Quality Improvement and Care Coordination:

Implementing the CDC Guideline for Prescribing Opioids for Chronic Pain

Centers for Disease Control and Prevention
National Center for Injury Prevention and Control

Chapter One

Evidence-based Opioid Prescribing

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Introduction

CDC released the CDC *Guideline for Prescribing Opioids for Chronic Pain* (CDC *Prescribing Guideline*) in March 2016. The Guideline offers recommendations to primary care providers about the appropriate prescribing of opioids to ensure patients, 18 years and older, have access to safer, more effective treatment for chronic pain (pain lasting longer than three months or past the time of normal tissue healing) outside of active cancer treatment, palliative care, and end-of-life care. While prescription opioids can be an appropriate part of pain management, the CDC *Prescribing Guideline* aims to improve the safety of prescribing and reduce the harms associated with opioids, including opioid use disorder (OUD) and overdose.

The CDC *Prescribing Guideline* encourages providers and patients to consider all treatment options, particularly nonopioid and nonpharmacological therapies that can be used alone or in combination with opioids. The CDC *Prescribing Guideline* helps providers assess when it is appropriate to initiate opioid use for the treatment of chronic pain and how to safely maintain or discontinue use in patients who are currently on long-term opioid therapy.

PRESCRIBE WITH CONFIDENCE.

GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN

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tip

Three principles that are especially important to improving patient care and safety:

1. Nonopioid and nonpharmacologic therapy is preferred for chronic pain outside of active cancer, palliative, and end-of-life care.
2. When opioids are used, the lowest possible effective dosage should be prescribed to reduce risks of opioid use disorder and overdose.
3. Providers should always exercise caution when prescribing opioids and monitor all patients closely.

CDC Guideline for Prescribing Opioids for Chronic Pain

This section summarizes the 12 recommendations contained in the CDC *Prescribing Guideline*. The recommendations are organized into three areas: (1) determining when to initiate or continue opioids for chronic pain; (2) opioid selection, dosage, duration, follow-up, and discontinuation; and (3) assessing risk and addressing harms of opioid use.

Providers are encouraged to read the full CDC *Prescribing Guideline* for additional information on improving patient outcomes, such as reduced pain and improved function. Within the CDC *Prescribing Guideline* there are recommendations that are tailored to specific populations (e.g., pregnant women, older adults) and additional guidance on opioid therapy and tapering. The additional details provided within the rationale statements will assist providers with improving the care and treatment of patients living with chronic pain. Patients should receive appropriate pain treatment based on a careful consideration of the benefits and risks of treatment options. In treating chronic pain, providers should continue to use their clinical judgment and base their treatment on what they know about their patients. Guidance provided within the rationale statements equips providers with both the information they need to empathically review and discuss benefits and risks of continued high-dosage opioid therapy and the ability to offer safer, more effective chronic pain treatment with patients.

DETERMINING WHEN TO INITIATE OR CONTINUE OPIOIDS FOR CHRONIC PAIN

1 Opioids are not first-line therapy.

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 Establish goals for pain and function.

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 Discuss risks and benefits.

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

- Establish and measure goals for improved pain and function.
- Discuss benefits, risks, and availability of nonopioid therapies with patient.
- Assess pain intensity, functional impairment, and quality of life.

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

4 Use immediate-release opioids when starting.

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

5 Use the lowest effective dose.

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) per day, and should avoid increasing dosage to ≥ 90 MME per day or carefully justify a decision to titrate dosage to ≥ 90 MME per day.

6 Prescribe short durations for acute pain.

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 Evaluate benefits and harms frequently.

Clinicians should evaluate benefits and harms with patients within one to four weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every three 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 Use strategies to mitigate risk.

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 per day), or concurrent benzodiazepine use, are present.

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 if needed.

9 Review prescription drug monitoring program (PDMP) data.

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 three months.

10 Use urine drug testing.

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 Avoid concurrent opioid and benzodiazepine prescribing.

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

12 Offer treatment for opioid use disorder.

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

- 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 OUD if needed.

Chapter Three

Practice-level Strategies for Care Coordination

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Practice-level Strategies for Care Coordiation

Improving management and coordination of long-term opioid therapy requires not only a refined approach to the clinical care of patients but also strategies that can be deployed at the practice- and system-level of care delivery.

These strategies include establishing or revising internal opioid policies, developing registries and using panel management, employing team-based approaches, and effectively using technology, each of which is briefly described below. All of these strategies can be used together to have a comprehensive approach. Throughout this chapter, tips for specific strategies are provided that are based on the experience of a healthcare system aimed to implement this plan into its primary care practices. Toolkit Part A provides links to examples of comprehensive management and coordination approaches.

STRATEGY

Use an Interdisciplinary Team-based Approach

- **Use an interdisciplinary, team-based approach to managing and coordinating long-term opioid therapy to the extent possible (e.g., have a medical assistant manage opioid refill requests or schedule UDTs).**
- **Determine which specialists are available within the practice or need to be identified for referrals (e.g., psychologists, psychiatrists, clinical pharmacists, addiction specialists, social workers, rehabilitation medicine, physical therapists, chiropractors, anesthesiologists, occupational therapists, and acupuncturists or other providers of complementary and alternative medicine).**
- **Determine if patients with an opioid use disorder have sufficient access to providers of MAT. If availability is inadequate, strongly consider having one or more providers seek a waiver to provide buprenorphine to these patients. (For waivers, see http://www.samhsa.gov/medication-assisted-treatment/buprenorphine-waiver-management.)**
- **If needed, use telemedicine consultations (e.g., Project Extension for Community Healthcare Outcomes [ECHO]) to obtain advice from pain specialists via videoconference. (See Toolkit Part D for more details.)**
- **Identify workflow modifications that may be necessary to support selected strategies.**

tip

Managing long-term opioid therapy successfully is not something one provider can easily manage alone.

STRATEGY

Establish Opioid Policies and Standards

▶ Develop and implement policies or standards to promote consistency in long-term opioid therapy management and coordination.

Practice-wide policies and standards both support providers in making clinical decisions that protect patient safety (e.g., decisions to avoid inappropriate dose escalation)[1] and promote consistency in long-term opioid therapy management and coordination. (See Toolkit Part B for a list of potential policies.) Examples of policies include:

- All patients receiving long-term opioid therapy must sign or review an opioid treatment agreement and informed-consent form;
- All patients receiving long-term opioid therapy must notify the practice three or four days prior to receiving an opioid refill; and
- Providers check the PDMP data periodically for patients receiving long-term opioid therapy, no less often than every three months. PDMPs are state-based databases that collect information on controlled prescription drugs dispensed by pharmacies in most states and, in some select states, by dispensing physicians as well.

The following are policies the practice could consider developing, establishing, or updating. Internal policies should allow for some flexibility and discretion to be consistent with the spirit of the CDC *Prescribing Guideline*. Clinical decision-making should be based on a relationship between the clinician and patient, and an understanding of the patient's clinical situation, functioning, and life context. Clinicians should consider the circumstances and unique needs of each patient when providing care, and policies should allow for this as well.

Standard treatment agreement for all providers to use

Treatment agreements are useful for defining the responsibilities of the patient and provider, creating a structure to guide and evaluate opioid use, reducing opioid misuse, enhancing adherence to opioid therapy as prescribed, reducing providers' legal risk, and improving practice efficiency.[2] It is important to emphasize the treatment agreement is not just about getting a form signed but is a tool for facilitating a conversation between the provider and patient.

▶ Develop treatment agreements that include the following information:

- Potential risks and benefits of opioid therapy;
- Clinical guidance that opioids may not improve pain or function;
- Prescribing and/or practice policies (e.g., dose limits, only one prescriber, only one pharmacy, refill policy);
- Methods of monitoring opioid use (e.g., urine drug tests, periodic visits, checking PDMPs); and
- Behaviors expected of the patient.

tip

Terminology is important

Treatment agreements are sometimes called "treatment contracts." Use of the term "contract" may have legal and punitive connotations to some, suggesting mistrust, whereas the use of "agreement" implies that parties have reached a mutually acceptable arrangement. When developing a treatment agreement, practices should be cautious with the use of adversarial or intimidating language. In discussing the agreement, emphasis should be placed on how its provisions are intended to protect patient safety. This may enable the patient and physician to find common ground on potentially contentious issues. Ensuring patient safety provides a rationale for erring on the side of caution when considering opioids for chronic pain.

[1] Kilaru AS, Gadsden SM, Perrone J, Paciotti B, Barg FK, Meisel ZF. How do physicians adopt and apply opioid prescription guidelines in the emergency department? A qualitative study. *Annals of emergency medicine*. 2014;64(5):482-489. e481.

[2] Chou R, Fanciullo GJ, Fine PG, et al. Clinical Guidelines for the Use of Chronic Opioid Therapy in Chronic Noncancer Pain. *The journal of pain: official journal of the American Pain Society*. 2009;10(2):113-130.

Examples of treatment agreements are provided in Toolkit Part C. More guidance on how the provider can address this with individual patients is provided in Chapter 1.

