT) is available, with Buprenorphine treatment for patients with Opioid Use Disorder (OUD)

Patient Family Services staff serve as Substance Use Navigators (SUNs) within the Medical Center

Also available 24/7 is the California Substance Use Line (844-326-2626)

Substance Use Navigators (SUNs) in all Bridge sites will assist the identification and treatment for patients in need of care



Kaweah Health is committed to ensuring a culture that does not stigmatize substance misuse

Medical Model of Addiction- addiction is a disease that requires appropriate treatment

Trauma Informed Care-4 "R's"

- **R**ealization about trauma and how it can affect people and groups
- **R**ecognizing the signs of trauma
- Having a system which can **R**espond to trauma
- **R**esisting re-traumatization

Motivational Interviewing-evidence-based treatment that helps patients find the motivation to make positive behavior change

Language/behaviors: Words Matter-avoiding words that can transmit stigma (eg. "frequent flyer" / "drug seeker")

In Summary

Pain management at Kaweah Health is a collaborative effort

- Set clear pain expectations for all patients
- Education and honest communication are essential
- Many resources are available to assist in management of pain
- Utilizing order sets and guidelines as intended will assist us in providing safe and effective care to our patients

Live with passion.

Health is our passion. Excellence is our focus. Compassion is our promise.



Appendix

1. Pain Pocket Card
2. Pain Services Directory

Pain Pocket Card

OPIOID-INDUCED SIDE EFFECTS:

Constipation:

1. Patients will NOT develop tolerance. Need to order a prophylactic bowel regimen to PREVENT
2. Goal is to have a BM every other day
3. Prophylaxis requires a stool softener **AND** a stimulant laxative (i.e. Docusate + Sennosides)
4. Bowel regimen should begin when opioid therapy is initiated

Nausea / Vomiting:

1. Patients develop tolerance in 3-7 days
2. Antiemetics prior to opioid dose may be helpful
3. Doses can be adjusted (higher doses of more potent opioid analgesics can result in greater incidence of nausea and vomiting)
4. Consider changing the current regimen or route to avoid fluctuations in drug serum concentrations
5. Consider rotating opioids

Pruritus:

1. Opioids can induce histamine release resulting in pruritis which should **NOT** be confused with an IgE mediated reaction
2. Highest with natural opioids, lower with semi-synthetic and synthetic opioids
3. Treat with non-sedating antihistamines (i.e. loratadine) or diphenhydramine or hydroxyzine

Sedation (refer to institutional RASS scale):

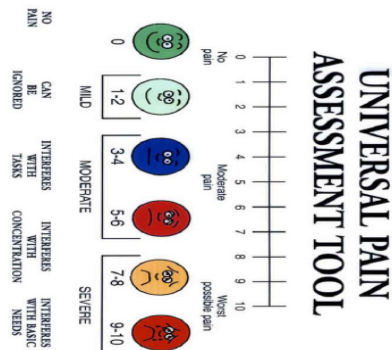
1. Evaluate underlying cause and manage comorbid conditions (i.e. CHF, anemia, etc)
2. Hold/reduce dosages of concomitant CNS depressants (i.e. sedatives, anxiolytics, etc)
3. Add/increase doses of non-opioid analgesics
4. Consider holding or reducing opioid doses by 25-50% depending on degree of sedation
5. Consider extending dosing frequency of both long/short acting opioids
6. Consider rotating opioids

Respiratory Depression:

1. < 12 breaths/min (BMP), unless comfort care
2. Stop opioids, including infusions & PCA basal rate
3. Wake patient if sleeping, if no response, call RRT
4. Establish patient airway and apply oxygen per RT
5. Give Narcan: Dilute 0.4 mg/ml with 9ml NS to final concentration of 0.04 mg/ml and give 1 ml every 1-2 min until respirations >12 BMP & O₂ sats >90%
6. If no response after 10 mg consider alternative causes of respiratory depression
7. Watch for re-sedation (marcan T_{1/2} → 60min)
8. Resume opioid at 50% of previous dosage and avoid basal rate if possible

Myoclonus:

1. Result of excessive dose or opioid accumulation
2. Most common with morphine
3. Rotate to a different opioid
4. Benzodiazepines are used symptomatically to treat moderate-severe movements / spasms



Wong-Baker FACES Pain Rating Scale

OPIOID TITRATIONS:

1. **Short acting opioids**, can be adjusted every 4-hrs as needed
 - Mild – Moderate pain: Increase by 25-50%
 - Moderate – Severe pain: Increase by 50-100%
2. **Long acting opioids and drips** should be reassessed after 24-hrs as it takes 5 half-lives to reach steady state (5 x 4hr half-life = 20 hrs)
3. Dose adjustments made prior to the steady state of a drug will result in drug accumulation / toxicity
4. PRN doses of short-acting medication should be used to control pain rather than early titrations
5. IV doses take effect within 5-10 min and PO doses take effect within 30-60 min
6. **Once pain controlled**, PRN doses from the previous 24-hrs can be calculated to determine total opioid needs and a long acting agent or opioid infusion can be started
7. Breakthrough doses should ALWAYS accompany long acting doses and be ~10-15% of the 24-hr total daily dose (TDD)
8. Breakthrough doses for opioid drips should be 50-100% of the hourly rate and dosed every 15-30min
9. Fentanyl patches should be titrated after 3-days following the 1st application and every 6-days with subsequent titrations to prevent accumulation
10. Methadone should only be titrated every 5-7 days as a result of an extended ½ life and risk for drug accumulation/oversedation

November 2020



ANALGESIC REFERENCE GUIDE

Pain Management Pharmacist ext 4527

Equianalgesic Conversion Equation

$$\frac{\text{Current opioid (equivalency)}}{\text{NEW opioid (equivalency)}} = \frac{\text{Total 24 hr dose of current opioid}}{\text{Total 24 hr dose of NEW opioid}}$$

Example: 20 mg / day IV dilaudid convert to PO morphine

$$\frac{\text{Dilaudid IV (1.5 mg)}}{\text{Morphine PO (30 mg)}} = \frac{\text{Dilaudid 20 mg / 24 hrs}}{\text{Morphine PO Dose = XXX}}$$

XXX = Morphine 400mg/day PO. Decrease by 25% to account for incomplete cross tolerance = 400 mg x 75% = 300 mg/day PO. Can start Morphine ER 100 mg POTID and adjust as needed.

Breakthrough Dose: Breakthrough doses are 10-15% of the daily long-acting dose. 10-15% of 300 mg = 30-45 mg per dose. Can start at 30 mg PO q3hr prn breakthrough pain

PAIN ASSESSMENT:

1. PQRSTAU – assess pain onset, quality, severity, duration, relieving / precipitating factors, and associated symptoms
2. If the patient is unable to communicate, assess pain based on the facial grimacing, crying, moaning, and / or irritability
3. Establish goals of therapy and manage patient's expectations regarding pain management needs
4. Re-assess pain 10 min after IV pain med administration and 45min after PO administration

PAIN TREATMENT PRINCIPLES:

1. IV - PO pain medications are NOT equianalgesic
2. Opioids DO NOT have a ceiling dose for analgesia unless combined with acetaminophen
3. Opioids should be titrated to analgesic effect in the absence of dose limiting toxicities
4. Chronic pain patients already taking opioids will require higher doses to control new / worsening pain (30-40% higher)
5. Short acting opioids should be dosed PRN for acute pain and scheduled when pain is expected to be prolonged
6. Only start long-acting opioids after pain has been stabilized using short-acting opioids
7. Elderly patients (>60) are more susceptible to opioid toxicity and should have doses reduced
8. Patients are considered opioid naive if taking < 60 mg of oral morphine, 8 mg of oral hydromorphone, 30 mg of oxycodone or equianalgesic dose of another opioid for at least 7 consecutive days

