ADAPTING YOUR PRACTICE

Recommendations for the Care of

Homeless Adults with

Chronic Non-Malignant Pain

Chronic Pain Management

Adapting Your Practice: Recommendations for the Care of Homeless Adults with Chronic Non-Malignant Pain was developed with support from the Bureau of Primary Health Care, Health Resources and Services Administration, U.S. Department of Health and Human Services.

Wismer B, Amann T, Diaz R, Eisen D, Elder N, Ho C, Hwang S, Johnston M, Joslyn M, Kertesz S, Kushel M, Preston C, Solotoroff R, Thompson L, Silva F, Smith S, Zevin B, Meinbresse M, Post P (Ed.). *Adapting Your Practice: Recommendations for the Care of Homeless Adults with Chronic Non-Malignant Pain*, 128 pages. Nashville: Health Care for the Homeless Clinicians' Network, National Health Care for the Homeless Council, Inc., 2011.

DISCLAIMER

The information and opinions expressed in this document are those of the Advisory Committee on Adapting Clinical Practices for Homeless Patients, not necessarily the views of the U.S. Department of Health and Human Services, the Health Resources and Services Administration, or the National Health Care for the Homeless Council, Inc.

PREFACE

Clinicians experienced in caring for individuals who are homeless routinely adapt their practice to foster better outcomes for these patients. This document was written for health care professionals, program administrators, other staff, and students serving patients with chronic pain who are homeless or at risk of homelessness. Its purpose is to enhance understanding of optimal chronic pain management among experienced homeless services providers and among primary care providers who are less experienced in the care of homeless and other marginalized people.

Standard clinical guidelines often fail to take into consideration the unique challenges presented by homelessness that may limit access to needed services or ability to adhere to a plan of care. To address this oversight, the Health Care for the Homeless (HCH) Clinicians' Network has made the development of recommended clinical practice adaptations for the care of impoverished people experiencing homelessness one of its top priorities. Over the last ten years, the Network has developed and revised eight prior sets of recommendations for the management of health problems that are common among homeless people and particularly challenging for their caregivers. These recommendations are available at www.nhchc.org and www.guideline.gov.

Chronic pain management for homeless and other marginalized people was identified as a Network training priority in 2008. A literature review revealed knowledge gaps in this area; and responses to a survey of homeless services providers conducted in 2010 revealed both knowledge and practice limitations. The 101 participants in this survey were from 26 states in the U.S. and one province in Canada. Results showed that these providers were uncomfortable prescribing opioid analgesics for pain, lacked access to nonpharmacological pain interventions, and lacked resources for optimal pain management. (A report of survey results can be found on the National HCH Council website at www.nhchc.org.) In 2011, an advisory committee comprised of 16 health and social service providers experienced in chronic pain management for underserved populations was convened to develop clinical and programmatic recommendations for the care of homeless adults with chronic non-malignant pain. These recommended practice adaptations reflect their collective judgment about optimal pain management interventions for this population.

The recommendations in this document specify what experienced clinicians know works best for patients experiencing homelessness, with the realistic understanding that limited resources, fragmented health care delivery systems, and loss to follow-up often compromise adherence to optimal clinical practices. We hope these recommendations provide helpful guidance to health care professionals serving adults with chronic non-malignant pain who are homeless or at risk of homelessness, and that they will contribute to improvements in both quality of care and quality of life for these patients.

Patricia A. Post, MPA (Editor)
Health Care for the Homeless Clinicians' Network

AUTHORS

Advisory Committee on Adapting Clinical Practice for Homeless Adults with Chronic Non-Malignant Pain

Barbara Wismer, MD, MPH (Chair)
Physician, Internal & Preventive Medicine
Tom Waddell Health Center/Homeless Programs
San Francisco Department of Public Health
San Francisco, California

Ted Amann, MPH, RN
Director of Healthcare, FQHC Project Director
Central City Concern
Portland, Oregon

Rachel Diaz, MSW, LAc, LICSW, CDPT
Social Worker, Acupuncturist, Chemical Dependency Specialist
Former Acupuncture Program Manager
Evergreen Treatment Services
Seattle, Washington

David C. Eisen, LAc, MSW, OMD(am)
Executive Director, Acupuncturist
Quest Center for Integrative Health
Portland, Oregon

Nancy C. Elder, MD, MSPH
Medical Director, Health Care for the Homeless Program/ Cincinnati Health Network
Associate Professor and Director of Research
Department of Family & Community Medicine
University of Cincinnati
Cincinnati, Ohio

Cheryl J. Ho, MD
Medical Director
Valley Homeless Healthcare Program
Santa Clara Valley Health & Hospital System
San Jose, California

Stephen Hwang, MD, MPH
Research Scientist & Staff Physician
General Internal Medicine
Saint Michael's Hospital,
University of Toronto
Toronto, Ontario, Canada

Meredith Johnston, MD
Staff Psychiatrist
Health Care for the Homeless, Inc.
Baltimore, Maryland

Matthew Joslyn, MD
Staff Clinician
Boston Health Care for the Homeless Program
Boston, Massachusetts

Stefan Kertesz, MD, MSc
Associate Professor, Preventive & General Internal Medicine
University of Alabama
Birmingham, Alabama

Margot Kushel, MD
Associate Professor of Medicine in Residence
General Internal Medicine
San Francisco General Hospital
University of California
San Francisco, California

Charles Preston, PhD
Lead Psychologist
Valley Homeless Healthcare Program
Santa Clara Valley Health & Hospital System
San Jose, California

AUTHORS, continued

Frank Silva, RPh
Pharmacist
Albuquerque Health Care for the Homeless, Inc.

Frank Roland, RPh
PharmD Candidate 2011
University of New Mexico
Albuquerque, New Mexico

Shannon Smith, RN, MSN, CNL
Coordinator, San Francisco Sobering Center &
Medical Respite Program
San Francisco Department of Public Health/
Housing and Urban Health
San Francisco, California

Rachel Solotaroff, MD
Medical Director, Central City Concern
Assistant Professor of Medicine
Oregon Health & Science University
Portland, Oregon

Lisa Thompson, DNP, PMHNP-BC
Psychiatric Nurse Practitioner
Colorado Coalition for the Homeless
Denver, Colorado

Barry Zevin, MD
Physician Specialist, Lead in Addiction Medicine
Tom Waddell Health Center
San Francisco Department of Public Health
San Francisco, California

Molly Meinbresse, MPH
Program and Research Specialist
National Health Care for the Homeless Council
Nashville, Tennessee

Patricia A. Post, MPA
Editor, *Adapting Your Practice* series
HCH Clinicians' Network
National Health Care for the Homeless Council
Nashville, Tennessee

It is the policy of the National Health Care for the Homeless Council to require authors of its educational publications to disclose financial relationships with relevant commercial entities and to identify and resolve any related conflicts of interest. The authors listed above reported no such relationships or conflicts of interest. The content of this document is educational and based on clinical experience or rigorous scientific evidence. It was developed independent of commercial influence.

ACKNOWLEDGEMENTS

The clinicians listed above were primarily responsible for the development of recommendations contained in these supplemental guidelines. These dedicated caregivers from multiple clinical disciplines gave generously of their time to formulate guidance for practitioners less experienced in the care of patients whose comorbidities and limited resources, both financial and social, precipitate or exacerbate homelessness.

In addition, the Advisory Committee would like to thank the following individuals for reviewing and commenting on draft recommendations prior to publication:

- Daniel Alford, MD, MPH, Associate Professor of Medicine, Boston University School of Medicine, Boston, Massachusetts
- Roger Chou, MD, General Internal Medicine, Oregon Health & Science University, Portland, Oregon; Director of Clinical Guidelines Development for the American Pain Society
- Jay M. Griffith, MD, Psychiatry and Pain Medicine, Veterans Administration Medical Center, Mountain Home, Tennessee
- Ed Lor, PharmD, Pain Service, San Francisco General Hospital, San Francisco, California

Table of Contents

APPENDICES

A. Managing Pain in Patients with Co-occurring Substance Use Disorders: A Harm Reduction Addiction Medicine Perspective – Barry Zevin, MD, San Francisco Dept. of Public Health (SFDPH)

B. Chronic Pain Assessment and Treatment Plan, SFDPH

C. Centrality of Pain Scale – Christina Nicolaidis, MD, MPH, Oregon Health Science University, Portland, Oregon

D. Mental Health and Substance Abuse Screening Tools

E. Action Plan, Valley Homeless Health Care Program (VHHP), San Jose, California

F. Chronic Pain Recovery Program, Central City Concern, Portland, Oregon

G. Pain Medications: Frequently Asked Questions, SFDPH

H. Drug formulary, Albuquerque Health Care for the Homeless (HCH)

I. Non-opioid Medications for Management of Chronic Pain, Albuquerque HCH

J. Nurse Assessment Form: Refills for Controlled Substances, Tom Waddell Health Center (TWHC)

K. Patient-Provider Medication Agreement Forms, CareOregon

L. Low Literacy English Informed Consent and Patient-Provider Agreement, SFDPH

M. Low Literacy Chinese Informed Consent and Patient-Provider Agreement, SFDPH

N. Low Literacy Spanish Informed Consent and Patient-Provider Agreement, SFDPH

O. Patient Responsibilities for the Use of Chronic Controlled Substances, VHHP

P. Policy on Use of Controlled Substances in Chronic Pain Management, SFDPH

Q. Policy on Aberrant Drug-Related Behavior in the Use of Controlled Substances In the Treatment of Chronic Non-Malignant Pain, SFDPH

R. Urine Toxicology Screening Policy, TWHC

S. Provider Essential Elements for Presentation to Yellow Flag Committee, TWHC

T. Yellow Flag Committee: Template for Case Review and Guidelines, TWHC

INTRODUCTION

Pain is an intrinsically subjective phenomenon — "an unpleasant sensory and emotional experience associated with actual or potential tissue damage," according to the International Association for the Study of Pain. When it persists beyond the time normally associated with healing from an acute or subacute injury (generally three months), pain is considered to be chronic (Potter et al. in King & Wheeler, 2007, 331–340; APS-AAPM, 2009). Homeless health care clinicians report that chronic pain is extremely common among their patients and is particularly challenging to treat. Although the prevalence of chronic pain among people experiencing homelessness remains largely unknown, this population suffers disproportionately from health problems that are associated with chronic pain — including trauma, peripheral vascular disease, viral hepatitis, HIV/AIDS, psychiatric illness, and substance use disorders (O'Connell, 2004; Menchaca et al., 2008; Highley, 2008; Hwang et al., 2008; NCH, 2009; Griffith et al., 2010).

Conditions of homelessness exacerbate suffering caused by pain and create barriers to pain management and treatment (Alford & Waldmann, 2004; Matter et al., 2009; Miaskowski et al., 2011). Numerous factors common to the experience of homelessness increase chronic pain or complicate management, including more frequent injuries, complex and poorly treated medical conditions, inadequate shelter, minimal social supports, lack of resources to pay for pain medication, difficulty storing medications, and lack of health insurance limiting access to specialty care. Other realities that may increase pain and/or decrease the ability of people without stable housing to manage or cope with pain include: exposure to the elements (extreme heat and cold), sleeping out of doors/on floors/ in chairs, spending much of each day walking/ carrying/ pushing belongings, high vulnerability to assault, and living with unrecognized or untreated behavioral health problems, including psychological sequelae of trauma and cognitive impairment. These factors also make adherence to a treatment plan for chronic pain more difficult.

Barriers to effective pain management for homeless people include poor understanding of pain management in the general medical community, mutual mistrust between homeless persons and medical providers, lack of access to appropriate pain specialty clinics and other opportunities for rehabilitation, and lack of clear treatment recommendations and guidelines on how best to treat chronic pain within this population (Elder et al., 2011). Racial/ ethnic minorities (overrepresented among homeless people) suffer disproportionately from unrelieved pain compared with Whites — largely due to discrepancies in treatment access, misconceptions about pain severity, and patient/provider attitudes about pain (Shavers et al., 2010; Vijayaraghavan et al., 2011; Moskowitz et al, 2011). Limited access to health services and fragmented health care delivery systems present significant obstacles to appropriate medical care for homeless people (Sadowski, et al., 2009). When care is delayed, health problems often become more complicated. Health conditions requiring regular, uninterrupted treatment — such as HIV, addiction, and mental illness — are extremely difficult to manage without a stable residence, as is the management of chronic pain.