Policy on the threshold dosage levels for the patient population

Research has found that patients who receive high MME dosages have significantly increased risks of overdose compared with patients receiving low dosages (Exhibit 3).[3-6] (Even at low dosages, opioids present risk of overdose.) Establishing a practice-wide policy on dosage levels may assist prescribers in making evidence-based decisions and minimizing risks of adverse outcomes.

▶ Consider implementing CDC's guidance on dosing:[7]

- Use caution when prescribing opioids at any dosage and prescribe the lowest effective dose.
- Use extra precautions when increasing to ≥ 50 MME per day, such as:
  - Monitor and assess pain and function more frequently.
  - Discuss reducing dose or tapering and discontinuing opioids if benefits do not outweigh harms.
  - Consider offering naloxone.
- Avoid or carefully justify increasing dosage to ≥ 90 MME per day.

▶ Patients already at high levels may be willing to try reducing the dosage.

The practice should consider advising prescribers, as a matter of policy, to discuss this with their patients who are taking more than 50 MME per day. (See Chapter 1 for discussions of opioid dosage for individual patients.)

- Providers are encouraged to read the full CDC *Prescribing Guideline* for additional information on improving patient outcomes, such as reduced pain and improved function. Within the CDC *Prescribing Guideline* there are recommendations that are tailored to specific populations (e.g., pregnant women, older adults) and additional guidance on opioid therapy and tapering. The additional details provided within the rationale statements, will assist providers with improving the care and treatment of patients living with chronic pain. Patients should receive appropriate pain treatment based on a careful consideration of the benefits and risks of treatment options. In treating chronic pain, providers should continue to use their clinical judgment and base their treatment on what they know about their patients. Clinicians should empathically review benefits and risks of continued high-dosage opioid therapy and should offer to work with the patient to taper opioids to safer dosages. For patients who agree to taper opioids to lower dosages, clinicians should collaborate with the patient on a tapering plan.

tip

Treatment agreement

Determine where within the EHR the treatment agreement should be saved and how it should be labeled to ensure easy searching and retrieval for a provider to determine if a patient has a treatment agreement and when it was last reviewed and signed.

[3] Dunn KM, Saunders KW, Rutter CM, et al. Opioid Prescriptions for Chronic Pain and Overdose. *Annals of internal medicine*. 2010;152(2):85.

[4] Bohnert AS, Valenstein M, Bair MJ, et al. Association between opioid prescribing patterns and opioid overdose-related deaths. *JAMA*. 2011;305(13):1315-1321.

[5] Gomes T, Mamdani MM, Dhalla IA, Paterson JM, Juurlink DN. Opioid dose and drug-related mortality in patients with nonmalignant pain. *Archives of Internal Medicine*. 2011;171(7):686-691.

[6] Zedler B, Xie L, Wang L, et al. Risk factors for serious prescription opioid-related toxicity or overdose among Veterans Health Administration patients. *Pain Med*. 2014;15(11):1911-1929.

[7] Centers for Disease Control and Prevention. Calculating total daily dose for opioids for safer dosage. https://www.cdc.gov/drugoverdose/pdf/calculating_total_daily_dose-a.pdf

Prescription refill or renewal policy

- **Include any prescription renewal/refill policies in the treatment agreement.**

Examples of prescription refill or renewal policies are: limiting supply to 28 days; not allowing early refills; and requiring three business days advance notice for refills.

Policy for frequency of monitoring patients on long-term opioid therapy

Because most risk-assessment instruments are unable to predict future behavior with a high degree of accuracy,[8] a universal precautions approach to all patients on long-term opioid therapy is appropriate. That is, opioid use by *all* patients on long-term therapy should be monitored periodically. The frequency and intensity of monitoring individual patients, however, should be greater for those who are taking high dosages of opioids, who have other conditions that put them at higher risk (e.g., hepatic deficiency or sleep disordered breathing), whose behavior shows them to be at higher risk (e.g., frequent requests for early refills), or who report indicators of OUD when asked. How these decisions are made for individual patients is discussed in Chapter 1.

- **Establish policies for how monitoring should be calibrated to perceived risk.**

Policy for frequency of urine drug testing

UDTs are useful for determining if patients are taking their opioid medications as prescribed or are using other licit or illicit substances. UDTs should be supplemented by careful, non-judgmental interviewing by clinicians in the practice and patient observation to identify indicators of OUD or potentially hazardous opioid misuse.

There are two main types of UDT—immunoassay drug-testing conducted at a laboratory or at the point of care in a provider's office, and laboratory-based chromatography/mass spectrometry. (See Exhibit 4 for a description of the main differences in these two types of tests and further information regarding conducting UDT as part of monitoring and risk management.

tip

Urine drug testing

It can be helpful to determine the specific, urine drug test that should be used to capture all of the relevant licit and illicit drugs. Make this specific test readily apparent within the EHR order system for providers to choose.

[8] Chou R, Deyo R, Devine B, Hansen R, Sullivan S, Jarvik Jea. The Effectiveness and Risks of Long-term Opioid Treatment of Chronic Pain. Evidence Report/Technology Assessment No. 218. Rockville, MD: Agency for Healthcare Research and Quality; 2014.

Exhibit 4: Differences in Types of Urine Drug Tests

IMMUNOASSAY	GAS CHROMATOGRAPHY, MASS SPECTROMETRY
Less expensive, fast, easy to use.	More expensive, labor intensive.
Most frequently used technique in all settings, including hospital labs.	Requires advanced laboratory services.
Used commonly as screening test.	Used primarily to confirm positive immunoassay result.
Engineered antibodies bind to drug metabolites.	Measures drugs and drug metabolites directly.
Qualitative testing—positive or negative only.	Quantitative testing.
Screens for presence of drugs or a panel of drugs: amphetamine, marijuana, PCP, cocaine, natural opiates (morphine/codeine/thebaine but without differentiation). Heroin is metabolized to morphine and can therefore be detected.	Identifies specific drugs and their metabolites.
Does not differentiate various natural opiates.	Differentiates all opioids.
Typically misses semi-synthetic and synthetic opioids.	More accurate for semi-synthetic and synthetic opioids—methadone, propoxyphene, fentanyl, meperidine, hydrocodone, oxycodone, hydromorphone, oxymorphone, buprenorphine, heroin.
Often has high cut-off levels, giving false negative results.	Very sensitive, detects low levels of drug, minimizes false negatives.
Will show false positives: poppy seeds, quinolone antibiotics, over-the-counter medications.	Very specific, less cross-reactivity, minimizes false positives.

Source: Adapted from "Urine Drug Testing in the Management of Chronic Pain," at https://www.drugabuse.gov/sites/default/files/files/UrineDrugTesting.pdf

- **Establish a policy specifying how often UDTs should be given to patients at different levels of perceived risk.**

The practice should also consider whether tests are to be done at random or on a particular schedule. The cost of testing should be factored into this decision. As discussed in Chapter 1, the frequency of testing may be increased if results are inappropriate or unexplained, due to risk level, or following each dosage increase.

Policies and procedures for checking the prescription drug monitoring program

Periodic checks of the PDMP provide a direct means of monitoring the patient's use of multiple prescribers or multiple pharmacies as well as the frequency and amounts of controlled substances prescribed and purchased.

- **Providers in the practice should register to access the PDMP data.**
- **Check PDMP data frequently.**
- **Consider efficient procedures for integrating PDMP checks into the practice (e.g., delegating a medical assistant to obtain the patient's prescription history).**
- **Establish procedures for providers or their delegates, if applicable, to obtain PDMP data on their long-term opioid therapy patients periodically, in accord with the practice's policy.**

tip

PDMP

Create a single sign-on link to the PDMP to facilitate checking the PDMP into the clinicial workflow. Ensure all providers are registered with the PDMP, and if allowable, utilize delegates to access the PDMP data and give that to providers before a clinical encounter or refill authorization.

[9] Anderson D, Zlateva I, Khatri K, Ciaburri N. Using health information technology to improve adherence to opioid prescribing guidelines in primary care. *The Clinical Journal of Pain*, 2014.

In most states, providers may delegate their authority to access the PDMP data, although the procedures for doing so vary by state. Some state laws allow one provider in a practice to register for access and delegate to an assistant who can obtain PDMP information for all providers in the group. Information about state PDMPs and associated regulations for use is available at The National Alliance for Model State Drug Laws (http://www.namsdl.org/prescription-monitoring-programs.cfm).

STRATEGY

Use EHR Data to Develop Patient Registries and Track QI Measures

EHRs are critical sources of information for managing and monitoring the extent to which the long-term opioid therapy procedures are being implemented by the care teams.