Pain Pocket Card

EQUIANALGESIC DOSES OF COMMONLY USED ANALGESICS

OPIOID ANALGESIC	EQUIANALGESIC DOSE		PHARMACOKINETIC PARAMETERS			COMMENTS
	Parenteral (mg)	PO (mg)	Dosing Interval/ Duration of Analgesia (hr)	Onset of Analgesia (min)	Peak Effect (min)	
Buprenorphine (Buprenex – injection; Subutex – SL tablet; Suboxone – SL film or tablet w/naloxone) (mg)	0.4	1 (SL)	6	IM 5-10 SL 2-5	IM 45-60 SL 30-60	Caution: Elderly will have delayed onset and duration of opioid activity and doses should be started lower and titrated to analgesic effect
Buprenorphine buccal film (Belbuca) (mcg)	---	---	12		150-180	OME conversion factor = 0.03. Indicated for chronic pain management only. Caution advised when initiating in patients on chronic maintenance opioid therapy as it could result in acute withdrawal symptoms.
Buprenorphine transdermal patch (Butrans) (mcg/hr)	---	---	Weekly		SS by Day 3	OME conversion factor = 1.8. Indicated for chronic pain management only. Caution advised when initiating in patients on chronic maintenance opioid therapy as it could result in acute withdrawal symptoms. Risk for QTc prolongation at higher doses.
Codeine	130	200	3-4	IM 10-30 PO 30-60	PO 45-60	Needs to be metabolized to be an active analgesic and 10% of population may not have hepatic enzyme (CYP-2D6) to do so. Doses > 60 mg/day may result in a side effects outweighing analgesic effect
Fentanyl Injection (Sublimaze)	0.1	---	0.5-1	IV 1-2 SC 10-15 IM 5-10	IV 5 SC ~30 IM 15-30	Limited histamine release. No active metabolites. Opioid of choice for renally compromised patients and those with hemodynamic instability. Requires frequent dosing because of rapid clearance. When converting to a fentanyl patch use 1:1 ratio
Fentanyl Patch (Duragesic) (mcg/hr)	---	---	72	12-18 hrs	24-36 hrs	Patients must be on 60 mg oral morphine/day for 7 consecutive days in order to qualify for patch. Each 25 mcg patch ~ 50 mg PO morphine/day (manufacturer range is 60-134 mg/day). Determine daily oral morphine needs and divide by 2-3 to determine patch strength (depends on dose and pt specific risk factors). Steady state levels can take 48-72 hrs. Not appropriate for patients with actual body weight << ideal body weight. Analgesic effects continue for 18-hrs AFTER patch removal.
Hydrocodone (component of Norco, Vicodin, Lortab)	---	30	3-4	PO 15-30	PO 45-60	Tylenol component limits maximum dose (3-4 grams / acetaminophen / day) is available as a tablet and an elixir (7.5 / 325 mg = 15 ml)
Hydromorphone (Dilaudid)	1.5	7.5	3-4	IV ~5 SC 5-10 IM 5-20 PO 15-30	IV ~10 SC 30 IM 30-60 PO 45-60	IV is 7x more potent than IV morphine and is 5x more potent than PO dilaudid. Does have active metabolite (H3G) that can accumulate in renally compromised patients (CrCl < 30 ml/min) and result in increased CNS toxicity. Starting doses in elderly should be reduced by 50% (0.25 – 0.5 mg IV q 3 hr PRN pain)
Methadone	---	See Comments	6-12	IV 10-20 PO 30-60		Extended 1/2 life with repeated dosing (~35 hrs) can result in toxicity. Steady state levels achieved in 7-10 days. When converting from oral morphine to oral methadone use the following ratios (Modified Morley-Makin Model): < 1000 mg/day age < 65: 10:1 (morphine : methadone) < 1000 mg/day age > 65: 20:1 (morphine : methadone) 1000 mg/day - 2000 mg/day: 20:1 (morphine : methadone) > 2000 mg/day 30:1 (morphine : methadone) When converting from oral methadone to oral morphine use the ratio 1 : 3 (methadone to oral morphine)
Morphine	10	30	3-4	IV 5-10 SC 5-10 IM 5-20 PO ~30	IV 10-20 SC 50-90 IM 30-60 PO ~60	Active metabolites (M6G, M3G) which accumulate and result in significant CNS toxicity in renally impaired (CrCl <30 ml/min). Associated with histamine release which can result in hemodynamic instability. Available in oral solution (10 mg = 5 ml) and concentrated solution (20 mg = 1 ml)
Morphine Slow Release (MS Contin, Kadian, Avinza)	10	30	8-12	120-240	15-30 hrs	Do not crush or chew. MS Contin frequently associated with "wearing off effect" prior to 12-hrs and may need every 8-hr dosing. Kadian typically requires every 12-hr dosing and Avinza is a true 24-hr dosing medication. Can open and sprinkle beads of Kadian and Avinza on food
Oxycodone (Oxycodone IR, Percocet)	---	20	3-4	10-15	30-60	Available in combination with 325 mg of acetaminophen (Percocet) or as a pure agonist (oxycodone IR). Also available as a solution (5 mg = 5 ml)
Oxycodone Slow Release (OxyContin, Xtampza)	---	20	12	~30	240-300	Do not crush or chew. 40% of OxyContin tablet is designed as immediate release and remaining 60% is extended release
Tapentadol (Nucynta)	---	75	IR: 4-6 ER: 12		IR: 60-75 ER: 3-6 hr	CrCl <30 mL/minute: Use not recommended. SNRI properties that help modify pain signal transmission via the descending pathway.
Tramadol (Ultram)	---	300	4-6	30-60	60	Weak opioid agonist with SNRI properties that help modify pain signal transmission via the descending pathway. Can lower seizure threshold with doses >400 mg/day

This reference guide has been provided by the Pharmacy Pain Management Service as guide for converting between opioid therapies. It is not intended to guide prescribing practices and does not promote the use of opioid analgesics as first line for pain management. For questions regarding pain management or to place a consult for a pain management evaluation, please contact the Pain Management Pharmacist at ext 4527

Pain Services Directory

- Pharmacy Pain Management Service 624-4527
- Palliative Care Services 624-5942
- Outpatient Pharmacy Pain Management 624-6965