Despite these impediments, experienced homeless services providers and their clients have found that health outcomes and quality of life can be improved with a comprehensive, client-centered approach to the management of chronic pain and comorbid conditions, including the use of medical respite (convalescent) care and permanent supportive housing (Alford & Waldmann, 2004; HCH Clinicians' Network, 2004; Doorley et al., 2010; Griffith et al., 2010; Ciambrone & Edgington, 2009; Post, 2008).

Research findings and expert opinion indicate that chronic pain is a highly complex disorder, particularly in the homeless population. Use of opioids for chronic pain management is particularly challenging, in part because homeless individuals lead more chaotic lives, with consequently more behaviors that may fall outside the agreed upon treatment plan. In addition, increased risks of prescription opioid misuse and mortality have been demonstrated among people with co-occurring substance use disorders, which are common among homeless people (Vijayaraghavan et al., 2011; Hansen et al., 2011 (in press)). Among the most promising strategies for the successful use of opioids to treat chronic non-malignant pain in homeless adults are: clear organizational pain policies and procedures; a written, dynamic treatment plan which focuses on functional improvement and holistic care; a signed patient-provider agreement for treatment that specifies mutual responsibilities of providers and patients and the potential risks of treatments; a team approach to care delivery and case conferencing that employs a group medical visit model; and a consistent, nonjudgmental approach to evaluating behaviors inconsistent with the treatment plan (Griffith et al., 2010; Doorley et al., 2010; Hammer in King & Wheeler, 2007, 121–128).

Both research and clinical experience suggest that a multidisciplinary approach increases treatment effectiveness in pain management (Gersh et al., 2011), as in all aspects of homeless health care. Experienced homeless services providers recommend a comprehensive approach to pain management which simultaneously addresses comorbid medical conditions, employs both non-pharmacologic and pharmacologic treatment options, and includes education and self-management. Cognitive-behavioral approaches, relaxation techniques, and acupuncture are among the non-pharmacologic interventions most widely written about and used in the general population (Molton et al., 2007; Turk et al., 2008; Kelly, 2009; Lee & Ernst, 2011; Liang et al., 2011). Unfortunately, access to these therapies is still limited for people experiencing homelessness.

Clinical practice guidelines for people who are homeless employ the same standards of care as for people with stable housing. Nevertheless, primary care providers who routinely serve homeless individuals recognize an increased need to take living situations and co-occurring disorders into consideration when working with these patients to develop a plan of care. The practice adaptations recommended in this document are based on a comprehensive review of published reports and consensus opinion of clinicians with expertise in homeless health care, treatment of chronic pain, and addiction medicine. These recommendations are intended to be consistent with the standard clinical guidelines listed below. Their purpose is to facilitate adherence to these standards in the care of impoverished, displaced persons with multiple medical and psychosocial problems.

The primary sources for these recommendations are six sets of guidelines for chronic noncancer pain management developed by: the American Pain Society–American Academy of Pain Medicine Opioids Guidelines Panel, 2009; the University of Michigan Health System, 2009; the Institute for Clinical Systems Improvement, 2009; the Washington State Agency Medical Directors' Group, 2010; the U.S. Departments of Veteran Affairs and Defense (VA/DoD), 2010; and the State of Oregon's Medicaid health plan, CareOregon, 2003. (See page 45 for full citations.) In general, treatment recommendations found in these standard practice guidelines are not restated in this document except to clarify a particular practice adaptation or to emphasize practices that are especially important in homeless health care.

Summary of Recommended Practice Adaptations For the Care of Homeless Adults with Chronic Non-Malignant Pain:

These recommendations of the HCH Clinicians' Network were approved by the Advisory Committee on Adapting Clinical Practice for Homeless Adults with Chronic Non-Malignant Pain, whose members have expertise in homeless health care, treatment of chronic pain, and addiction medicine.

Recommended Clinical Practice Adaptations:

HISTORY

- Focus primarily on fostering a therapeutic alliance at the initial encounter, recognizing that this may be the only opportunity to engage a homeless patient in ongoing care. Use the initial visit as a critical opportunity to engage the patient and establish trust.
- Ask about physical and mental health (including history of traumatic brain injury/ substance use), history of chronic pain, and living situation (including residential stability).

PHYSICAL EXAMINATION

- Defer the physical examination to the second visit, if needed; or keep the initial exam focused on the area of concern. Perform serial focused exams (as tolerated), if needed. Look for evidence of occult alcoholism or addiction.
- Practice Trauma-Informed Care during the physical examination and in all patient encounters, recognizing that individuals who are homeless are likely to have experienced some form of previous trauma.

ASSESSMENT, SCREENING & DIAGNOSTIC TESTING

- Assess every chronic pain patient for substance use and mental health issues. Based on prevalence of behavioral health issues in the patient population served as well as provider and staff resources and experience, weigh benefits and costs of using standardized screening tools.
- Use urine drug tests (UDT) as an additional tool in initial assessment for substance use disorders and in the ongoing evaluation of patient outcomes. Use UDT and pill counts carefully and strategically to monitor treatment adherence and to minimize diversion, misuse, and abuse for patients on COT. Use a Universal Precautions approach to initial and ongoing assessment of all patients with persistent pain, particularly those receiving opioid analgesics.

PLAN OF CARE

- Jointly identify indicators of functional improvement with the patient to help determine whether the plan of care is "working." Develop a plan emphasizing holistic treatment with multiple modalities; assure patient understanding of the treatment plan; modify in response to functional change or if problems arise.

- Determine the patient's stage of change and how behavioral health problems are contributing to chronic pain. Include a behavioral health care plan in the plan of care.
- Plan for safe storage of medication and adaptation of prescribing/ dispensing practices, as needed.

EDUCATION, SELF-MANAGEMENT

- Review fundamental concepts of chronic pain management at every visit.
- Consider group visits as a vehicle for patient education; develop a core curriculum for all patients supplemented by special groups for those with higher needs.
- Educate providers about prescribing opioid analgesics to homeless persons with substance use disorders and adaptation of prescribing/ dispensing practices, as needed.
- Emphasize setting reasonable, attainable, short-term self-management goals while working toward long-term goals. Use motivational enhancement techniques to help patients resolve ambivalence about behavioral change.

TREATMENT, MANAGEMENT

- Select treatment based on context and available resources (e.g., street/shelter, bare-bones poorly resourced health center, full-service ambulatory clinic with access to specialists, well-equipped hospital/medical respite program).
- Encourage early and ongoing non-pharmacologic treatment. Address psychosocial needs.
- Choose non-opioid pharmacologic interventions based on etiology of pain, co-morbid conditions, medications, and other factors, some of which are more common among homeless people.
- Apply other guidelines cited in this document on use of opioids for chronic pain, with particular attention to identifying psychosocial factors that may complicate their use for homeless persons; structure monitoring and follow-up to address those factors.
- To promote successful use of opioid analgesics by homeless patients, use a written treatment plan, patient-provider agreement/informed consent (assuring that patients understand them), a multidisciplinary care team, and a consistently nonjudgmental approach to behaviors outside treatment plan.

ASSOCIATED PROBLEMS, COMPLICATIONS

- Monitor functional status closely and investigate any decline, which has a broad differential diagnosis but may indicate active substance abuse.
- Use a nonjudgmental approach to explore behaviors outside the treatment plan, which may indicate diversion or misuse of medications, and a harm reduction approach when addressing them. Recognize that a more structured treatment plan and/or discontinuation of opioids is/are sometimes indicated.

FOLLOW-UP

- Determine frequency of follow-up based on stability of the patient and his/her living situation and risk of misuse. For patients with comorbid behavioral health issues who are receiving COT, more frequent visits with random urine drug tests may be necessary. In general, opioid prescriptions should be of shorter duration (1 month or less) to help reduce risk of diversion/ overdose/ loss of medications.
- At each visit, assess for behaviors outside the treatment plan, including a psychosocial assessment. Consider causes related to homelessness — missed appointments due to competing priorities or unexpected events (e.g., in jail, delayed by another appointment), stolen medications (e.g., assault, theft in shelter).
- Refer homeless patients to Medical Respite/convalescent care facilities and facilitate entry into permanent supportive housing, to reduce problems and complications associated with chronic pain.

Recommended Programmatic Adaptations:

SERVICE DELIVERY DESIGN

Optimum design includes the following:

- Use integrated care and multidisciplinary clinical teams.
- Given the challenges and risks of opioid analgesics, the central role of behavioral approaches in chronic pain management, and the benefits of non-pharmacologic interventions, develop and utilize strategies for effective pain management other than or in addition to chronic opioid therapy. Consider combining opioids with non-opioids for synergistic or additive effects.
- Ensure that all clinical service providers know the basics of chronic pain management and have appropriate skills to work with persons experiencing homelessness, including Trauma-Informed Care.
- Develop policies and procedures to improve treatment effectiveness, clinic safety, and satisfaction of staff and patients, including patient registries and case review mechanisms to promote appropriate tracking and follow-up, identify/address repeated behaviors outside the treatment plan, and provide support for staff.
- Develop relationships with outside partners and/or hire/train staff to provide services – e.g., pharmacy or program that can dispense medications weekly or more often, addiction medicine specialist, pain clinic, cognitive behavioral therapist, physical/occupational therapist, acupuncturist.

OUTREACH AND ENGAGEMENT

- Focus on the pain, not the pill. Where pain medicines are sought, explore the patient's expectations, experience, and potential to benefit.
- Consider using a member of the care team other than the primary care provider (behavioral health counselor, acupuncturist, panel manager, occupational therapist, nurse, social worker, case manager) as the primary contact person for the patient, to lower potential access/ communication barriers.

STANDARDS OF CARE

- Adapt clinical practices to optimize care for patients who are homeless or at risk of becoming homeless, considering the recommendations contained in this guide.
- Integrate service with advocacy to improve access for homeless people to a broader range of interventions for chronic pain management. Address structural causes of homelessness. Involve service providers and recipients in advocacy.

TRANSITIONS IN CARE

From hospitals to Medical Respite/recuperative care:

- Confirm that long- and short-acting pain medications are prescribed by the hospital discharge team, and that at least a 7-day supply of medication is dispensed to the patient at discharge.
- Coordinate appropriate follow-up care for community provider(s) who will be prescribing medication before accepting the patient into a Medical Respite program following hospital discharge.

Recommendations for the Care of Homeless Adults with Chronic Non-Malignant Pain

Diagnosis and Evaluation

HISTORY

Major Recommendations:

- **Focus primarily on fostering a therapeutic alliance at the initial encounter, recognizing that this may be the only opportunity to engage a homeless patient in ongoing care.**
- **Ask about physical and mental health (including history of traumatic brain injury/ substance use), history of chronic pain, and living situation (including residential stability).**

Rationale: Homeless patients with chronic pain may have had negative experiences with the health care system, so developing a therapeutic relationship is a key objective, in addition to getting an accurate history. Both are important for developing a successful plan to address chronic pain.

Evidence: Expert consensus. Although there is limited scientific evidence to support these recommendations, many clinicians with expertise in homeless health care, treatment of chronic pain, and addiction medicine find this approach to history-taking helpful. Sources: Potter et al. in King & Wheeler, 2007, 331–340; HCH Clinicians' Network, 2004, 2010.

- **Initial history:** Recognize that the clinical history is a critical opportunity to foster a therapeutic alliance. The most important goals of history-taking are to allow patients to tell their story and feel heard nonjudgmentally, to build confidence that as their provider you have their best interest in mind, and to help them understand that pain management involves comprehensive health care. Defer requests for medical information until these prior goals are addressed. Be aware that many homeless people have negative associations with medical settings.

  1. ***Basic questions:*** "*How old are you? Where are you from originally? How long have you been in this city/town? How is your general health?*" These questions yield detailed information about the patient's well being, self image and agenda, and confirm your interest in his/her health.
  2. ***Provider's experience and limits of clinical setting:*** Briefly explain your medical background and what your facility might have to offer the patient. This is critical for homeless health care settings, which range from triage sites to comprehensive primary care clinics. E.g.: "*I am a physician and I have been doing health care for the homeless work for 20 years. I specialize in internal medicine and also addiction medicine. This clinic is equipped to provide comprehensive health care including treatment for mental health problems and substance use disorders.*"
  3. ***Information to be requested:*** Explain that you are going to ask about their "physical health, mental health, and history with substances." (At the first visit, ask about substance use or not,

based on the level of engagement, what the patient has reported so far, and estimation of whether or not the patient will be able to respond truthfully.) Tell patients that the first visit will be devoted primarily to addressing any urgent, life-threatening situations and taking a thorough history of their health; and the physical examination will be deferred to a follow-up visit (ideally within a week or two), if there isn't time to complete one during the first visit. Recognize that a shorter interval between visits can facilitate follow-up and help establish necessary rapport. Explain that you cannot prescribe any opioid pain medications until you have completed the history, physical, and possibly other tests.