- **Develop a clinical dashboard, so providers can see how their patients and their implementation of specific clinical practices compare to their colleagues.**
- **Use dashboards to measure the extent to which providers adhere to the practice's policies or for monitoring improvements.[9]**
- **Implement QI measures using EHR data (as described in Chapter 2).**

Registries are used to identify patients to target for specific interventions—in this case, for management and coordination of long-term opioid therapy. They are also used to generate quality measures and to monitor progress at the provider and practice levels. Consider:

- **A registry of patients on long-term opioid therapy to measure progress toward practice goals and to support providers in managing their panel of patients on long-term opioid therapy.**
- **A registry to identify patients who may be transitioning from short-term use for acute pain to long-term opioid use for chronic pain and may need to be evaluated prior to making the decision to use prescription opioids long term.**
- **A written procedure that specifies who is responsible for entering the data and when, who manages the data, and when and how reports are produced and distributed to providers and to the leadership team.**

tip

EHRs

Ensure that any EHR templates and fields are incorporated into the clinical workflow of providers and auto-populated to the extent possible to facilitate use.

tip

Registry

It is important to not just develop a registry as data for management or monitoring but also to feed back the information to providers to motivate prescribing behavior changes and ideally pair report results with accountability or incentives.

References

[1] Kilaru AS, Gadsden SM, Perrone J, Paciotti B, Barg FK, Meisel ZF. How do physicians adopt and apply opioid prescription guidelines in the emergency department? A qualitative study. Annals of emergency medicine. 2014;64(5):482-489. e481.

[2] Chou R, Fanciullo GJ, Fine PG, et al. Clinical Guidelines for the Use of Chronic Opioid Therapy in Chronic Noncancer Pain. *The journal of pain: official journal of the American Pain Society*. 2009;10(2):113-130.

[3] Dunn KM, Saunders KW, Rutter CM, et al. Opioid Prescriptions for Chronic Pain and Overdose. Annals of internal medicine. 2010;152(2):85.

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[5] Gomes T, Mamdani MM, Dhalla IA, Paterson JM, Juurlink DN. Opioid dose and drug-related mortality in patients with nonmalignant pain. Archives of Internal Medicine. 2011;171(7):686-691.

[6] Zedler B, Xie L, Wang L, et al. Risk factors for serious prescription opioid-related toxicity or overdose among Veterans Health Administration patients. Pain Med. 2014;15(11):1911-1929.

[7] Centers for Disease Control and Prevention. Calculating total daily dose for opioids for safer dosage. https://www.cdc.gov/drugoverdose/pdf/calculating_total_daily_dose-a.pdf

[8] Chou R, Deyo R, Devine B, Hansen R, Sullivan S, Jarvik Jea. The Effectiveness and Risks of Long-term Opioid Treatment of Chronic Pain. Evidence Report/Technology Assessment No. 218. Rockville, MD: Agency for Healthcare Research and Quality; 2014.

[9] Anderson D, Zlateva I, Khatri K, Ciaburri N. Using health information technology to improve adherence to opioid prescribing guidelines in primary care. The Clinical Journal of Pain. 2014.

Appendix F
Toolkit

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Please note that the CDC does not endorse the resources and websites cited throughout this document. Further, those included here do not present an exhaustive list of references, but rather are those taken into consideration by CDC scientists in developing this document.

Toolkit Part A.

Examples of Comprehensive Management Approaches

- **There are several existing resources that outline the components of safer management of long-term opioid therapy, including:**
  - Kaiser Permanente's *Patients on Chronic Opioid Therapy for Chronic Non-Cancer Pain Safety Guideline* (**https://www.ghc.org/static/pdf/public/guidelines/opioid.pdf**); and
  - Oregon Pain Guidance's *Opioid Prescribing Guidelines* (**http://www.oregonpainguidance.org/wp-content/uploads/2014/04/OPG_Guidelines.pdf**).
- **There is also literature on different practices' and organizations' approaches to managing long-term opioid therapy:**

1. Anderson D, Wang S, Zlateva I. Comprehensive assessment of chronic pain management in primary care: A first phase of a quality improvement initiative at multisite Community Health Center. Quality in Primary Care. 2012;20.
2. Anderson DR, Zlateva I, Coman EN, Khatri K, Tian T, Kerns RD. Improving pain care through implementation of the Stepped Care Model at a multisite community health center. Journal of pain research. 2016;9:1021.
3. Cahana A, Dansie EJ, Theodore BR, Wilson HD, Turk DC. Redesigning delivery of opioids to optimize pain management, improve outcomes, and contain costs. Pain Medicine. 2013;14:36-42.
4. Chelminski PR, Ives TJ, Felix KM, et al. A primary care, multi-disciplinary disease management program for opioid-treated patients with chronic non-cancer pain and a high burden of psychiatric comorbidity. BMC Health Services Research. 2005;5(3).
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7. Losby JL, Hyatt JD, Kanter MH, Baldwin G, and Matsuoka D. Safer and more appropriate opioid prescribing: a large healthcare system's comprehensive approach. J Eval Clin Pract. 2017 Jul 14.
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10. Pade PA, Cardon KE, Hoffman RM, Geppert CMA. Prescription opioid abuse, chronic pain, and primary care: A co-occurring disorders clinic in the chronic disease model. Journal of Substance Abuse Treatment. 2012;43:446-450.
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13. Westanmo A, Marshall P, Jones E, Burns K, Krebs EE. Opioid Dose Reduction in a VA Health Care System—Implementation of a Primary Care Population-Level Initiative. Pain Medicine. 2015.
14. Wiedemer NL, Harden PS, Arndt IO, Gallagher RM. The opioid renewal clinic: a primary care, managed approach to opioid therapy in chronic pain patients at risk for substance abuse. Pain Med. Oct-Nov 2007;8(7):573-584.

Toolkit Part B.

Examples of Local Healthcare System Policies

- **The following are examples of policies for managing and coordinating long-term opioid therapy:**
  - The practice develops an administrative definition of long-term opioid therapy to enable identification of long-term opioid therapy patients (e.g. receiving at least 70 days' supply of opioids in a 90-day period).
  - The practice develops an administrative definition to identify patients potentially transitioning into long-term opioid use (e.g., filling a third opioid prescription within six months when not identified as a long-term opioid therapy patient).
  - Long-term opioid therapy patients receiving daily doses in excess of 90 Morphine Milligram Equivalent (MME) should have their opioid regimen reviewed by a pain and/or rehabilitation medicine specialist.
  - Providers obtain signed, informed consent from patients initiating long-term opioid therapy.
  - The practice will not refill lost or stolen opioid prescriptions except in extraordinary circumstances.
  - A standard advance notification period (e.g., 4 days) prior to receiving an opioid refill is required.
  - A standard monthly refill will be for 28 days, so refills can be picked up on the same day of the week, avoiding refills that fall on a weekend.
  - Guidance for appropriate duration of opioid prescriptions (e.g., 3-7 days) for managing common acute pain conditions.
  - The practice will not provide opioid pain medicines to long-term opioid therapy patients already getting opioids from other healthcare providers.
  - Patients on particularly high-dose opioids (e.g., 200 MME) have their use reviewed by a pain medicine specialist every month.
  - The practice checks the prescription drug monitoring program (PDMP) periodically for patients receiving long-term opioid therapy, ranging from every prescription to every three months.
  - All long-term opioid therapy patients must sign or review an opioid treatment agreement and informed consent form, which is placed in the medical record.
  - Providers use standardized forms and templates in the electronic health record (EHR) for managing long-term opioid therapy patients.
  - Patients receiving long-term opioid therapy have urine drug tests every 12 months.
  - Providers must assess the functional status, quality of life, and pain intensity in all patients receiving long-term opioid therapy at baseline and follow-up visits, using a standard scale (e.g., PEG).
  - The practice will educate and engage the patient in order to ensure effective pain management.
  - Patients receiving long-term opioid therapy are expected to concurrently use nonopioid therapies and self-care management strategies to increase engagement in life activities and enhance quality of life.

Toolkit Part C.

Treatment Agreements

- **The following are potential talking points to discuss with patients as part of the treatment agreement conversation:**
  - Discuss that opioid therapy at any dosage level carries potential risks as well as benefits.
  - Discuss that opioid therapy may not improve pain or function, and initial benefits may diminish with prolonged use.
  - Ensure the patient understands the practice's policies regarding prescribing, refills, and use of different prescribers and pharmacies.
  - Discuss the methods and reasons for monitoring the patient's opioid use by means of UDTs, periodic v isits, checking the state's PDMP, and asking about symptoms of OUD. Assure the patient this is done for the sake of their safety.
  - If needed, introduce the patient to others on the care team and describe what their roles and responsibilities will be.
  - Conclude by summarizing the main responsibilities the provider and the patient will have.