- **Physical health history** Ask patients to describe their physical health history and listen to them without interrupting. Then ask specifically about individual and family history of ***medical conditions associated with chronic pain*** for which homeless people are known to be at increased risk (e.g., trauma, diabetes, viral hepatitis, HIV/AIDS). Ask whether they have ever been hospitalized, and if so, where and for what reason(s). Ask specifically about ***medications***, including contraceptives, over-the-counter medicines, herbal remedies, dietary supplements, and any "borrowed" medicine prescribed for others. If medical records and patient recollection are insufficient to identify medications taken, ask to see old prescriptions or medicine bottles. Ask about any problems adhering to prescribed treatment. Assess ability to take pills daily and return for follow-up care. Inquire about ***other health care providers*** seen; ask if the patient already has a regular source of primary care and whether access to this provider is limited in any way.

- **Mental health history** Ask patients to tell you about their mental health. Normalize discussion of mental health issues by asking about any problems with "stress, low energy, difficulty focusing, or mood swings" rather than "mental illness." Consider asking if they have ever seen a psychiatrist or therapist. If the answer is yes, ask specifically, "*Were you given a diagnosis?*" Ask if they have ever been treated for depression, anxiety or other mental health concerns and if they are currently experiencing any of these problems. Ask about suicide attempts, psychiatric hospitalizations, and past or current use of medications "for nerves." Inquire about ***symptoms of psychological problems often associated with chronic pain***: stress, anxiety, problems with appetite, sleep, concentration, mood, speech, memory, thought process and content, suicidal/homicidal ideation, hallucinations, insight, judgment, impulse control or social interactions.

- **Substance use history** Information about use of alcohol, illicit drugs, and/or prescribed opioids can be useful in developing the treatment plan, and should be standard in assessing patients who present with chronic pain. Be aware that serious medical problems associated with chronic pain and comorbid addictive disorders (e.g., traumatic injury, sexual/physical abuse, HIV/AIDS) are highly prevalent among homeless people. Recognize that patients with a history of opioid addiction may experience long-term neurochemical changes which increase the perception of pain in response to stimuli that others find merely annoying ("hyperalgesia"). In a primary care setting, the optimal method of inquiry may include standardized questions suggested by the National Institute on Alcohol Abuse and Alcoholism, and the National Institute on Drug Abuse.

Ask about current and past substance use in different ways, depending on the setting and what you have already learned about the patient:

Tailoring a Substance Use History to the Patient

Ask patients who have not disclosed a substance use problem: "*Do you smoke cigarettes? Do you drink alcohol?*" If the answer is no, ask, "*Have alcohol or other drugs ever been a problem for you?*" If the answer is yes, consider standard questions from the CAGE or other behavioral health assessment tools (listed in Appendix D), and say, "*Tell me about your experience with drugs.*" Consider following up with questions about age of onset of use, history of use, and current patterns of use. Then ask if they have ever been treated for alcohol or drug use (e.g., "*Ever been to detox, a rehab program, or an outpatient clinic for drug treatment?*") To explain your reasons for asking, you might add: "*As a doctor, this history really helps me understand where you are coming from*." or "*Information about your drug and alcohol use can really help me figure out what is the safest and most effective treatment for you.*"

***If a substance use problem is suspected*:** Evasive responses to uncomfortable questions in clinical settings are not uncommon. Reasons for attempting to conceal a problem with alcohol or drugs include shame and fear of stigma. Building a trusting relationship with patients over time may lead to more accurate and comprehensive information. Talk about your obligation to tell them the truth, and observe that it usually works best if both the provider and the patient are honest with each other. Ask, "*What would I find if I did a urine test for drugs today?*" It is helpful to remember that for many homeless patients, their pain has never been taken seriously before. The clinician's job is to understand and explain benefits of being honest *for the patient.*

Ask patients who have already disclosed a substance use problem: "*Can you run me through your history with alcohol and drugs?*" Depending on their response, inquire about current and previous use (amount, frequency, duration) of alcohol and drugs, including nicotine. Ask specifically about cigarette smoking, if not already mentioned. Inquire about use of alcohol and/or street drugs to treat pain on initial assessment and at follow-up, when there is greater trust/ rapport between patient and provider. Seek a collateral history of the patient's alcohol and/or street drug use from shelter staff or other homeless service providers, with the patient's permission. Look for factors related to substance use that may complicate management of other health issues.

If seeking controlled substances for secondary gain is suspected: The initial history may help to identify these patients. It is crucial to understand the reasons for diversion (e.g., profit motive, treating other ailments such as depression/ anxiety/ insomnia, exchange for other drugs of choice, victimization, sharing with others in need). "*Where are you from and how long have you been here?*" may help identify individuals with a monetary intent for seeking controlled substances. Patients may say they just arrived in town and have run out of essential pain medications. A request for more details can help distinguish those legitimately seeking health care from those solely interested in diversion. Ask, "*Why are you here now?*" and "*Why did you leave your previous provider?*" Recognize that ability to verify medical histories may be limited due to patient mobility. While failure to provide information about prior providers may be an indicator of risk for opioid misuse or diversion in a housed patient, lack of documentation is a common complication of homelessness, whether misuse or diversion is an issue or not. Avoid or make a practice of no opioid prescriptions on the first visit.

- **History of chronic pain** If a patient reports longstanding pain, ask: "*Where is it? How long has it lasted? Does it come and go? What does it feel like? Sharp, burning, throbbing or something else? How does it affect your function, or what you are able to do?*" Solicit other information to clarify characteristics of the pain and the diagnosis, which can inform treatment and identify methods that could help reduce the functional impact of pain. Ask about the interval between onset/ exacerbation of pain and the first/current episode of homelessness (e.g., "*Did the back injury occur a few months before you became homeless or while you were living in the shelter?*") Because homeless patients with pain may be irritable and are accustomed to having their concerns discounted, the conversation may not feel like an easy one for clinicians. Following are some tips to make it go more smoothly:

Tips for Taking a History of Chronic Pain

Attend closely to the patient's mood and your own emotional reactions to the patient. Many homeless individuals with chronic pain have difficult relationships in general, not just with medical providers. Distrust and fear of being seen as unreliable or dishonest may inhibit candor, resulting in a history that is clipped, unclear, distorted, or colored by unexpected notes of anger. Patients who are afraid or ashamed can rarely provide as full and helpful a history as those who are confident that the caregiver is genuinely interested in their concerns. Faced with a hostile, questioning patient who may demand opioids from the start, clinicians may feel on trial, under attack, or subject to unfair and unwarranted skepticism of their good intentions. A defensive response is unnecessary and may exacerbate tension and prematurely limit the history. Skepticism can be defused by gently acknowledging it and demonstrating a genuine interest in the patient (e.g., "*I hear how frustrating it's been to have this pain and try to find relief from it. Tell me more about how this pain began and what makes it better and worse*.")

Look for a plausible origin of pain. While the etiology of many chronic pain syndromes is elusive (e.g., fibromyalgia or sympathetic dystrophy), identification of an injury from which the pain originated is sometimes possible: Long-term back pain may originate from severe trauma, such as falling off a building, or from athletic injuries or physical labor. Diffuse abdominal pain may be the result of chronic pancreatitis in a patient who no longer drinks. Burning toes may reflect the impact of repeated hypothermia. Lingering dental pain that interrupts sleep may be a symptom of irreversible pulpitis or chronic infection. In none of these cases does the precipitating condition point to an easy fix; but in each case, the original injury may help the clinician think about potential allies in care from relevant specialties. A careful history may help to defuse any skepticism about the pain. The origin of pain may have significant meaning for the patient and offer ideas about treatment approaches. Pain which originated in a traumatic event may have both physical and psychological components that must be addressed.

Inquire about factors that intensify or relieve pain and activities limited by pain. Inquire specifically about factors related to homelessness that may cause or exacerbate pain (e.g., poor mattress/ sleeping surface, sleep disturbance, exposure to the elements, inability to rest during the day). Ask if there are particular actions or conditions that affect the patient's pain (e.g. lifting, walking, sleeping arrangements, exertion, ambient temperature, weather, mood or substance use). Inquire about activities limited by pain (e.g., walking, sitting, working, sleeping, or self-care), and explore ways to help reduce the functional impact of pain. Therapeutic interventions are sometimes discovered through adjusting external factors (changes in bedding/ daily physical activity, bracing a body part/ application of creams or ointments/ adjustments to lifting techniques).

Inquire about prior treatment. Ask what treatments have been helpful and if there were problems with particular treatments. Ask about both pharmacologic and non-pharmacologic interventions (e.g., acupuncture, relaxation techniques) that reduced severity of pain. Ask if opioids were ever prescribed and if so, what benefits/ problems resulted from their use. If the patient is taking methadone or other opioids at the first visit, assess for physical tolerance. If opioids are reported to be helpful, ask, "*Did you see any downsides to them? Did you find that they influenced your mood in ways that affected how much you wanted the medicine? Did you find yourself in conflict with your doctors or caregivers regarding those medicines?*" These questions may help identify potential challenges to future clinical management. Obtaining this information early helps to neutralize any concerns that the clinician has prematurely judged the patient or the diagnosis.

Long-term therapeutic alliance versus one-time visit Consider asking, "*This problem has been with you for a pretty long time. Will we be seeing each other again?*" Clinical decision making is influenced by the anticipated duration of the clinical relationship. For homeless patients, the history of medical care often includes clinical relationships that were fragmented and/or brief due to the setting of care (e.g., emergency walk-in settings), lack of stability associated with homelessness, and/or a history of difficulty in developing stable relationships. One-time clinical encounters preclude treatment decisions that require follow-up. Prescribing opioids for anything other than very short-term problems (e.g., a fracture) requires long-term follow-up. Explaining this to patients denied an initial request for opioids may help to alleviate resentment that they have been unfairly judged. If follow-up is likely, the clinician can begin to consider treatments and referrals that may eventually be appropriate, even if it will take several visits to arrive at a decision.

- **History of Trauma** Ask about head injuries, falls, assaults, accidents, participation in contact sports, and if the patient has ever been knocked unconscious or been in a coma. Assess for symptoms associated with traumatic brain injury (TBI): headaches, seizures, short and long-term memory loss, mood lability and irritability, dizziness, fatigue, insomnia, concrete thought processes, impulsivity, distractibility and poor organizational/ decision making skills.

  Recognize that chronic pain is a common complication of TBI, independent of psychological disorders (Nampiaparampil, 2008). Significant numbers of persons experiencing homelessness report histories of blows to the head, often related to severe physical abuse sustained in childhood, motor vehicle accidents, falls, or military combat (Highley, 2008; Hwang, 2008).

- **Living conditions** Ask patients about their living situation to assess residential stability and the possibility that they are homeless.[1] ("*Where do you live? Who lives there with you? How long have you lived there? Where did you sleep last night?*") Ask where they sleep and spend time during the day, and how they can be contacted. Ask explicitly about access to food, water, shelter, restrooms, and a place to store medications. Assess environmental factors that may threaten health and safety. If staying in a shelter/vehicle/on the street or in any other unstable living situation, ask if this is the first time "without a home," recognizing that some people are reluctant to admit they are homeless or don't consider themselves homeless if staying with a relative or friend. Try to determine whether residential instability is chronic or episodic. Try to understand the circumstances that precipitated homelessness and explore available housing options, recognizing that chronic pain management is especially difficult without stable housing (HCH Clinicians' Network, 2010).

[1] A homeless person, as defined by the Bureau of Primary Health Care, is "… an individual without permanent housing who may live on the streets; stay in a shelter, mission, single room occupancy facility, abandoned building or vehicle; or in any other unstable or non-permanent situation. An individual may be considered to be homeless if that person is 'doubled up,' a term that refers to a situation where individuals are unable to maintain their housing situation and are forced to stay with a series of friends and/or extended family members. In addition, previously homeless individuals who are to be released from a prison or a hospital may be considered homeless if they do not have a stable housing situation to which they can return. A recognition of the instability of an individual's living arrangement is critical to the definition of homelessness." (*Principles of Practice: A Clinical Resource Guide for Health Care for the Homeless Programs*, Bureau of Primary Health Care/HRSA/HHS, 3/1/99; PAL 99–12.)

PHYSICAL EXAMINATION

Major Recommendations:

- **Defer the physical examination to the second visit, if needed; or keep the initial exam focused on the area of concern. Perform serial focused exams as tolerated (if needed). Look for evidence of occult alcoholism or addiction.**
- **Practice Trauma-Informed Care[2] during the physical examination and in all patient encounters, recognizing that individuals who are homeless are likely to have experienced some form of previous trauma.**

Rationale: There may not be sufficient time during the initial encounter to conduct a comprehensive physical examination. Complex medical and psychosocial issues associated with homelessness often warrant deferral of the physical exam until a therapeutic relationship is better established. A history of trauma, common among homeless people, may present psychological barriers to a comprehensive examination which can be reduced through an approach to care that makes the patient feel safe and in control. Because a history of substance use problems may not be initially revealed, it is important to look for physical signs of alcohol or other drug abuse/ dependence (including addiction to nicotine).

Evidence: Recommendations are based on expert consensus of practitioners experienced in homeless health care with expertise in pain management and addiction medicine. Sources: Hopper, et al., 2010; Hwang et al., 2008; Morrison, 2007; Waldmann in O'Connell, 2004

- **Initial physical examination** Because history-taking is particularly time-consuming, ***the physical exam may need to be deferred to a second visit*** — a practice which enables the clinician to invest this time on patients who are more likely to engage in ongoing care, rather than on patients who are only coming for a single visit. If time and the patient's comfort level permit, focus the initial exam on the painful area, to assure the patient that you take his or her pain seriously. As with history-taking, a primary goal of the physical exam is to establish trust and rapport, particularly with homeless patients. Gathering medical information may be more successful once a trusting patient-provider relationship has been established.

- **Comprehensive exam/ serial, focused exams** A full-body, unclothed examination of a homeless adult is rarely possible before engagement is achieved. The patient may be too fearful to be examined, indicating the need to build a therapeutic relationship first. Conduct serial, focused exams until a therapeutic relationship is better established (e.g., examine feet, listen to the chest); ask permission to perform each physical exam. Explain at the first visit what a comprehensive physical examination will entail (measurement of height, weight, body mass, blood pressure, and heart rate; examination of the eyes, ears, mouth, neck, heart, lungs, abdomen, reproductive organs, and lower extremities, as well as musculoskeletal and neurological systems), and ask permission to perform one. Be alert to conditions common among homeless people that are unrelated to the pain syndrome (e.g., infestations, cellulitis). Be familiar with indications of occult alcoholism or addiction,

[2] ***Trauma-Informed Care*** is "a strengths-based framework that is grounded in an understanding of and responsiveness to the impact of trauma that emphasizes physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment (Hopper, et al., 2010, p.82)."

which are covered in standard clinical guidelines (VA/DoD, 2010). For example, be aware that current or old track marks generally indicate a history of injection drug use.

- **Physical origin of pain** Recognize that elements of the physical examination which are designed to disclose acute processes related to reported pain may show little abnormality for chronic pain. The expression "pain out of proportion to exam" often applies, but the common interpretation — that the pain is factitious — is quite often incorrect.

- **Trauma survivors** Be aware of the association between trauma and chronic pain, recognizing that a high percentage of homeless people have experienced physical, sexual, and/or emotional abuse. Homeless women and transgendered persons are among those at highest risk for sexual and physical assault (Kushel et al., 2003). Practice Trauma-Informed Care (HCH Clinicians' Network, 2010 Dec): Be sensitive to the patient's comfort level and pay attention to nonverbal cues; do whatever she or he can tolerate at the time. Schedule a return visit within a short period of time and plan frequent follow-up encounters to complete the examination. If a history of sexual abuse is suspected, defer the genital exam until the patient is ready. Whenever possible, offer patients the option of being examined by a health care provider of the gender with which they are most comfortable. To decrease anxiety, explain the purpose of each visit and what they can expect to happen. Always explain what you are going to do before touching the patient; describe what you are looking at or palpating while you perform the procedure, and if it is normal, say so. Stress what is healthy about the person during the examination. Minimize periods of silence to help the patient focus on constructive information rather than projecting previously perceived negative intent on the examiner.

ASSESSMENT, SCREENING & DIAGNOSTIC TESTING

Major Recommendations:

- **Assess every chronic pain patient for substance use and mental health issues. Based on prevalence of behavioral health issues in the patient population served as well as provider and staff resources and experience, weigh benefits and costs of using standardized screening tools.**
- **Use urine drug tests (UDT) as an additional tool in initial assessment for substance use disorders, and in ongoing evaluation of patient outcomes. Use UTD, pill counts, and Prescription Monitoring Program data (if available) carefully and strategically to monitor treatment adherence and to minimize diversion/ misuse/ abuse for patients on COT.[3] Use a Universal Precautions approach[4] for all patients with persistent pain, particularly those receiving opioid analgesics.**

Rationale: Homeless patients have high rates of mental health and substance use disorders which complicate the management of chronic pain; they should be assessed for behavioral health problems in the history and/or screened with standard tools. Homeless patients with chronic pain have high rates of substance abuse/ dependence and higher risk for opiate misuse/ diversion; they should be assessed for these outcomes through functional assessment, review of progress toward meeting pre-established health goals, and direct questioning. Urine drug tests should be used as an adjunct to other monitoring methods, with clear plans for what actions will result from possible test results. When used in an inconsistent manner or without careful consideration and explanation to patients of what the outcomes of possible results will be, UDT may be perceived as punitive and could disrupt a therapeutic patient-provider relationship. A Universal Precautions approach is warranted by the risk to individual and public health from increasing abuse and diversion of prescribed opioids, and the variable success of providers in identifying patients engaged in these behaviors.

Evidence: Expert consensus of practitioners in homeless health care with expertise in pain management and addiction medicine. Specific studies of patients with chronic pain and comorbid substance use disorders are lacking, and research has not yet been conducted to assess the discriminant validity of urine drug tests at initial assessment or ongoing treatment of homeless patients with chronic pain. Sources: Bohnert et al., 2011; Gourlay et al., 2005, 2010; Gourlay & Heit, 2009; HCH Clinicians' Network, 2004; Krebs et al., 2009; Lum et al., 2011; Matter et al., 2009; Nicolaidis, 2011; Potter et al. in King & Wheeler, 2007, 331–340; Smith et al., 2009, 2010; Starrels et al., 2010

- **Standardized assessment of pain and function** Use standard measures to assess patients' experience of pain and how it affects their ability to perform activities of daily living and other functions deemed important to quality of life. These measures can also be used to monitor effectiveness of treatments.

  Pain assessment: Pain severity assessment tools commonly used by homeless services providers include: the *verbal rating scale* (none, mild, moderate, and severe); *numeric rating scale* (0 to 10, with 0 indicating no pain and 10 the worst pain imaginable); *visual analog scale* (a 10 cm line with one end

[3] ***Diversion:*** The intentional transfer of a controlled substance from legitimate distribution and dispensing channels. This may be done due to other underlying behavioral health disorders, for pure profit motive, or for some type of altruistic purpose.
Misuse: Use of a medication (for a medical purpose) other than as directed or as indicated, whether willful or unintentional, and whether harm results or not.
Abuse: Any use of an illegal drug, or the intentional self-administration of a medication for a nonmedical purpose such as altering one's state of consciousness, leading to clinically significant impairment or distress.

[4] A ***Universal Precautions*** approach to assessment of all patients with persistent pain includes: differential diagnosis; psychological assessment including risk of addictive disorders; pre- and post-intervention assessments of pain level and function; regular reassessment of pain severity and level of function; routine assessment of analgesia, activity, adverse effects of therapy, and aberrant behavior; periodic reviews of pain diagnosis and comorbid conditions including addictive disorders; and thorough documentation of initial and follow-up evaluations (Gourley et al, 2005).

labeled "no pain" and the other end labeled "worst pain imaginable"); and the *faces pain scale* (6 to 8 different facial expressions from a smiling face (no pain) to a face that is crying (worst pain possible), which is useful with patients who have mild to moderate cognitive impairment and patients with language barriers (Elder et al., 2011; HCH Clinicians' Network, 2004). The Centrality of Pain Scale (See Appendix C), which assesses the extent to which chronic pain is "central" to a patient's life, can be used to develop goals for chronic pain management and track progress toward achieving them (Nicolaidis et al., 2011).

Functional assessment: Explore how pain interferes with daily activities, including sleep. The Brief Pain Inventory (BPI), which has been validated for use in chronic non-malignant pain (Tan, 2004), includes questions about function. This instrument can be administered by trained staff, and if used, should be administered in full prior to consideration or initiation of therapy. Some questions about work role, sleep, and source of pain may not be appropriate for homeless populations, however. *Suggested alterations:* Ask specifically how pain interferes with sleep. In the section about source of pain, consider asking whether patients believe pain was caused by their living situation and whether they believe pain is attributable to physical or sexual assault, given the high percentage of homeless people who have experienced severe assault during their lifetime. These alterations have not been validated, but may be reasonable to make with homeless patients. The recently validated three-item Pain, Enjoyment in life and General activity (PEG) scale, an abbreviated version of the BPI, assesses average pain intensity, interference with enjoyment of life, and interference with general activity (Krebs et al., 2009). Another choice is the Two Item Graded Chronic Pain Scale (Washington State guidelines, Appendix C), a brief and simple tool that measures perception of pain severity/ quality and attribution. This instrument has been used to measure severity of chronic pain among HIV-infected homeless and marginally housed patients, many of whom attributed pain to their "living conditions" (Miaskowski et al., 2011).

- **Assessment of mental health and substance use** Behavioral health disorders are common among homeless people and frequently co-occur in those experiencing chronic pain. All patients should be screened for these disorders as a standard part of pain assessment. Some health care providers prefer to defer screening until the therapeutic relationship is better established or include general questions in the history (see above). Engagement of homeless patients is particularly critical to their retention in care. Moreover, screening tools recommended by standard guidelines are not always validated for use in homeless populations. (Behavioral health screening tools that have been used with homeless patients are listed in Appendix D and are briefly noted below.[5])

  Mental health assessment: Be aware that posttraumatic stress disorder, depression, and anxiety are strongly associated with chronic non-malignant pain. Routinely assess for interpersonal violence, which is highly prevalent among homeless people and known to be associated with chronic pain.

[5] Mental health screens: MHSF III, PHQ-9, BDI, BAI, MDQ, PC-PTSD, MOCA, MMSE, HITS, RBANS
Substance use screens: NM-ASSIST, Single-Question Alcohol Screening Test, CAGE, AUDIT-C, Single-Question Test for Drug Use, DAST

Also assess for cognitive impairment and test for specific competencies (Can the patient understand directions? Make competent decisions? Organize time well?). Although comprehensive neuropsychological testing is optimal for the diagnosis of comorbid psychiatric disorders and cognitive problems, many clinics may not have this resource. A mental status exam can be performed as part of a physical exam by a primary care provider or behavioral health professional, if available. Screening can also be conducted by other trained staff and, in some cases, via self-administered questionnaires (e.g., MHSF III, PHQ-9). For patients with low literacy or visual impairments, some resources developed for self-administration should be converted to staff-administered tools. If possible, these screens should be administered prior to the clinical visit.

Assessment of substance use: Standard clinical guidance in chronic pain management is to screen for substance use disorders. In general, both active substance use disorders and family history of substance use are considered to increase the risk of poor outcomes for patients experiencing chronic pain. In homeless health care settings that serve patients with a high prevalence of substance abuse/ dependence, the majority of chronic pain patients "screen in." Thus, the challenge is less in identifying hidden substance use disorders, and more in managing pain in patients already determined to have some degree of substance use disorder or risk. The added value of substance use screens is questionable with high prevalence populations when direct questioning and observation confirms the presence of these disorders. In lower prevalence settings or with patients who have not disclosed a substance use problem, validated screening tools may be more useful.

For example, the Single-Question Alcohol Screening Test (Smith et al., 2009 Jul) and the Single-Question Test for Drug Use (Smith et al., 2010 Jul) can be used to identify unhealthy/illicit/ nonmedical substance use. CAGE, AUDIT, DAST and substance dependence check lists can help determine where the patient is within the spectrum of substance use disorders. SOAPP-R, ORT, and COMM were designed to assess risk for opioid misuse, which is important to determine the level of monitoring required for patients with a personal or family history of substance abuse (including nicotine dependence). Although a few studies have shown that these tests are somewhat effective in predicting current or future behaviors outside the treatment plan (Chou et al, 2009 Feb), they may lack discriminant capacity in high risk (including homeless) populations.