- **The following are examples of treatment agreements for opioid therapy, followed by a health literacy-appropriate treatment agreement:**
  - Washington State Treatment Agreement (**http://www.lni.wa.gov/Forms/pdf/F252-095-000.pdf**)
  - VVA/DoD Clinical Practice Guideline Opioid Therapy: Chronic Pain Sample Opioid Pain Care Agreement (**https://www.nhms.org/sites/default/files/Pdfs/OpioidTxAgreement-VA2010.pdf**)
  - Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain (**http://nationalpaincentre.mcmaster.ca/documents/opioid_guideline_part_b_v5_6.pdf**) "Appendix B-5: Sample Opioid Medication Treatment Agreement"
  - Treatment Plan Using Prescription Opioids (**http://health.utah.gov/prescription/pdf/guidelines/treatment_plan.pdf**)
  - University of Michigan Health System Managing Chronic Non-Terminal Pain in Adults Including Prescribing Controlled Substances (**http://www.med.umich.edu/1info/FHP/practiceguides/pain/pain.pdf**) "Appendix C. Patient-Provider Agreement for Ongoing Use of Controlled Medication"
  - Oregon Pain Guidance (**http://www.oregonpainguidance.org/app/content/uploads/2016/05/Patient-Treatment-Agreements.pdf**) "Patient Treatment Agreement (Sample 3)"

Example of a Treatment Agreement

Patient name: _____ MR#:_____

[Name of Clinic]

Pain Medicine and Other Controlled Substances Agreement

This agreement is for patients who are prescribed certain pain medicines called opioids and other "controlled substances." These medicines are sometimes called narcotics.

This agreement pertains to the following list of your medicine(s).

1 _____

2 _____

3 _____

4 _____

The purpose of this agreement is to describe how you, your physician, and your treatment team will work together to make sure your medicine is used safely and works well to help you.

You and a [clinic] physician will sign the agreement to show you both understand and agree with it. It will be saved in your medical record, so you and your treatment team can look at it again later. You will get a copy to take home.

My pain/symptoms and goals

My pain/symptoms is/are (describe):

_____

What (activities) do I hope to be able to do?

_____

Goals for me are (describe):

_____

I understand the following:

- ☐ My pain/symptoms will probably not go away completely.
- ☐ My medicine may not work for me.
- ☐ The long-term use of opioid pain medicine is controversial.
- ☐ It is important not to miss appointments with my physician.
- ☐ Treating pain/symptoms often includes physical therapy, counseling, and/or other treatments.
- ☐ I will try additional treatments that my physician suggests.
- ☐ Increasing my participation in family, social, and/or work activities is part of my treatment program, which can make pain less bothersome.

Risks and safer use of controlled substances

Using this medicine might cause problems like:

☐ addiction ☐ allergic reactions ☐ breathing problems ☐ sleep apnea

☐ constipation and/or upset stomach

☐ dangerous driving and/or being charged with DUI

☐ feeling sleepy, dizzy, or confused

☐ overdose or death—especially if taken with alcohol or other drugs, or if I take more than my doctor prescribes

☐ problems urinating, problems with erections, reduced testosterone levels

☐ worse pain or feeling sick if I stop my pain medicine suddenly

I will:

☐ only get my medicine from my physician, Dr._____, or a covering doctor at this office if my physician is not available. If any other physicians prescribe pain medicine or other controlled substances for me in an emergency, I will let my [clinic name] physician know as soon as possible.

☐ call my nurse, _____, between the hours of 9 a.m. to 5 p.m. Monday through Friday with any questions or concerns about my pain/symptoms or medications.

☐ only get the medicine(s) listed here from one pharmacy:_____

Phone number: _____

I will:

☐ be honest and open with my physician and members of my treatment team about medicines and drugs I am taking, including over-the-counter medications and illegal drugs.

☐ talk to my physician if I feel I need more medicine than was prescribed, but I will not change it on my own or take pain medicine from other people.

☐ talk to my physician if I stop or would like to stop the medicine(s) listed here.

☐ never give or sell any of my medicine to anyone else.

☐ always keep my medicine in a safe place AND away from children and other people who come to my home.

☐ allow my doctor to check my urine to see what medicines or drugs I am taking.

☐ bring all of my unused medicines in their pharmacy bottles to my office visits if my doctor asks me.

My physician will:

- ☐ work with me to find the best treatment for my pain/symptoms.
- ☐ be honest and open with me about my pain/symptom treatment.
- ☐ ask me about problems caused by my medicine and treat these effects.
- ☐ make sure my medicine is refilled on time.
- ☐ refill my medicine during a visit.
- ☐ allow my nurse to refill my medicine if I don't have a scheduled appointment, and I will call at least 4 days before I run out of medicine.
- ☐ arrange for a covering physician at the clinic to refill my medicine when my physician is not available.
- ☐ will not provide extra refills if my medicine or prescription is lost, stolen, destroyed, misplaced, or if I run out earlier than expected.

Stopping and changing medicine (should involve provider-patient partnership and consent):

- ☐ My physician will stop or change my medicine if:
  - my goals are not being met, OR
  - I do not follow this agreement, OR
  - my physician thinks my medicine may be hurting me more than it is helping me.
- ☐ My physician might refer me to a specialist for treatment of pain/symptoms or drug problems.
- ☐ If my physician believes I have stolen or forged prescriptions, I sell my medicine, or if I threaten or act violently in any way, I will no longer be prescribed controlled substances from this clinic.

I have been able to ask questions about this agreement, and I understand and agree with what it says.

Patient signature: _____ Date: _____

Physician signature: _____ Date: _____

Source: Adapted from a form used with permission of Dr. Jessica Merlin, Assistant Professor, Division of Infectious Diseases, Division of Gerontology, Geriatrics, and Palliative Care, University of Alabama at Birmingham.

Toolkit Part D.

Telemedicine Consultation

Telemedicine consultations have been a way for healthcare providers without ready access to experts in a specific clinical area can connect providers with those experts across the country and obtain provider-to-provider feedback on specific patient cases. The following are two specific telemedicine consultation initiatives.

Project ECHO

"Project ECHO exponentially increases access to specialty care by moving knowledge, instead of moving patients." (http://echo.unm.edu)

Project Extension for Community Healthcare Outcomes (Project ECHO) was developed by the University of New Mexico with the goal of breaking down the walls between specialty and primary care. It focused on creating "communities of practice," building primary care providers' expertise, improving patients' access to specialty care, and improving the retention of primary care providers in rural and underserved communities. The development of Project ECHO was sparked by the fact that thousands of people are unable to access appropriate specialty care for their complex health conditions merely because there are not enough specialists to treat everyone who needs care; the gap between the need to access specialty care and the ability to access specialty care is even more pronounced in isolated and underserved communities. Project ECHO reduces these health disparities and revolutionizes medical education and care delivery by training primary care physicians on how to provide these specialty services. As a result, "primary care doctors, nurses, and other providers learn to provide excellent specialty care to patients in their own communities" and are consequently able to treat patients they otherwise would have referred out (http://echo.unm.edu). Initially launched so primary care providers could treat hepatitis C in their own communities, Project ECHO has been expanded to address 11 different disease conditions, including chronic pain and headache management.

The foundation of the Project ECHO model is its hub-and-spoke knowledge-sharing networks. These networks are led by teams of experts who use multipoint videoconferencing to conduct virtual clinics with community providers. Expert specialist teams at an academic hub are linked with primary care providers in local communities, who represent the spokes. The model orients itself around a learning community, where information exchange is multidirectional—"community providers learn from specialists, they learn from each other, and specialists learn from community providers as new best practices emerge" (http://echo.unm.edu).

▶ Pain and opioid-specific teleECHO clinics

Expert specialists and primary care providers participate in weekly TeleECHO clinics, which resemble virtual grand rounds and are combined with mentoring and patient care presentations. "The Chronic Pain & Headache TeleECHO Clinic (ECHO Pain) facilitates a multifaceted approach to chronic pain by incorporating a team of specialists that support primary care providers in rural communities who lack the resources necessary to sufficiently understand the management of [chronic] pain."

- The University of New Mexico: Project ECHO was developed by the University of New Mexico and launched in 2003. Specialist teams at academic medical centers throughout the state are linked to local providers. There are more than 45 sites receiving medical education and care management training with a treatment focus of "Chronic Pain and Headache" within the state of New Mexico. (http://echo.unm.edu/)
- The Integrative Pain Center of Arizona: The Integrative Pain Center of Arizona (IPCA) and its partner, the Community Health Clinic, Inc. (CHC) conducted the first Project ECHO replication project in Arizona and Connecticut. This is known as the CHC-IPCA ECHO. The Weitzman Institute is a branch of the Community Health Center, Inc. It is the first community-based research center established by a Federally Qualified Health Center. The Institute uses weekly Project ECHO telemedicine conferences to connect primary care

providers with expert faculty and improve the management of chronic pain.