Benefits and Limitations of Substance Use Screens

Benefits	Limitations
▪ May identify patients with occult substance use disorders, which are considered to increase risk of poor outcomes for patients on COT ▪ Consistent with standard clinical guidance	▪ May undermine the patient-provider relationship if not yet well established ▪ May not be helpful; in some clinical settings, the majority of homeless patients with chronic pain "screen in"

Effective use of urine toxicology: Urine drug tests can be useful in managing patients receiving opioids for chronic pain who have co-occurring substance use disorders or have increased risk of misuse, abuse, or diversion. If used in an inconsistent manner or without careful consideration and explanation to patients of what the outcomes of possible results will be, however, urine drug tests

may be perceived as punitive and could disrupt a therapeutic patient-provider relationship. As with any diagnostic test, clinicians must be clear about their reason for ordering the test and what their response will be to all expected or unexpected test results. They also need to know the technical characteristics of the particular test used and whom to consult for assistance in interpreting results. Urine drug tests are designed to detect various opioid medications and illicit substances; what they measure depends on the laboratory and timing of the test. Metabolism of opioids is complicated, and clinicians can be misled by test results.

It is essential to explain to patients why you are using a urine drug test and what your response will be to test results. Many patients have very strong negative associations with urine drug tests due to their ubiquitous and punitive use in the criminal justice system, sports, and employment settings. Records of test results may be stigmatizing and present barriers to insurance, employment, and housing. Be forthright about the reason for the test; explain that regulatory agencies expect caregivers to monitor adherence to opioid medication and check for substance use, and that urine drug tests are one way to do so. In discussing UDT and other monitoring, focus on the risks and benefits of opioid therapy and keeping the patient safe, rather than on judging whether or not the patient is trustworthy. Developing a policy for periodic testing of all patients is one way to "normalize" use of drug tests (e.g., Appendix R).

Questions every patient should be asked prior to a urine drug screen:

1. When was your last dose of the opioid medication prescribed for pain?
2. Have you taken any other medications for pain in the past week?
3. Have you used any other drugs or non-prescribed medications in the past week?
4. What should we expect to find on this drug screen?

Patients with substance use disorders of moderate to severe degrees have functional impairments which usually worsen over time. Careful observation of the patient over time can reduce the need for urine drug tests. Consider the expense involved in using multiple drug tests, and recognize that many patients can be managed without them. In some circumstances, however, the tests can be very valuable (see Appendix A for examples).

<u>Recommendations for Urine Drug Testing:</u>

- **Use urine drug tests for patients who are prescribed controlled pain medications in accordance with laws, regulations, and clinic policy — e.g., within three months of initiation of therapy and at least annually thereafter with verbal consent of the patient — to monitor for use of prescribed and non-prescribed controlled substances and illicit substances.**
- **Use urine drug tests strategically — e.g., to identify use of illicit drugs by patients suspected of diversion of prescribed opioid analgesics.**
- **Explain early on to patients receiving COT that urine drug screens will be needed to completely address their needs. Include this information in patient-provider agreements and informed consents.**

- **Understand what tests your toxicology lab uses, how to interpret them, and whom to contact for expert consultation.**
- **Be clear on how you use urine drug tests and what action you will take for each possible result.**
- **Weigh benefits and costs of urine drug tests.**

Benefits and Costs of Urine Drug Tests

Benefits	Costs
▪ May indicate whether prescribed drug is being taken ▪ May reveal hidden use of illicit/ non-prescribed drugs ▪ Opportunity to talk about drugs and drug use ▪ Clinician adherence to law/ regulations/ policies	▪ May undermine the therapeutic relationship ▪ Expensive and often unnecessary; careful observation, functional assessment, pill counts, and directly observed therapy may be more cost-effective monitoring strategies, if available. ▪ May exacerbate barriers to insurance, employment, and housing for homeless patients ▪ May not accurately reflect medication/ drug use

Universal Precautions approach: Homeless patients have high rates of substance abuse/ dependence and may be at higher risk for opioid abuse, misuse, and/or diversion than other patients. The rise in overdose mortality secondary to abuse and diversion of prescribed opioids over the last decade has serious implications for individual and public health (Bohnert et al., 2011). Yet research has demonstrated that many primary care providers are unable to discern which of their patients are engaged in abuse or diversion of prescribed opioids (Vijayaraghavan et al., 2011).

To balance the benefits and risks of chronic opioid therapy, many clinicians believe that a "Universal Precautions" approach is warranted for all patients with persistent pain, particularly those receiving opioid analgesics. Recommended monitoring strategies include functional assessment, review of progress toward meeting pre-established health goals, direct questioning, use of treatment agreements, urine drug testing, pill counts, and prescription monitoring programs. This thorough and respectful approach to patient assessment and ongoing monitoring can reduce stigma, improve patient care, and contain overall risk associated with the treatment of chronic pain (Gourlay et al., 2005; Smith et al., 2009 Sep-Oct; Lum et al., 2011).

Plan and Management

PLAN OF CARE

Major Recommendations:

- **Jointly identify indicators of functional improvement with the patient to help determine whether the plan of care is "working." Develop a plan emphasizing holistic treatment with multiple modalities to assure patient understanding of the treatment plan; modify in response to functional change or if problems arise.**
- **Determine the patient's stage of change and how behavioral health problems are contributing to chronic pain. Include a behavioral health care plan in the plan of care.**
- **Plan for safe storage of medication and adaptation of prescribing/ dispensing practices, as needed.**

Rationale: The realities of homelessness (residential instability, extremely limited resources, lack of social supports) make adherence to a plan of care more difficult. Limited access to non-pharmacologic interventions may increase use of medications, including opioids. Thus, written goals, plans, and provider-patient agreements that are realistic and change in response to changing circumstances are particularly important to assure appropriate care for these patients.

Evidence: Expert consensus of practitioners experienced in homeless health care with expertise in pain management and addiction medicine. Sources: Griffith et al., 2010; CareOregon, 2003; Potter et al. in King & Wheeler, 2007, 331–340.

- **Goals** Establish diagnosis/es and determine treatment regimen/s (if incomplete) to optimize functional status. Discuss risks and benefits of treatment, and how to minimize risk of misusing opioids (if prescribed). Tailor the plan of care to patient needs and behaviors, including treatment adherence or behaviors outside the treatment plan ("aberrant").

- **Patient centered, holistic** Discuss the importance of focusing on the entire person and the entire treatment plan for successful pain management. Opioids (if used) are only one type of medication, and medications are only one aspect of treatment. Use an approach based on the patient's strengths.

- **Functional focus** Recognize that improvement of quality of life and functionality are as important as pain relief (Alford & Waldmann, 2004). For patients experiencing chronic pain, it is often more helpful to focus on function, emphasizing that treatment cannot be expected to eliminate pain entirely. The long-term management of pain is more successful if the patient and clinician jointly identify indicators of functional improvement. Encourage the patient to select tangible, measurable goals (e.g., getting up earlier in the morning, doing daily errands, completing assigned chores in a residential program or group living situation, walking, taking the bus, building social relationships, continuing a hobby, going to school). These functional measures can be used to help determine whether the plan of care is "working." Consider use of "action plans" for patient visits. These plans can be about any type of health related behavior, not just those related to pain. (A standard form that can be used to generate an action plan is included in Appendix E.)

- **Structured, written, mutually agreed-upon treatment plan** Include goals of treatment in the plan, focusing on function and quality of life. Ask the patient to identify important activities on which to focus functional goals (see history section above), in addition to measures of function and quality of life. If starting opioids, frame as a trial. Clarify measures of success and failure, and specify how treatment will be monitored. Include in the plan diagnostic/specialty referral, self management plan, non-pharmacologic treatments, opioid and/or non-opioid medications, and treatment of other conditions impacting pain or treatment (e.g., behavioral health disorders). Include a plan for getting medications and treatments, and a plan for follow-up (e.g., Appendix B).

- **Patient-provider agreement** A pain management agreement between the patient and provider can be useful to help specify expectations for care, particularly when opioids are prescribed (e.g., appendices K–O). The agreement should specify responsibilities for both parties, including the clinician's responsibility to provide prescribed medication on an agreed-upon basis. Caveats: Avoid the term "contract" and rigidly binding language; the agreement should change over time in response to changes in the plan of care and in the patient's function and behavior. Develop the agreement in partnership with the patient, and carefully explain its purpose. Review the agreement in depth at the outset; review it again at regular intervals and if problems arise. Make sure the patient understands what the agreement means. Homeless health care programs that use patient-provider agreements in this way find them to be a valuable clinical tool as well as a means of assuring mutual accountability.

- **Informed consent** Review and sign an informed consent with the patient if opioids are prescribed, describing the risks and benefits of treatment (e.g., Appendices K–O). As with the patient-provider agreement, make sure that patients understand what they are signing.

- **Behavioral health plan** Identify and treat comorbid substance abuse/dependence and/or mental illness. Determine the patient's stage of change and how behavioral health problems may be contributing to chronic pain. Patients actively abusing addictive substances or with untreated mental illness are unlikely to be sufficiently stable to be treated with opioids outside a drug/alcohol/ mental health treatment program. Coordinate primary care plans with behavioral health care plans, and facilitate coordination between primary care and mental health/addiction treatment agencies. (See CareOregon, 2003, Sections 4 & 5)

- **Medication storage** Make a plan about safe storage of medication. Adapt prescribing/ dispensing practices as needed (e.g., prescribe small amounts at a time, more frequent dispensing, help patients obtain a locked box or make arrangements for storage of medications in the clinic or shelter, if necessary).

EDUCATION, SELF-MANAGEMENT

Major Recommendations:

- **Review fundamental concepts of chronic pain management at every visit.**
- **Consider group visits as a vehicle for patient education; develop a core curriculum for all patients supplemented by special groups for those with higher needs.**
- **Educate providers about prescribing opioid analgesics to homeless persons with substance use disorders and adaptation of prescribing/ dispensing practices, as needed.**
- **Emphasize setting reasonable, attainable, short-term self-management goals while working toward long-term goals. Use motivational enhancement techniques to help patients resolve ambivalence about behavioral change.**

Rationale: Reviewing fundamental concepts and self management goal setting may increase involvement in comprehensive care and improve coping mechanisms. Group visits are an efficient and effective way of delivering care and may increase ability to provide comprehensive care and decrease fragmentation of the health care team. Many physicians are uncertain about prescribing opioid pain medications to persons with past or active substance abuse/dependence for fear of drug misuse and diversion.

Evidence: Expert consensus of practitioners experienced in homeless health care with expertise in pain management and addiction medicine. Sources: Doorley et al., 2010; Elder et al., 2010; Griffith et al., 2010; Hammer in King & Wheeler, 2007,121-128; Lorig & Holman, 2003; Morrison, 2007

Education

Recommended components of a patient education program for individuals with chronic pain:

- **Fundamentals of Chronic Pain Management:** (Griffith, 2010, slides 26–27)

  1. **Emphasize that this is a collaborative effort between the patient and clinician, not solely a clinician responsibility.**
  2. **Facilitate acceptance of living with chronic pain.**
  3. **Educate regarding pacing, relaxation techniques, and physical therapy or exercise as the chief interventions.**
  4. **Emphasize that behavioral approaches and medications are of equal importance.**
  5. **Inform that a 30 percent reduction of pain intensity is a successful intervention.**
  6. **Identify negative pain attitudes and address these through supportive and motivational interventions.**

  At the first and subsequent visits, review these principles with the patient, carefully explaining the use of behavioral techniques (pacing, relaxation, exercise). Because stress is generally increased in homeless people and scarce non-pharmacologic and specialty resources may promote over-reliance on opiates, it is especially important to review these concepts at every visit.