- Project ECHO was introduced to the Department of Veterans Affairs (VA) in 2010. "Specialty Care Services adopted and expanded this program to transform the delivery of specialty care throughout VA. Specialty Care Access Network-Extensions for Community (SCAN-ECHO) extends the reach of specialty services and coordinates with the Veterans Patient Aligned Care Team (PACT)." (http://www.va.gov/HEALTH/docs/Specialty-Care-Access-Network.pdf)
- "The Rural Opiate Addiction Management Project for Rural Washington Physicians (Project ROAM) trains rural physicians in opioid use and helps them apply for the waiver to legally prescribe buprenorphine. After Project ROAM trains providers, Project ECHO's interdisciplinary experts monitor them as they begin to treat addiction in their practices." (http://depts.washington.edu/givemed/magazine/2011/03/addiction-and-chronic-pain/)

University of Washington TelePain (UW TelePain)

UW TelePain multidisciplinary pain expert tele-mentoring has already successfully demonstrated an effective means to disseminate and implement guidelines for prescribing opioids for chronic pain (Washington State Agency Medical Director's Group Interagency Guideline on Prescribing Opioids for Pain) across a large regional network (Washington State, Wyoming, Alaska, Montana, Idaho, Oregon, and Colorado) of primary care providers. Since March 2011, a multidisciplinary team of pain experts has delivered to more than 7,300 total attendees > 10,500 hours of chronic pain training, education, and consultation (30 avg./session, unique attendees 1,200+), reaching out to 270+ unique locations.[3]

Launched in direct response to extremely poor access to pain specialists, and confronting statewide high opioid use and escalating dose, with poor patient outcomes and "distressed" primary and specialty care practices , the Washington State legislature instructed the WA State Department of Health to impose 2011 regulatory requirements. These requirements necessitated access to pain specialty consultation for patients who met one or more of these criteria: on high-dose opioids, have poor pain outcomes, or are at high risk of addiction.

▶ Didactic curriculum (repeats every six months)

- Pain history and assessment
- Motivational interviewing
- Functional assessment
- Addiction assessment
- Establishing a pain diagnosis
- Risk screening for opioid safety
- UDT: use, interpret, respond
- Opioids and MME calculation
- Controlled substance agreements
- Prescription drug monitoring programs: how to access, use, and respond
- Pain tracker: patient outcomes
- Adjuvant analgesics
- Anxiety: assessment and treatment
- Depression: assessment and treatment
- PTSD as comorbid condition: assessment and treatment
- Cognitive-behavioral therapy
- Exercise and pain

▶ Supplemental curriculum (repeats every year)

- Medicinal cannabis
- Methadone
- Sleep disturbances and chronic pain
- Disability
- Complementary and alternative medicine
- Pain in children
- Pain in older adults
- Pain during pregnancy
- Primary care pain disorders (e.g., fibromyalgia, headaches, osteoarthritis, low back pain, diabetic peripheral neuropathy, visceral abdominal and pelvic pain)

Toolkit Part E.

Examples of Training Resources

- **The following table describes existing resources for training on the topics relevant to safer and more effective management of long-term opioid therapy in non-cancer pain patients. The table provides the URL to access each training and indicates the topics covered by each resource.**

CDC Clinician Outreach and Communication Activity (COCA) Calls/Webinars: CDC's National Center for Injury Prevention and Control (NCIPC) partnered with CDC's Clinician Outreach and Communication Activity (COCA) and the University of Washington to present a webinar series about the CDC Guideline for Prescribing Opioids for Chronic Pain. This seven-part series is intended to use a data-driven approach to help providers choose the most effective pain treatment options and improve the safety of opioid prescribing for chronic pain. The primary objective is to provide informative, case-based content that will demonstrate and instruct participants on how the 12 recommendations of the the CDC *Prescribing Guideline* can be incorporated and applied in a primary care practice setting.

- CDC's seven-part COCA Call Webinar Series

CDC's Online Training Series for Healthcare Providers: This interactive online training series aims to help healthcare providers apply CDC's recommendations in clinical settings through patient scenarios, videos, knowledge checks, tips, and resources. Providers can gain a better understanding of the recommendations, the risks and benefits of prescription opioids, nonopioid treatment options, patient communication, and risk mitigation. Additional topics are planned. Each stand-alone module is self-paced and offers free continuing education credit (CME, CNE, and CEU).

- Applying CDC's Guideline for Prescribing Opioids Online Training Series

Additional resources:

- CDC Train
- CDC Learning Connection

Select educational resources for providers

- **The following are resources that can be used in training providers and other healthcare professionals to support care coordination of long-term opioid therapy:**

- Group Health Research Institute's "Principles for more selective and cautious opioid prescribing" (https://depts.washington.edu/anesth/education/forms/pain/Principles_opioidPrescribing.pdf)
- Deyo, Von Korff and Duhrkoop's state of the art review of opioids. See: Deyo, R. A., Von Korff, M., & Duhrkoop, D. (2015). Opioids for low back pain. Bmj, 350, g6380. (http://www.bmj.com/content/350/bmj.g6380)

Additional resources:

- Safe and Effective Opioid Prescribing for Chronic Pain (Boston University School of Medicine)
- Prescriber's Clinical Support System for Opioid Therapies (PCSS-O)
- Prescriber's Clinical Support System for Medicated Assisted Treatment (PCSS-MAT)
- COPE-REMS (University of Washington)

Toolkit Part F.

Challenges or Barriers to Implementing Long-term Opioid Management Strategies and Potential Solutions

▶ Table 1. Solutions for implementing long-term opioid management strategies

CHALLENGES OR BARRIERS	POTENTIAL SOLUTIONS
Lack of provider understanding of the safety issues with long-term opioid therapy and extent of misuse and abuse.	Provide training to providers; retrain and update on findings in practice (e.g., rates of misuse).
Insufficient access to needed patient information.	Use strategies like the Prescription Drug Monitoring Programs (PDMPs) and other sources mentioned in CDC *Prescribing Guideline*.
Competing demands on providers' time.	Educate practices and providers on the real safety issue with long-term opioid therapy and the importance for providing high-quality care.
Inadequate time for providers to participate in telemedicine or e-consulting (Project ECHO).	Encourage medical directors to prioritize ongoing training, support, and provider participation in telemedicine efforts.
Insufficient provider adherence to new opioid policies	Have the leadership provide incentives
Challenges with applying policies or strategies because of the difficult conversations to hold with patients.	Provide robust training on difficult conversations with patients in managing long-term opioid therapy.
Consistency across providers' approaches to assessment, care plan, documentation.	Create templates embedded in the EHR (e.g., treatment agreement, pain assessment components).
Excessive number of calls from patients demanding medication renewals and other requests.	Develop a treatment agreement to set consistent response to calls and demands from patients. Designate a person who has a list of patients on opioids—print out prescription for provider to sign (after ensuring that the patient has a follow-up scheduled within 3 months of last evaluation).
Unknown prejudice and bias against patients who develop opioid addiction among staff.	Address prejudice and bias at the beginning of implementation and as part of training to enhance non-judgmental interviewing skills of providers.
Limited uptake and utilization of standardized templates for documentation.	Use a clinical dashboard or other monitoring tool to share each provider's rates.
Providers "got no time for pain," as one leader in long-term opioid therapy described it. Providers have inadequate time to discuss with patients about their pain.	Use a team-based approach to leverage providers' time, and provide a template of aspects to cover in pain assessment to support the provider-patient encounter. Use other staff to do tasks that they can (e.g., print PDMP results, order UDT per protocol).
Inefficient work procedures or workflow to implement some strategies successfully.	Determine the appropriate workflow for staff in their role implementing the strategies is important (e.g., understanding who, how, and when random UDTs will be drawn).
Some PDMP systems are clunky; a non-delegable duty to check; difficulty to register on system.	Many states are making improvements to their PDMP systems; New Jersey developed an app to access their PDMP. Health systems can work with EHR vendors to integrate PDMP information into the EHR.
Inconsistent implementation; providers do not complete or integrate all components.	Create EHR templates and monitor progress and rates of adherence to policy.
Adhering to templates for assessment or monitoring long-term opioid therapy /pain.	Use clinical dashboard to closely monitor and display utilization by provider and make the dashboard publicly visible and available; providers can see ratings of themselves and other providers—incentive not to be an outlier with poor adherence to templates (negative incentive).
Limited resources.	Leverage existing infrastructure (i.e., EHR, QI), utilize staff to the top of their licenses (e.g., MAs), and select strategies that are appropriate and feasible given current resource constraints.

Toolkit Part G.

PEG: Scale to Assess Pain Intensity and Interference

▶ **The PEG is a three-item scale to assess pain intensity and interference.**

1. What number best describes your pain on average in the past week?

0	1	2	3	4	5	6	7	8	9	10
No pain										Pain as bad as you can imagine

2. What number best describes how, during the past week, pain has interfered with your enjoyment of life?

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

3. What number best describes how, during the past week, pain has interfered with your general activity?

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

Source: Krebs EE, Lorenz KA, Bair MJ, et al. Development and Initial Validation of the PEG, a Three-item Scale Assessing Pain Intensity and Interference. *J. Gen. Intern. Med. 2009;24(6):733-738*

Toolkit Part H.