- **Group visits** Consider utilization of integrated group medical visits for patients with chronic pain and behaviors outside the treatment plan. Basic goals of group-based care include peer support during the clinical encounter, point-of-care collaboration by an interdisciplinary team, and interactive group education (Hammer in King & Wheeler, 2007, 121–128). This model of care has been successfully used by Valley Homeless Health Care (VHHP) in San Jose, California, to more

efficiently manage chronic pain for a small number of patients who were using a disproportionate amount of clinic services. Most of these patients had co-occurring addiction and mental illness, including Axis II personality disorders. VHHP's multidisciplinary integrated team approach involves the entire clinic staff (two primary care physicians, one psychiatrist, one or two psychologists, a registered nurse, a social worker, registration staff, and a medical assistant). Their use of group visits as an integral part of chronic pain management has resulted in higher provider satisfaction, improved clinic efficiency and flow, as well as an increase in patient adherence and self-efficacy (Doorley et al., 2010).

- **Patient education curriculum** Develop a ***core curriculum*** (Level One) for all patients with chronic pain to be used in group visits. Suggested topics:
    a. Pharmacologic approach to pain management: what to expect
    b. Behavioral approaches to pain management
    c. Complementary medicine and pain management

  The patient education program developed by Central City Concern (CCC), a Health Care for the Homeless project in Portland, Oregon, features these core components (three one-hour classes offered to every chronic pain patient), supplemented by more comprehensive curricula for patients with more intensive needs.

  Occupational therapy curriculum (Level Two): Provide instruction by an occupational therapist, a physical therapist, or other trained staff. (An occupational therapist is preferable in this clinic's experience, combining knowledge of physical medicine, biomechanics, and behavioral health with a strong focus on meaningful activity/occupation, which significantly decreases the centrality of pain for these patients.)

  Suggested topics:
  Every session: breathing, stretching, Tai Chi
  Monthly, in sequence: Modify components based on available expertise.

1. Back Health	8. Home Safety/Fall prevention
2. Body Mechanics	9. Stress management
3. Communication Skills	10. Time Management
4. Nutrition	11. Cognitive Behavioral Therapy for chronic pain and advocacy
5. Relaxation	12. Meditation
6. Sleep	13. Tai Chi & vision boards
7. Energy Conservation/Pacing	14. Leisure exploration

  A***ddictions and chronic pain program*** (Level Three): A curriculum for patients with chronic pain and comorbid substance dependence might focus on the following topics (examples derived from Central City Concern's "Hot Sauce" program):
  Every Session: breathing, meditation, Xi Gong, check-in, homework

  Look for community resources or consider skills or interests of your staff that could be shared with chronic pain patients. (The Portland HCH project happens to have an addictions counselor with a

strong background in Chinese Medicine, hence the emphasis on Tai Chi and Xi Gong.) Other behavioral or physical modalities that might be provided are: yoga, stretching, walking groups, art therapy, kickboxing, etc. — whatever your staff or the community can offer. The emphasis is on "getting patients outside of their pain."

Weekly topics, in sequence: Most practices serving homeless patients could offer some or all of the following components:

1. HALTS/recovery basics/intro outline
2. Triggers/Cravings, containing them (more recovery basics)
3. Relationships (e.g. church, NA, self)
4. Diet
5. Pharmacology (medications and their actions)
6. MD relationship
7. Complementary Medicine
8. Stretching: static, dynamic, tension/release
9. Cycle of Change (Precontemplation/ Contemplation/ Preparation/ Action/ Maintenance)
10. Where are you going? (Raise the Bar)
11. Recap/Review

These curricula were developed to accommodate different levels of risk and intensity of need. Basic classes were largely supplanted as the occupational therapy and addictions tracks became more robust, but the core curriculum remains useful to patients with the lowest needs. (See diagrams of CCC's Chronic Pain Recovery Program and levels of care in Appendix F.)

- **Provider education** Recognize that many providers are uncertain about prescribing opioid pain medications to persons with past or active substance abuse/dependence for fear of drug misuse and diversion (Elder et al., 2010). Educate providers about how to differentiate and evaluate chronic pain and substance use, and how best to minimize/ respond to drug misuse/ diversion. (See Associated Problems, Complications below.) Ensure that all staff know the basics of chronic pain management and have skills to work with homeless patients who suffer from severe chronic pain, including Trauma- informed Care (Hopper et al., 2011). "With proper education of the medical community, patients should receive humane and compassionate treatment of their chronic pain syndromes" (Heit, 2001).

Self-Management

- **Goals** of self-management are to decrease the centrality of pain — the extent to which chronic pain is "central" to a patient's life — and avoidance behaviors, and to increase self-efficacy.

- **Measurement tools** Consider tracking progress toward self-management goals using measurement tools such as the Patient Activation Measure and Centrality of Pain Scale (Appendix C).

- **Emphasis** is on setting reasonable, attainable, short-terms goals (with a confidence level of 7 or higher on a scale of 1–10 that the goal can be achieved), while reiterating long-term goals and keeping those in sight (UCSF Action Plan Project: What Are Action Plans?; Lorig & Holeman, 2003).

- **Self-management progress model** describing a continuum of functionality sometimes seen in homeless patients with pain (developed by a psychiatrist at Central City Concern):

  Spin: Patient is not doing well – on the streets, using, diverting meds, in and out of hospital/ jail, no social connections, medically fragile

  Float: Patient is stabilized in housing (maybe an SR0), with some income, but no meaningful activity or relationships. (These people may be spending time watching TV, smoking, eating pizza, hanging around the clinic.)

  Integrate: Full recovery of spiritual life, meaningful relationships, purposeful activity

  Articulate this model to patients, stressing that the care management team is not satisfied with "float," and patients do not have to be either.

  Favorite mottos:
  "Raise the bar."
  "Avoid the soft bigotry of low expectations."

- **Behavioral change** Use motivational enhancement techniques including Motivational Interviewing (MI) to help patients explore and resolve ambivalence about behavioral change (Morrison, 2007; HCH Clinicians' Network, 2000). MI is a client-centered, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence. Originally developed by William R. Miller and Stephen Rollnick (Miller & Rollnick, 2002) to help problem drinkers, this counseling approach has been successfully applied to address a variety of behaviors that affect health, including smoking, other drug use, physical activity, and sexual practices. MI is also recommended as a psychologically based treatment approach for the management of pain; see examples of this approach provided by Osborne and colleagues in their publication on Psychologic Interventions for Chronic Pain (Osborne, et al., 2006).

TREATMENT, MANAGEMENT

Major Recommendations:

- **Select treatment based on context and available resources (e.g., street/shelter, bare-bones poorly resourced health center, full-service ambulatory clinic with access to specialists, well-equipped hospital/medical respite program).**
- **Encourage early and ongoing non-pharmacologic treatment. Address psychosocial needs.**
- **Choose non-opioid pharmacologic interventions based on the etiology of pain, co-morbid conditions, medications, and other factors, some of which are more common among homeless people.**
- **Apply other guidelines cited in this document on use of opioids for chronic pain, with particular attention to identifying psychosocial factors that may complicate their use for homeless persons; structure monitoring and follow-up to address those factors.**
- **To promote successful use of opioid analgesics by homeless patients, use a written treatment plan, patient-provider agreement/ informed consent (assuring that patients understand them), a multidisciplinary care team, and a consistently nonjudgmental approach to behaviors outside treatment plan.**

Rationale: Choice of treatment depends on context and available resources. Successful management of pain may not be possible without also addressing psychosocial needs (e.g., food, clothing, shelter, safety). Limited access to non-pharmacologic interventions may increase use of medications, including opioids. Many homeless patients have higher risk for opioid and/or substance misuse/ abuse/ diversion, so more structured planning and monitoring is warranted. Practitioners experienced in homeless health care contend that harm reduction is helpful, especially where substance dependence is suspected. Evidence for the efficacy of treatment for chronic pain is limited. There is very little evidence for the efficacy of long-term opioid therapy. Use of cognitive behavioral therapy for chronic pain management has moderate support. Although multiple studies have confirmed the use of acupuncture as analgesia, few have focused on chronic pain. Evidence for the efficacy of other non-pharmacologic interventions in chronic pain management is limited or inconclusive. Controlled studies on chronic pain management in homeless populations are lacking.

Evidence: Recommendations are based on expert consensus of practitioners experienced in homeless health care with expertise in pain management and addiction medicine. Sources: Alford & Waldmann, 2004; APS-AAPM, 2009; CareOregon, 2003; Chou et al., 2009 Feb; Gersh et al., 2011; ICSI, 2009; Johnstone et al., 1994; Lee & Ernst, 2011; Liang et al., 2011; Molton et al., 2007; Passik, 2009; Potter et al. in King & Wheeler, 2007, 331–340; Tan et al., 2007; Turk et al., 2008; UMHS, 2009; VA/DoD, 2010; Washington SAMDG, 2010; Weaver & Schnoll, 2007, 2002.

- **Treatment goals** With chronic pain, the overall goal is to support improvement in function and quality of life by reducing pain and improving the patient's ability to cope with it. In general, chronic pain cannot be eliminated entirely.

- **Treatment options** The choice of treatment approach depends on context and available resources. A single visit in a shelter or under a bridge creates only a few opportunities for intervention. A health center creates additional resources, but many clinicians in health centers lack access to specialists — e.g., surgeons, pain specialists, physical therapists and behavioral medicine experts — who would ideally be available. Because resources so frequently fall short of the ideal treatment, clinicians ultimately need to respond in a manner that addresses three questions simultaneously. (If meeting a patient with chronic pain for the first time, the first two questions can be handled by offering a thoughtful, educational conversation. The third question can be pursued in depth at subsequent encounters.)

1. ***What might help the patient understand the problem that causes pain?*** The patient meeting a doctor in a bare-bones clinic will readily understand that ideal clinical tools are missing. What helps many patients endure unavoidable suffering is for a clinician to help them understand what is happening in their bodies: Is the process inflammatory, due to neural injury, autoimmune, or perhaps the result of pain sensory mechanisms left out of kilter by opioids or other drugs?
2. ***What can we do NOW that might help?*** What can be done immediately is heavily dependent on the care setting. Options are summarized in the Table below. Clinicians are not obligated to deliver all possible services, and patients will rarely accept all interventions at once.

Treatment Options for Chronic Pain in Different Care Settings

	Street/Shelter	**Bare Bones, poorly-resourced health center**	**Full service ambulatory clinic with access to specialists**	**Well-equipped hospital or Medical Respite program**
Physical Modalities	Simple exercises; changes to footwear, bedding	Items at left	Items at left	Items at left
Cheap Pain Relief Medication	NSAIDs, Acetaminophen, Lidocaine or benzocaine jelly	Items at left + amitriptyline, gabapentin, other neuropathic pain medications, muscle relaxants, opioids	Items at left + spinal or joint injections where indicated	All items at left
Physical Interventions	Secure a second pillow to buttress stressed joints while asleep; stiffen a bunk bed with a board	Ace bandages, foot warming baths purchased from drug store	Items at left + referrals to physical therapy, physiatrist, surgical consultation	Items at left may be accompanied by acupuncture
Other interventions	Identify less strenuous work duties, if applicable		Psychiatric consultation to address contributory emotional stressors (anxiety, PTSD)	Behavioral Medicine coaching for self-management
Follow-up Diagnostic Assistance		Mental Health consultation X-rays	Items at left + referral to a surgical or other consultant	All items at left

3. ***What steps might be worthy of consideration in the future?*** Explain that there is a menu of potentially helpful options to be worked through systematically, and that pain treatment is multimodal and occurs in an ongoing therapeutic relationship. This will help reassure patients that although some treatments are not indicated on the first visit, diagnostic/ treatment options not currently available may be so in the future. For example, even if an orthopedic specialist is nowhere available, it is important for the clinician to explain that one is likely to be needed (e.g., "*As we help you get back on your feet, I want you to keep in mind that at some point you need to have that shoulder looked at by an orthopedist.*").

Non-pharmacologic interventions

- **Comprehensive pain management strategy** Medications are only one part of a comprehensive pain management approach. Non-pharmacologic options, such as those listed below (Passik, 2009. 594), are recommended (when indicated) for use with homeless patients:
  Self-administered therapies – physical activity/ exercise, heat or cold application
  Physical medicine – massage therapy, physical and occupational therapy
  Psychological therapies – cognitive-behavioral therapy, progressive relaxation, goal-setting and pacing strategies
  Interventional therapies – bracing, nerve blocks, transcutaneous nerve stimulation
  (See Education, Self-Management for more information about some of these interventions.)

- **Early intervention** Use of non-pharmacological approaches such as those mentioned above should be initiated early (when indicated) and encouraged continuously throughout treatment.

- **Addressing psychosocial needs** such as finances, housing, relationship issues, and stress reduction should be incorporated into any comprehensive treatment plan (see Alford & Waldmann, 2004; Potter et al. in King & Wheeler, 2007, 331–340; Gregg et al., 2008).

- **Cognitive Behavioral Therapy (CBT)** for chronic pain management involves modifying negative thoughts related to pain and on increasing the patient's activity level and productive functioning. Therapy is tailored to individual needs but may include: relaxation training, cognitive restructuring, stress and anger management, sleep hygiene, and/or activity pacing. In addition, pain management programs often include a behavioral goal-setting component in which patients set weekly goals. As part of a multi-disciplinary pain treatment team, CBT may incorporate exercise goals set by the physical therapist, or may include recommendations for taking pain medications at prescribed time intervals. (The Health Psychology Network, Boston University) CBT can be adapted to meet the needs of persons experiencing homelessness and, in groups, can be even more successful than one-to-one therapy in a homeless health care setting. The group approach can normalize shared anxiety and resistance to joining in a plan with the prescriber. Sometimes clients are able to convince one another to try it "because it really does work." The group is also a great opportunity for psychoeducation and reinforcement of ideas about living with behavioral health disorders.

- **Acupuncture** can be an effective tool in the treatment of many different types of pain, as a non-pharmacological approach to chronic pain management and/or to help patients gradually stop using pain medications. Group acupuncture, in which one provider treats many people at the same location, has been reported to be an effective, low-cost pain management strategy for homeless and marginally housed adults (Johnstone et al., 1994). Acupuncture in a group setting also establishes a "community" in which pain patients can support each other in coping with pain. The group can help the provider teach patients new ideas about pain and its treatment. The National Acupuncture Detoxification Association's 5 Needle Protocol (manual manipulation of needles rather than electrical stimulation) has been demonstrated to reduce opioid withdrawal symptoms and prolong retention in addiction treatment programs (Bullock, et al., 1989), relieve symptoms of

posttraumatic stress disorder (Hollifield et al., 2007), and effectively treat musculoskeletal pain and headaches (Kelly, 2009; Lee & Ernst, 2011; Liang, et al, 2011). Moreover, acupuncture helps patients with stress, coping, and relapse prevention issues, and can help to alleviate grief, fear, insomnia, depression, and anxiety. An acupuncture treatment program can be a bridge to their other providers, encouraging the patient to pursue necessary medical follow-up

Pharmacologic interventions

- **Opioids versus non-opioids** It is important to understand that both opioid and non-opioid therapies have side effects and risks. Both are supported by inconsistent research data, with supportive evidence often emerging from studies of poor quality. Although opioid therapies introduce a measure of misuse/overuse/addiction risk for the patient and legal/regulatory risk for the medical provider, they can be used safely and effectively for many homeless patients, even those with comorbid behavioral health problems (see below).

- **Use of non-opioids in chronic pain management** In general, non-opioid medications and non-pharmacologic interventions are recommended for initial management of chronic non-malignant pain. Choice of non-opioid medication is based on the characteristics and causes of pain and on comorbid conditions. Risks associated with comorbid conditions common among homeless persons are noted below:

  1. **Analgesics**
     for musculoskeletal/ myofascial pain: *acetaminophen, nonsteroidal anti-inflammatory drugs (NSAIDS), muscle relaxants, or intraarticular steroids*
     Use acetaminophen with caution or avoid in patients with hepatic or renal impairment, alcohol abuse, dehydration or malnutrition. Use NSAIDS with caution in patients with hepatic or renal impairment, chronic alcohol use, or asthma as well as in elderly persons (a growing portion of the homeless population).

  2. **Adjuvant medications** (in addition to analgesics)
     for fibromyalgia/ neuropathic pain: *muscle relaxants; anticonvulsants such as gabapentin, topiramate, and lamotrigine; tricyclic anti-depressants (TCAs), or serotonin- norepinephrine reuptake inhibitors (SNRIs) such as duloxetine and venlafaxine*
     Use gabapentin with caution in patients with chronic alcohol use, depression, suicide risk or renal impairment. Monitor closely in patients taking methadone, barbiturates, benzodiazepines and anti-seizure medications. Use TCAs with caution in patients with hepatic impairment, heart disease, schizophrenia, bipolar disorder, alcohol abuse, suicide risk and the elderly (higher risk for these disorders in homeless persons already noted). TCA clearance can be dramatically decreased by other medications, potentially leading to toxic levels even at conservative doses. Counsel patients taking TCAs to avoid excessive sun exposure — particularly those who are living without shelter.
     for chronic headache/ migraines: *triptans, calcium channel blockers, anticonvulsants, beta blockers, tricyclic anti-depressants*

(More information about analgesics and adjuvant medications used in homeless health care is available in Appendices G–H; see also Potter et al. in King & Wheeler, 2007, 335.)

3. **Pain medications for patients with co-occurring mental health disorders**
   The following medications can be used to treat mental illness and chronic pain simultaneously (Griffith et al., 2010, slide 18):
   TCAs or serotonic neurepinephine reuptake inhibitors **(*SNRIs*)** in depression/anxiety and migraine
   Valproic acid in bipolar disorder and migraine
   Lamotrogine may be considered after other medications have failed for neuropathic pain and bipolar disorder.
   Gabapentin/pregabalin in neuropathic pain or fibromyalgia and generalized anxiety disorder (GAD) or other anxiety
   Baclofen for muscle spasm with possible benefits for post-traumatic stress disorder (PTSD) / other anxiety disorders and for alcohol/ cocaine dependence

- **Use of Opioids in Chronic Pain Management**

1. **When are opioids warranted?** Opioids are reserved for more severe pain, impaired function, worse quality of life, or when there are contraindications to less potent medications (Potter et al. in King & Wheeler, 2007, 335).

2. **Challenges in the clinical management of opioid therapy:** Be cautious about prescribing opioid analgesics for homeless patients suffering from chronic pain. Concerns include:

   a. ***Will the prescribed opioid be misused or diverted to others' use?*** Problems with emotional decision making associated with chronic pain are often exacerbated by comorbid psychiatric disorders, which impair concentration and judgment. These co-occurring disorders are common among homeless people and increase their risk of substance misuse. Moreover, opioid medications have a high street value, which increases risk of diversion. To further complicate matters, research has shown that clinicians are poor at assessing who is actually misusing/ diverting these medications (Vijayaraghavan et al., 2011). Urine drug testing and pill counts are tools to monitor opioid and illicit substance use in patients at high risk for misuse/abuse/ diversion. A "universal approach" to drug testing can be used in clinics serving populations with high prevalence of these outcomes.

   b. ***Does this medication have the potential to precipitate or reactivate an addictive disorder?*** A barrier to management of chronic pain in homeless patients is their high risk for substance abuse/dependence. In the early stages of treatment, it can be difficult to determine whether prescribed opioids will contribute to an underlying addiction disorder. Even diagnosing active substance abuse/dependence in patients receiving opioid analgesics is challenging, particularly if there is ongoing pain, significant anxiety about continued access to pain-relieving medications, and/or a history of addiction. Stress the importance of adherence to the treatment plan; explain that it is unacceptable for the patient to self-titrate opioid doses due to the risk of unintentional overdose.

In light of these challenges, pay careful attention to whether opioid use or opioid-seeking is related to behaviors that cause harm in multiple areas of the patient's life (e.g., legal, medical, social, emotional). Be aware that physiologic dependence is an expected and non-pathological outcome of long-term use of prescribed opioids for pain. Scientific evidence is weak on how best to manage opioid treatment of chronic pain in patients (homeless or not) with active substance dependence or in recovery (Weaver & Schnoll, 2002). It is well established, however, that a ***harm reduction approach*** is appropriate for homeless patients with substance use disorders (Kraybill & Zerger, 2003).[6]

c. ***Does the patient have sufficient self-management skills to benefit from opioid treatment without placing excessive demands on clinic staff?*** Not all clinics have sufficient staffing to assure that an optimal management plan can actually be implemented. For example, if medical prescribers are rarely available or routinely rotating (as in a volunteer clinic), a long-term opioid treatment plan may not be feasible, even for patients who are cooperative and adherent. Even in clinics with regular prescribing physicians and sufficient staff support (nursing, case management, etc.), there are likely to be patients who are difficult to manage, whether they have a formal diagnosis of substance dependence or not. For example, a patient who cannot regularly appear for scheduled appointments, who erratically requests prescription refills, or who repeatedly loses prescriptions presents a management challenge. Staff require time to determine whether such irregularities constitute a clinical problem or a one-time challenge. Additional work is required to re-educate the patient about the plan of care and/or to offer new prescriptions. Additional communication with the pharmacy is often required in such situations. Where patient self-management is poor, some clinical practices may find that they lack sufficient staff, time, information resources, or logistical support to formally re-assess and revise COT as needed.

   For these reasons, it is important for all clinical practices serving this population to focus on development of better self-management skills (see the Education, Self-management section for ideas), and to consider using strategies such as more frequent prescribing, medisets, directly observed or daily dispensing opioid therapy for those who are unable to manage medications by themselves. Moreover, it is incumbent upon clinics serving high-risk patients (including those who are homeless) to ensure sufficient expertise and resources to carefully select and monitor candidates for chronic opioid treatment before offering it.

---

[6] ***Harm reduction*** is a nonjudgmental approach to facilitating behavioral change that is designed to reduce or minimize the damage caused by high-risk behaviors, with the ultimate goal of eliminating them. "Based on stages of change theory and coupled with the use of motivational enhancement techniques, harm reduction…views change as a series of incremental steps along a continuum — .any change in a positive direction that reduces risk or harm is viewed as a success. …Harm reduction as related to substance [use] problems does not preclude abstinence as a goal, but… acknowledges participants' ambivalence about change and that people are at different levels of readiness to change their behavior in regard to substance use and other issues they face. …The role of staff is to help resolve ambivalence and build motivation towards any positive change. (Kraybill and Zerger, 2003, p. 18)

ASSOCIATED PROBLEMS, COMPLICATIONS

Major Recommendations:

- **Monitor functional status closely and investigate any decline, which has a broad differential diagnosis but may indicate active substance abuse.**
- **Use a nonjudgmental approach to explore behaviors outside the treatment plan, which may indicate diversion or misuse of medications, and a harm reduction approach when addressing them. Recognize that a more structured treatment plan and/or discontinuation of opioids is/are sometimes indicated.**

Rationale: Harms can be caused directly by opioid treatment (e.g., sedation, overdose, drug-drug interactions), by the interplay with medical and/or mental health/ substance use issues, and by problems related to misuse/ abuse/ diversion of medications. Clinicians working with homeless patients must guard against stereotyping while appreciating the high rates of addiction, mental illness, and extreme poverty in this population.

Evidence: Recommendations are based on expert consensus of practitioners experienced in homeless health care with expertise in pain management and addiction medicine. Sources: Hansen et al., 2011(in press); Moskowitz, 2011; NMA, 2004; Vijayaraghavan et al., 2011

Problems/ Complications Related to Chronic Opioid Therapy (COT)

- Physical Complications and Considerations

  1. Change in clinical condition(s) with an increase in pain
     Pain reports may increase and function may deteriorate as a result of progression of the underlying etiology of pain (e.g., chronic low back pain with degenerative joint and disc disease resulting in nerve root impingement and radicular pain). ***Work with the patient to try to understand the underlying cause(s) of pain***, recognizing that this may not be possible. Prescribe appropriate pain medication and document why you prescribed it

  2. Changes in other medical conditions which have implications in COT
     Consider a short-term increase in opioid dosage to treat acute pain syndromes related to an acute exacerbation of chronic pain or a separate etiology (e.g., broken arm).
     Be alert to possible drug-drug interactions. Remember that some drugs, such as HIV medications, methadone, and other opioids, can increase or decrease the effects of pain medications.