Nonopioid Options for Managing Chronic Pain

▶ CDC resources:

Fact Sheets:

- Nonopioid Treatment for Chronic Pain
- Promoting Safer and More Effective Pain Management

Training:

- Treating Chronic Pain Without Opioids

▶ Table 2. Nonopioid options for managing chronic pain

Patient lifestyle	Physiotherapy interventions
• Increasing engagement in meaningful, rewarding and/or pleasant life activities that reduce focus on chronic pain • Healthy sleep management including sleep restriction and stimulus control techniques • Weight reduction • Improve healthy eating and nutrition • Stress reduction, relaxation, mindfulness meditation • Exercise (including non-aerobic, low impact activities that reduce sedentary time lying down or sitting)	• Functional therapies – Physical therapy (PT) – Occupational therapy (OT) – Passive modalities ("activities performed by the physical therapist on the patient without any form of exercise involving patient volitional efforts")
Behavioral interventions	**Medical interventions**
• Educational groups – Preventive – Support – Peer-to-peer/Living well workshops – Shared medical appointments • Psychotherapy – Individual counseling – Group therapy – Cognitive behavioral therapy – Acceptance and commitment therapy • Supportive care – Case management • Trauma-informed care – PTSD screening – Domestic violence screening – Child abuse screening	• Nonopioid medications that may aid in chronic pain management – NSAIDS, acetaminophen – Tricyclic antidepressants (neuropathic pain) – Anti-epileptics (neuropathic pain) – Antidepressants – Topical medications • Minimally invasive surgical procedures – Nerve blocks, steroid injections – Interventional treatments: ablations, injections, – Surgical treatment • Complementary and alternative treatments – Manipulation therapy

Source: Oregon Pain Guidance Group. Opioid Prescribing Guidelines. *Oregon Pain Guidance*. 2014.

Toolkit Part I.

Additional Guidance on Urine Drug Testing

Who should be tested?

All patients on long-term opioid therapy should have UDTs periodically. Patients can be targeted for testing based on the risk of abuse or be selected randomly, though implementing random testing can be difficult for practices. [4-11] Universal testing similar to universal precautions is another approach that aims to "de-stigmatize" testing and to remove any perceived bias related to patients selected for testing. [1-4, 6-7, 13-16]

Key points to provide patients before conducting UDT

▶ **Discuss the following key points regarding UDT with the patient beforehand:**

- Purposes of testing.
- Provider/patient trust—requiring UDT does not imply a lack of trust on the part of the provider; it is part of a standardized set of safety measures.
- What drugs the test will cover.
- What results does the patient expect?
- Prescribed drugs or any other drugs (including marijuana and other illicit drugs) the patient has taken.
- Time and dose of most recently consumed opioids.
- Potential cost to patient if the UDT is not covered by insurance.
- Expectation of random repeat testing depending on treatment agreement and monitoring approach.
- Actions that may be taken based on the results of the test.

Interpreting results and actions to be taken

Providers need to be aware of the limits of UDTs and have a resource for questions regarding drug testing or results.[12] This could be a certified medical review officer, clinical laboratory director, or manufacturer for point of care (POC) testing.[10] Multiple variables affect the diagnostic accuracy of UDTs, including cutoff selection, pharmacokinetics, pharmacodynamics, and pharmacogenetics, laboratory technology, and subversion or adulteration of the urine specimen. [3-4, 16]

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[3] Manchikanti L, Abdi S, Atluri S, et al. American Society of Interventional Pain Physicians (ASIPP) guidelines for responsible opioid prescribing in chronic non-cancer pain: Part 1 - Evidence assessment. Pain Physician. 2012;15:S1-S66.

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[10] Department of Veterans Affairs, Department of Defense. VA/DoD Clinical Practice Guideline for Management of Opioid Therapy for Chronic Pain. The Management of Opioid Therapy for Chronic Pain Working Group. 2010.

[11] Washington State Agency Medical Directors' Group. Interagency Guideline on Prescribing Opioids for Pain 2015.

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[13] Park TW, Saitz R, Ganoczy D, Ilgen MA, Bohnert ASB. Benzodiazepine prescribing patterns and deaths from drug overdose among US veterans receiving opioid analgesics: case-cohort study. 2015;350.

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[15] Timm KE. A randomized-control study of active and passive treatments for chronic low back pain following L5 laminectomy. Journal of Orthopaedic & Sports Physical Therapy. 1994;20(6):276-286.

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Unexpected UDT results, interpretation, and options for providers' response

Table 3. Unexpected results, possible explanations, and potential actions for providers to take

Unexpected result	Possible explanation	Actions for provider
UDT negative for prescribed opioid	• False negative. • Non-compliance. • Diversion.	• Repeat test using chromatography: specify the drug of interest (e.g., oxycodone often missed by immunoassay). • Take detailed history of the patient's medication use for the preceding 7 days (e.g., could learn that patient ran out several days prior to test). • Ask patient if they've given the drug to others. • Monitor compliance with pill counts.
UDT positive for non-prescribed opioid or benzodiazepines	• False positive. • Patient acquired opioids from other sources (double doctoring, "street").	• Repeat UDT regularly • Ask the patient if they accessed opioids from other sources. • Assess for opioid misuse/addition? • Review/revise treatment agreement.
UDT positive for illicit drugs (e.g., cocaine, cannabis)	• False positive. • Patient is occasional user or addicted to the illicit drug. • Cannabis is positive for patients taking dronabinol (Marinol). THC: CBD (Sativex) or using medical marijuana.	• Repeat UDT regularly. • Assess for abuse/addiction and refer for addiction treatment as appropriate. • Ask about medical prescription of dronabinol, Delata-9-Tetrahydrocannabinol (THC): Cannabidiol (CBD) or medical marijuana access program.
Urine creatinine is lower than 2-3 mmol/liter or < 20 mg/dL	• Patient added water to sample.	• Repeat UDT. • Consider supervised collection or temperature testing. • Take a detailed history of the patient's medication use for the preceding 7 days. • Review/revise treatment agreement.
Urine sample is cold	• Delay in handling sample (urine cools within minutes). • Patient added water to sample.	• Repeat UDT. • Consider supervised collection or temperature testing. • Take a detailed history of the patient's medication use for the preceding 7 days. • Review/revise treatment agreement.

Source: National Opioid Use Guideline Group (NOUGG). Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain. 2010.

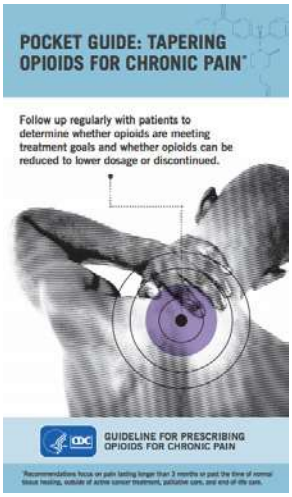
Actions to take after UDT results

- **Act on the UDT results in the following ways:**
  - Inform the patient of the test results.
  - Discuss with the patient any unexpected results or findings of drug use that the patient had talked about prior to the test. It can be helpful to ask patients what to expect the UDT will show beforehand.
  - Review the treatment agreement and reiterate concerns about the patient's safety.
  - Determine if frequency and intensity of monitoring should be increased.

For additional information on using UDTs to monitor opioid therapy, see the Washington State Agency Medical Directors' Group's Interagency Guidelines on Prescribing Opioids for Pain. (http://www.agencymeddirectors.wa.gov/Files/2015AMDGOpioidGuideline.pdf).

Toolkit Part J.

Tapering and Discontinuing Opioids



- CDC's Pocket Guide for Tapering Opioids for Chronic Pain (**https://www.cdc.gov/drugoverdose/pdf/clinical_pocket_guide_tapering-a.pdf**)
- Dosing and Titration of Opioids (**https://emergency.cdc.gov/coca/calls/2016/callinfo_081716.asp**)
- "Tapering or Weaning Patients off of Chronic Opioid Therapy" (**https://7cd526d7dc73a4cc6c93-d371975f3074159d211824381bcd2df5.ssl.cf1.rackcdn.com/GroupHealthTapering_Patients_off_Chronic_Opioid_Therapy.pdf**)
- Tapering Long-term Opioid Therapy in Chronic Noncancer Pain: Evidence and Recommendations for Everyday Practice. Mayo Clin Proc. 2015;90(6):828-842.

Toolkit Part K.

Working Collaboratively with Patients Receiving Long-term Opioid Therapy: Principles and Examples

▶ **CDC resources:**


- **Guideline resources:** CDC Opioid Guideline Mobile App
- **Training:** Communicating with Patients
- **Checklist:** PDO Checklist for Prescribing Opioids
- **Brochure:** Pharmacists on the Front Lines
- **Fact sheet:** Prescription Drug Monitoring Programs
- **Pocket guide:** SAMHSA Pocket Guide for Medication-Assisted Treatment (MAT)

Use these principles and language suggestions when discussing with the patient, opioid risks and safety monitoring or introducing a change in treatment plan.

Principles for talking with patients about opioids

Keep the primary focus on outcomes patients care about.

- Conversations should focus on improving overall quality of life, enabling participation in important life activities, protecting patients from opioid-related harm, and achieving their long-term goals, not on eliminating pain. Emphasize concern for the patient's well-being.

▶ When discussing risk, focus on the medications.

- Make it clear that drug-related harms can happen to anyone, so all patients are monitored for signs they are having problems with opioids.
- Emphasize that new information on opioid risks and harms are leading providers to change when and how opioids are prescribed.
- Particularly if patients are prescribed moderate-to-high opioid doses or are using other sedating substances (sedatives, alcohol), discuss risks of opioids suppressing respiratory drive.
- Particularly if patients have a history of substance abuse disorder, discuss risks of opioids inadvertently endangering their sobriety.

▶ Develop a differential diagnosis for patient behaviors that cause concern.

- If a patient is misusing opioids, expressing concerns about opioid effects, reports symptoms of OUD when asked relevant questions, getting opioids from multiple sources, using more than prescribed, or has unexpected urine results, consider it a sign of potential opioid-related harm or an unrecognized serious condition (e.g., substance use disorder, depression)—not as a "treatment agreement violation."
- When deciding on treatment changes, consider all evidence you have about the benefits and harms the patient is experiencing.

- **Focus on what patients can do to improve their quality of life.**
  - Opioids are not a "panacea" and should not be the main approach to managing chronic pain. On average, patients can expect a 30 percent reduction in pain at 12 weeks, but long-term benefits for pain relief are unknown. Initial analgesic benefits may not be sustained long term.
  - Instead, help patients explore ways to live better and become more engaged in life activities—the ability to do more of what the patient values most. Have patients define treatment goals without using the word "pain." Alternatively, ask what they would be doing if they had less pain.
  - Options to increase activities that patients have more control over than pain can be more effective over the long run and carry fewer risks than prescriptions for pain medications.
  - Even with chronic pain, many patients can go for walks or do other pleasant activities that reduce their suffering. Emphasize the importance of using multiple therapies and self-care strategies in addition to using opioids.
  - Help address any unrealistic anxieties or fears patients may have about physical activity.
  - If a patient asks for a higher dose, redirect the conversation to strategies more likely to improve their quality of life in the long run.
  - Emphasize the potentially temporary nature of pain relief from opioids—but the permanent dependence on opioids—to avoid withdrawal symptoms. Over time, it can be difficult to distinguish benefits of pain relief from the avoidance of withdrawal symptoms.
  - Remember that your relationship with and empathy for the patient, along with optimism that your patient can achieve a better quality of life, are the most important things you offer, not the drugs, tests, and procedures you prescribe.

Effective patient communication and education

In high-quality care for chronic pain, the provider's relationship with the patient can be much more important than the drugs, tests, or procedures prescribed.

- **Remember the importance of the patient-provider relationship.**
  - It is important to work collaboratively with patients, conveying empathy for the difficulties living with chronic pain, and adopt a non-judgmental stance. Communication with the patient is a building block of the therapeutic relationship. Emphasize the shared goal of ensuring safety and improving quality of life, while acknowledging the patient's own experiences with the limitations of medications for controlling chronic pain. During pain exacerbations, help the patient recall that pain will improve and identify temporary management strategies (pharmacologic or otherwise) rather than escalating opioid dose for the long run. Remember, what the provider says is only part of what is being communicated. Body language, eye contact, and expressions of respect and empathy send messages that engender trust. Because long-term opioid therapy is inherently risky, patients' trust in their providers is essential to safe and successful treatment.
- **Use a patient-centered, empathic communications style.**
  - Some conversations with patients treated for chronic pain are difficult for both providers and patients.
- **Use suggested approaches to working collaboratively with patients when dealing with difficult and sensitive issues:**
  - Introduce the changes being made in the practice to manage long-term opioid therapy.
  - Introduce the need for monitoring.
  - Discuss patient preferences regarding dose-reduction or tapering.
  - Introduce non-drug approaches to managing chronic pain.
  - Discuss refills and irregularities in supply of medications.
  - Respond to unexpected findings in UDT or PDMP.

- **Talk with patients about UDT.**

- **Review the model approaches for working with patients through difficult situations and consider adapting the suggested language to your practice.**
  - Providers can also utilize education resources to help patients understand the risks, develop realistic expectations regarding the long-term effectiveness of opioid therapy and the limited scientific evidence, and better understand the many different ways of managing chronic pain that some patients find helpful.
- **Use patient education resources to help patients understand the risks of opioid therapy and different ways of managing chronic pain that patients find helpful.**
  - (See Toolkit Part L for a list of existing patient education resources.)

Having difficult conversations

- **Introducing a change in practice[1] (Krebs et al.)**

Focus on new information and how expert thinking on opioids has changed.	"I want to talk with you about how what we know about opioids has changed based on the latest science and clinical recommendations."
	"Fifteen years ago, many physicians were taught that these medications were good for most kinds of pain and almost risk free. But recent evidence has shown us they were wrong."
	"Have you been paying attention to the news about pain meds lately? Do you have concerns or questions about what you've been hearing?"
	"From what you have been telling me, these medications aren't as effective as you would like. Let's think about trying something different." *If patient is defensive:* "Patients who expect drugs alone to improve their overall quality of life are usually disappointed. What are other things you do that seem to help you be more active? Let's talk about approaches that I have seen work for other patients with problems like yours."

- **Introducing monitoring for opioid harms (Krebs et al.)**

Focus on the harms opioids can cause.	"These drugs have serious risks even when used as directed, especially at higher doses."
	For patients on higher doses, using extra for flare-ups, or using sedatives and/or alcohol: "These drugs can stop your breathing which can cause you to die. It happens even when people have been on the same dose for a long time."
	"We used to think people suffering from pain did not become addicted to prescription pain medicines. We now know that you can become addicted to pain killers used for chronic pain, even if you haven't had problems with drugs or alcohol in the past."
	"We used to think the dose didn't matter as long as we went up slowly, but now we know higher doses lead to higher risks of serious injuries and accidental death. And, higher doses don't seem to reduce pain over the long run."

[1] Krebs E, Von Korff M, Deyo R, et al. Safer Management of Opioids for Chronic Pain: Principles and language suggestions for talking with patients. Minneapolis: Center for Chronic Disease Outcomes Research, Women's Veteran's Comprehensive Health Center

Reduce stigma by treating everyone the same.	"Our clinic has a policy recommending against moving to higher doses because there is no evidence of benefits, but risks and harms are much greater, and it can be much harder to quit if problems arise."
	"Our clinic is making changes for all of our patients, so pain medication prescribing is safer than it has been in the past."
	"It's my job to consider potential benefits and harms and prescribe treatments only when they are safe and the benefits are greater than the potential harms."
	"Our clinic suggests monitoring opioid safety using standard approaches for all patients."
	"People don't choose to develop an addiction, and I have no way to predict who might have trouble with these medications."
Be your patient's ally by expressing empathy and support for their concerns and uncertainties.	"Do you know anyone who has had an opioid problem, such as becoming addicted, or been hurt by these medications, such as an overdose?"
	"I promise to be honest with you if I have any concerns about how you are using your medications. In turn, I ask you to let me know right away if you develop any cravings or other concerns about how the drugs are affecting you. It is common to experience these problems, and they aren't your fault, so let me know right away."

▶ Introducing dose reduction or tapering (Krebs et al.)

Provide information and redirect the conversation.	"Some call them 'pain killers,' but they don't work that well for most people with back pain. Studies show that 4 out of 5 people continue to have bad pain and pain-related activity limitations when using opioids long term." "My experience is that patients who taper opioids end up with clearer thinking and more energy to engage in positive activities that help them focus less on their pain."
	"It seems the body just gets used to the long-acting, around-the-clock medicines, and they quit working. Many of my patients seem to do better taking the short-acting medications only when they need them."
	"For most people, the benefits wear off as the body gets used to the medications. Then they're stuck on a medicine that isn't really doing much for them. They often assume they'd be worse off without it, but it turns out that's not true. Let's talk about what you can do to live a better life, so all your eggs aren't in one basket."
	"These drugs have risks for everyone who takes them. You are more likely to have a serious harm because you [have been taking them for a long time; are taking them every day; are taking > 50 mg morphine equivalent dose a day; are taking sleeping pills, too; have a family history of alcoholism; have depression; etc.]. We can't do much about your family history, but you could reduce your risk by [going down on the dose; stopping the sleeping pills; taking them less often]."
Ask about the patient's concerns.	"Do you ever worry about harmful effects of your pain medications?"
	"You're on a very high dose and have been for [number of] years. Do you ever wonder if the drugs are still working for you?"
	"How would you feel about taking these medications for the rest of your life?"
	"Have you ever thought about trying to cut back?"

Suggest a change.	"You're telling me that your pain is really terrible, and I hear you. It seems to me that what we're doing just isn't working. I know they helped you at first, but I think the effect of the medications has worn off. We should consider making some changes."
	"I wonder if you really need to be on this high a dose. In my experience, most people can cut their doses back quite a bit without any increase in pain. I'd like to try going down just [5 mg; 1 pill a day; etc.] and see if you notice a difference. What do you think?"
	"I want to start making changes to make sure this medication is safe for you. There are several different things we could start with … [provide options]. Where would you like to start?"
	"While we're working on the medications, I also want to work on some of the underlying things that are contributing to your pain. For you to get better, you'll need to [get stronger; start being more active; get back to your social life]. I'd like to talk about some goals we can keep track of together, so we know how well our plan is working."
Continually revisit readiness to change.	"Last time, we talked about [the safety of your pain meds; whether the opioids are really working]. I still recommend [making some changes; going down on the dose]. Have you thought more about whether you're ready for that?" *If yes, suggest options. If no, remind of reasons, suggest potential options, ask again next visit.*
Be honest and reassuring about what patients can expect.	"We can push the pause button any time you need to."
	"I don't want to make any sudden moves—just one baby step at a time. Then we'll talk about the results together."
	"I promise I'm going to stick by you."
	"Remember, you might feel a little worse before you feel better. I want to see you again in four weeks to check how you're doing. By then, your pain should be evened out again."
	"Since your body is used to having this drug in your system, you might feel withdrawal symptoms after we decrease your dose. This might mean you feel more pain or get worse sleep. But it will be temporary. It doesn't mean the drug is actually helping—it's just that your body needs to get used to the new dose."
Be honest and reassuring about what patients can expect.	"As a back-up plan, in case of a seriously bad day, I could give you some extra [short-acting opioid]."
	When tapering after a small dose reduction, ask the patient about any positive changes—such as increased energy, alertness, ability to be active, sleeping better. It helps to have patients focus on any beneficial outcomes. It may also be helpful to note expected negative effects that did not materialize: "From what you are saying, your pain seems to be about the same as before."
Respond to setbacks and focus on problem-solving.	"Remember how miserable you were on the medications? If your pain was really well-controlled back then, we wouldn't be doing this at all."
	"Let's just hold on the current dose and not try to make more changes right now. How are things going with your goal to [walk every day; keep a regular sleep schedule; join the gym]?" *Focus on ways to problem-solve and reach the patient's goals.*
	"Usually these flare-ups only last a few days. Is there anything that would help to take your mind off it in the meantime? I know you mentioned that [you do better when you're with other people; that it feels good to float in the pool]."
	"I'm not holding out on you. If I had an easy solution for the pain today, I'd give it to you right now. I still think this is going to be worth it in the long run.' *Remind the patient of their long-term goals.* "How can you get back on track with [your short-term goal]?"

Introducing nondrug approaches to managing chronic pain (Krebs et al.)

Introduce materials on other ways to manage chronic pain.	*Try giving a limited amount of reading material that will be discussed at the next visit. Information on sleep and pacing are helpful for many patients.* "This workbook has helped other patients of mine with chronic pain. It gives a lot of different ideas for ways to manage chronic pain"
	Check in on progress at every visit, even if not discussed in depth: "How are things going with the relaxation techniques we talked about?"
	"There are a lot of things that make pain worse, like not sleeping well, or doing too little or too much exercise. When the pain is really bad, people do things that make it worse, like shallow breathing, tensing muscles, and thinking that the pain will never get better. This provides a menu of options." *Focusing discussion on these kinds of options can change the conversation from what the doctor is doing to control pain to what the patient is doing to improve quality of life This can be helpful, even if the changes seem small initially.*

Talking with patients about medication supply[2] (SAMHSA, 2012)

Provider	"I see that you are here because you ran out of your pain medication before you were due to pick up the next prescription."
Patient	"I took extra pills for a few days, and now I'm out. I'm hurting more because I don't have any pills."
Provider	"Can you tell me what happened?"
Patient	"I fell and hurt my knee, and it was really bothering me, so I took more than I usually do."
Provider	"We have a written agreement that you'll take your medications only as prescribed."
Patient	"Yeah, but it made sense because my knee hurt so bad."
Provider	"Knee pain is a different kind of pain, and increasing your opioid medication is not necessarily the best treatment for that. Next time, please call me first as we agreed."
Patient	"OK, I'm sorry."
Provider	"Whenever one of my patients breaks the agreement for any reason, I always ask for a urine sample. When did you last take your medicine?"
Patient	"I just ran out yesterday."
Provider	"So you did not take anything else when you ran out of your prescription?"
Patient	"No! I didn't have anything else to take."
Provider	"OK, I'll write your prescription while you go see the nurse. If your urine sample is OK, I'll give you your prescription."

Responding to unexpected findings, UDT or PDMP results, or concern for substance use disorder or diversion (Krebs et al.)

Keep the focus on the patient's well-being.	"I called because I'm concerned about you. There was something I didn't expect in your [urine/ pharmacy records], so I wanted to check in with you about how you're doing." *Followed by silence to allow patient to talk.*
	"This pattern can sometimes be a sign that a person is at risk for opioid addiction, which is a serious disease that needs treatment." *Followed by assessment questions and offer of resource/referral.*
	"It's my job to weigh up the potential benefits and potential harms, and to prescribe medications only when the benefits are greater than the harms. In your situation, I'm worried the risks outweigh the benefits, so I can't keep prescribing them for you."

[2] Substance Abuse and Mental Health Services Administration (SAMHSA). A Treatment Improvement Protocol: Managing Chronic Pain in Adults With or in Recovery From Substance Use Disorders. 2012.

Avoid backing the patient into a corner.	"I know that medications get lost and things happen. But this pattern can also look like there is a problem developing—like someone is getting hold of your medicines, or there is loss of control over how much you are using. As a doctor, I just can't prescribe if I'm not 100% sure where the medications are going and how they are being used."
	"As a doctor, my job is to be careful with these medications and to watch out for your health."
	"I'm not sure what's been happening with you, but I'm concerned for your well-being."
Redirect the conversation while maintaining the relationship.	"These drugs aren't an ideal treatment for pain in the long term, anyway. For many people, their effects wear off over time. I'd like to try some new approaches to see if we can do better."
	"Patients who expect drugs to control their pain are usually disappointed. With or without chronic pain, my patients who are doing better use multiple approaches. Let's talk about what might help you become more active and do more things that you enjoy [walking; pleasant activities; relaxing activities; mindfulness meditation; avoiding thoughts that everyday pain means you are harming your body]." *It can be difficult to talk about alternatives if opioids are being cut off or reduced against the patient's wishes. In difficult circumstances, taking time to listen to concerns (within limits) and expressing empathy without changing your decision can be helpful for the future.*
Redirect the conversation while maintaining the relationship.	"I want to work with you to find a better pain management plan."
	"When can you come back to see me?"

▶ Addressing resistance to urine drug testing (SAMHSA, 2012)

Patient	"Why do I need to give you a urine sample? Don't you trust me?"
Provider	"The urine sample gives me a great deal of useful information about how you are using your medications and whether you are running into problems with other substances."
Patient	"It feels like spying."
Provider	"It may seem like that to you, but it's a standard part of care for all my patients. Any level of substance use can affect a patient's life and the management of the pain. I do this as part of my responsibility to lower risks for all my patients, along with asking about your concerns. Is there something we need to talk about?"
Patient	"But I gave you a urine sample last time I was here."
Provider	"Yes, you did. Let's look at the standard treatment agreement. Let's see. Here it is. We agreed that you might be asked for a screen at every appointment."

▶ Talking with Patients about unexpected UDT results (SAMHSA, 2012)

Provider	"It seems you have been taking medications that I haven't prescribed."
Patient	"No, I haven't."
Provider	"Your last urine test was positive for benzodiazepines. Can you think of any reasons why they might have appeared?"

Toolkit Part L.

Patient Education Resources

- The following are examples of patient education resources:

- **Fact Sheet:** Prescription Opioids: What You Need to Know
- **Patient Poster:** Expectations for Opioid Therapy
- **Video:** Prescription Opioids: Even When Prescribed by a Doctor
- **Videos:** RxAwareness Campaign
- **Tip Card:** Preventing an Opioid Overdose
- **Additional patient resources:**
  - Pregnancy and Opioids
  - Podcast
  - Get the Facts

- SAMHSA Resources:
  - Opioids
  - Finding Quality Treatment for substance Use Disorders
  - Clinical Guidance for Treating Pregnant and Parenting Women With Opioid Use Disorder and Their Infants
  - Medications for Opioid Use Disorder – Executive Summary

- Videos on chronic pain and opioids from Oregon Pain Guidance:
  - Understanding Pain: What to do about it in less than five minutes
    Animation by Hunter Integrated Pain Service (5 minutes)
  - Best Advice for People Taking Opioid Medication
    Animation by Dr. Mike Evans (11 minutes)

Toolkit Part M.

Patient Health Questionnaire (PHQ-9)

- The Patient Health Questionnaire (PHQ-9) can be accessed here.

Generalized Anxiety Disorder seven-item (GAD-7) Scale

Over the past two weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on the edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about difficult 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

Column totals: _____ + _____ + _____

Add totals together: _____

8. If you checked off any problems, how difficult have those 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

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

[1] http://www.agencymeddirectors.wa.gov/Files/2015AMDGOpioidGuideline.pdf

[2] Franklin G, Sabel JC, Jones CM, Mai J, Baumgartner C, Banta-Green CJ, Neven D, Tauben, D. A comprehensive approach to address the prescription opioid epidemic in Washington State - milestones and lessons learned. Am J Pub Health. 2015 Mar;105(3):463-9.

[3] depts.washington.edu/anesth/care/pain/telepain/index.shtml.

[4] Upshur CC, Luckmann RS, Savageau JA. Primary care provider concerns about management of chronic pain in community clinic populations J Gen Intern Med. Jun 2006; 21(6): 652–655

[5] Medical Quality Assurance Commission Chapter 246-919 WAC: 850 -863