- Behavioral Problems and Complications

  1. Overall Functional Decline or Behaviors Outside the Treatment Plan (e.g., missed appointments, dropped attendance at substance abuse support meetings or nonmedical treatments, deterioration of mental health, and/or decline in personal appearance and hygiene) These factors, particularly if they are sudden changes, can be indicators of active substance abuse. ***Explore possibilities that the etiology of pain may have evolved and that changes in behavior may be related to inadequate pain management, decline of the patient's mental health stability, social stressors (e.g., personal safety), or loss of 'control' of medication or alcohol/ illicit drug use.***

2. **Urine Drug Test Abnormalities and Variations** A detailed discussion of urine drug tests, interpretation and management is beyond the scope of these recommendations. What follows is a list of some basic considerations and interpretations of test results.

   a. **Unexpected absence** of prescribed medication:
   Pseudo-addiction: The patient is not getting sufficient pain management and is taking medication more often than prescribed, thus running out early
   ***Misuse/ Abuse*:** The patient may be impulsively consuming medication.
   ***Diversion*:** The patient may be diverting medication for secondary gain (supplemental income, to treat other ailments); through exchange for other drugs of choice; through theft/ victimization or loss due to unstable living conditions or carelessness; or sharing it with others in need.
   Patient/ Test factors: The patient is a rapid metabolizer, or medication is present in levels too low to be detected by the test, or the test does not include the prescribed medication.

   b. **Unexpected presence** of drugs not prescribed by the provider ordering the test**:**
   Other opioids: The patient may have other providers, pseudoaddiction, or opioid misuse/abuse. Other opioids may be metabolites of the prescribed opioid.
   ***Illicit drugs*:** The patient may have pseudoaddiction, a substance use disorder, and/or be diverting opioids for other drugs.

   Note that the presence of prescribed medication and the absence of other drugs do not exclude the possibility of problems such as diversion. For example, a patient who is diverting may keep a few pills to take just prior to the test. The urine drug test is only one source of information to be considered within the context of the patient's functional status, behaviors outside the treatment plan, and other information.

3. **Strategies for Dealing with Misuse/ Abuse of Medications** (e.g., overuse, inappropriate attempts to quit meds, hoarding meds, running out early, injection or snorting meds intended for oral use, mixing prescribed meds with illicitly obtained meds or drugs with potential dangerous effects)
   a. ***Identify the problem*:** Do regular functional assessments. Deterioration in functioning requires diagnosis.
   b. ***Use Motivational Interviewing:*** Identify what positives the patient is getting out of the current way of taking meds; use discrepancies between the patient's expressed goals and current outcomes to open up a dialogue; and move toward positive change.
   c. ***Consider an increase in structure*** (e.g., weekly or daily dispensing or observed treatment) Referral to substance abuse treatment is frequently indicated.
   d. ***Recognize that not all drug-seeking behaviors outside the treatment plan are signs of addiction.*** "*…patients receiving good pain relief may exhibit drug-seeking behaviors because they fear not only the reemergence of pain but perhaps also the emergence of withdrawal symptoms. Rather than indicating addictive disease, such behaviors, termed therapeutic dependence, are actually efforts to maintain a tolerable level of comfort …* (Alford et al., 2006)." An Addiction Medicine specialist can help determine the cause of these behaviors.

4. Strategies for Managing Suspected Diversion

   a. **Strict profit motive** Take a full history; be suspicious if the history is inconsistent and/or there are no objective findings of disease. Be suspicious of non-homeless/ underserved patients coming to a homeless health care/ poverty medicine site. Know the street value of drugs in your local area and avoid prescribing the most desirable drugs, if possible (in general, brand names are more desirable). Drugs less able to be altered and used intravenously or smoked are often preferred. Use a statewide prescription drug-monitoring program (PMP). (Current information about individual state PMPs is available on the National Alliance of Model State Drug Laws Prescription Drug Monitoring Project website at www.namsdl.org/presdrug.htm.) Policies that universally prohibit patients from getting a controlled substance prescription on their first visit and/or policies in which a state database is checked or the previous provider is called before issuing a prescription can also be helpful in discouraging this type of diversion.

   b. **Exchange for other drugs of choice** Counsel patients about this prior to prescribing. Make prudent use of urine drug tests and pill counts. Take a careful history and observe the patient over time, including when admitted to hospital, jail, or other controlled setting. Pay attention to the functional assessment; patients abusing stimulants are usually deteriorating functionally (e.g., loss of housing, criminal justice problems, conflict with staff and other patients). Patients using stimulants may have pain and stimulant dependence or simply be diverting to obtain a drug of choice. Patients using opioid medication to obtain illicit opioids may be undertreated or receiving the wrong pain medications. When asked nonjudgmentally, patients will frequently be truthful and ask for help. Some may need referral to a highly structured addiction treatment program (methadone clinic) before attempting treatment or re-treatment of pain with opioids. If indicated, consider making continued prescriptions contingent on available residential drug treatment or other programs.

   c. **Reports of lost or stolen medications** Although a report of lost/stolen medications may indicate diversion, recognize that homeless people are particularly vulnerable to loss, theft, and victimization. Counsel patients on strategies to avoid this. Formulate patient-provider agreements which explicitly state there will be no refill for lost or stolen meds, or only once. Counsel the patient to keep meds to him/herself, confidential, in a locked box (as you would cash). Use more frequent prescriptions or dispense one week's supply at a time. Identify intimate partner violence and intervene if possible.

   d. **Sharing with others in need** Take a careful history. If the patient is diverting medication to a partner or friend, encourage engagement of that individual in care. Employ a harm reduction strategy; teach the patient how to keep their partner/ friend safe.

- **Discontinuation of Chronic Opioid Therapy (COT)**

  a. <u>Stopping opioids when there is not enough benefit</u>:

  - Stress your genuine concern about the patient's pain severity and impact.
  - Express frustration regarding the lack of a good pill to fix it.
  - Focus on the patient's strengths.
  - Encourage therapies for "coping with" pain.
  - Show your commitment to continue caring for the patient and helping to alleviate his/her pain, even without opioids (i.e., you are abandoning the treatment, not the patient).
  - Schedule close follow-ups during and after tapering opioid analgesics.

  b. <u>Stopping opioids when there is too much risk</u>:

  - Give specific and timely feedback why the patient's behaviors raise your concern about possible addiction.
  - Explain that benefits no longer outweigh risks — e.g., "*I cannot responsibly continue prescribing opioid therapy, as I feel it would cause you more harm than good.*"
  - Always offer referrals for treatment of addiction; recognize that cessation of COT may trigger relapse into heavy abuse.
  - Stay 100% in the "benefit versus risk of medication" mindset.

Problems and Complications Related to Other Factors:

- **Mental illness** An estimated 20–25 percent of homeless people in America suffer from serious mental illness, compared to only 4–6 percent of the general population (HCH Clinicians' Network, 2010). Be aware of the relatively high prevalence of comorbid psychiatric conditions among homeless people experiencing chronic pain, and recognize that Axis II Personality Disorders can complicate all aspects of treatment and negatively impact providers and other staff. Mental health problems such as depression, anxiety, and posttraumatic stress disorder should be addressed simultaneously with pain. Recognize that exacerbation of mental illness and erosion of coping capacity may result from cessation of COT.

- **Cognitive impairment** Cognitive problems — memory deficits, impulse control, low intellectual functioning — may not be readily apparent and may interfere with treatment adherence. As many as 80 percent of homeless persons receiving neuropsychological testing have marked deficits in cognitive functioning (Highley, 2008). Cognitive impairments seen in homeless patients are often associated with traumatic brain injury (TBI), mental illness, chronic substance abuse, infection, strokes, tumors, poisoning or developmental disabilities; and many of these patients were victims of assault during childhood prior to becoming homeless. Homeless people experience high rates of head injury (Carlson, et al., 2008). A recent study in Toronto found a lifetime prevalence of TBI in 53 percent of a representative sample of 904 homeless adults, with significantly increased likelihood of seizures, mental health problems, drug problems, and poorer physical and mental health status (Hwang et al., 2008). Chronic pain is a common complication of TBI (Nampiaparampil, 2008).

FOLLOW-UP

Major Recommendations:

- **Determine frequency of follow-up based on stability of the patient and his/her living situation and risk of misuse. For patients with comorbid behavioral health issues who are receiving COT, more frequent visits with random urine drug tests may be necessary. In general, opioid prescriptions should be of shorter duration (1 month or less) to help reduce risk of diversion/ overdose/ loss of medications.**
- **At each visit, assess for behaviors outside the treatment plan, including a psychosocial assessment. Consider causes related to homelessness — missed appointments due to competing priorities or unexpected events (e.g., in jail, delayed by another appointment), stolen medications (e.g., assault, theft in shelter).**
- **Provide Medical Respite Care facilities where homeless patients can convalesce when ill, recuperate following hospitalization, or receive end of life care. Facilitate entry into permanent supportive housing to alleviate many associated problems and complications.**

Rationale: Homeless people's lives are unstable, and they have a higher prevalence of mental health and substance use problems compared to the general population. Medications prescribed for homeless patients are more often stolen, overused, traded and/or sold. Most aspects of chronic pain management are more difficult without stable housing. Substance use declines when people become housed.

Evidence: Recommendations are based on expert consensus of practitioners experienced in homeless health care with expertise in pain management and addiction medicine. Sources: Aidala et al., 2005; Alford & Waldmann, 2004; Ciambrone & Edgington, 2009; Larimer et al., 2009; Post, 2008; Potter et al. in King & Wheeler, 2007, 331–340.

- **Frequency** Determine frequency of follow-up based on the stability of the patient and his/ her living situation and risk of misuse. Recommended follow-up can be weekly (or more frequently) to every 3–4 months. If prescribing an opioid analgesic, make sure follow-up occurs before the prescribed medication runs out. Coordinating opioid prescription refills with medical appointments helps encourage patients to come to the clinic for follow-up of comorbid medical conditions. For patients with comorbid behavioral health issues, more frequent visits with random urine drug tests may be necessary. In general, opioid prescriptions should be of shorter duration (1 month or less) to help reduce misuse/ diversion, overdose, or loss of medications. Consider dedicating every other visit to non-pain-related issues, to allow time for preventive care and management of other chronic illnesses.

- **Medication refills** Designate a capable provider to refill opioid and other medications if the prescriber is unavailable to do so. The clinician's responsibility to the patient lies in providing the medications on an agreed-upon basis.

- **Progress review** At every visit, review progress toward completion of the diagnostic work up, behavioral interventions (listed under Plan of Care), medication adherence, receipt of/ adherence to other treatments, and progress toward patient goals. Assess the patient's response to treatment (each visit), functional improvement (each visit), and mental health and substance use (at regular intervals, depending on original assessment results). Assess medication side effects. Change medications/ treatments/ treatment goals as needed. Keep expectations clear.

- **Substance use evaluation** Assess regularly for development of behaviors outside the treatment plan. Include in the differential diagnosis causes related to homelessness — missed appointments due to competing priorities or unexpected events (e.g., in jail, delayed by another appointment), stolen medications (e.g., assault, theft in shelter). If taking opioids, also assess for analgesia, function, and side effects. Use urine drug tests to assess for presence of prescribed opioid (if used) and other illicit substances.

- **Medication storage evaluation** Medications prescribed for homeless patients are frequently stolen, overused, traded or sold. Follow-up should include a re-evaluation of the patient's ability to manage a certain quantity of medications and strategies to keep medications safe.

- **Medical Respite Care/ permanent housing** Substance use declines when people become stably housed (Aidala, 2005; Parvensky & Perlman, 2006; Edens et al., 2007; HUD, 2007; Larimer et al., 2009). Because substance use is associated with higher risk for misuse/diversion of medications, housing should be a component of any treatment strategy to manage chronic pain. Provide or refer to Medical Respite Care facilities where homeless patients can convalesce when ill, recuperate following hospitalization, or receive end of life care (Ciambrone & Edgington, 2009). Facilitate entry into permanent housing with supportive services to reduce problems and complications associated with treatment for chronic pain (Post, 2008, pp. 5–6).

Model of Care

SERVICE DELIVERY DESIGN

Major Recommendations:

Optimum design includes the following:

- **Use integrated care and multidisciplinary clinical teams.**
- **Given the challenges and risks of opioid analgesics, the central role of behavioral approaches in chronic pain management, and the benefits of non-pharmacologic interventions, develop and utilize strategies for effective pain management other than or in addition to chronic opioid therapy. Consider combining opioids with non-opioids for synergistic or additive effects.**
- **Ensure that all clinical service providers know the basics of chronic pain management and have appropriate skills to work with persons experiencing homelessness, including Trauma-Informed Care.**
- **Develop policies and procedures to improve treatment effectiveness, clinic safety, and satisfaction of staff and patients, including patient registries and case review mechanisms to promote appropriate tracking and follow-up, identify/ address repeated behaviors outside the treatment plan, and provide support for staff.**
- **Develop relationships with outside partners and/or hire or train staff to provide services – e.g., pharmacy or program that can dispense medications weekly or more often, addiction medicine specialist, toxicologist/ clinical pathologist, pain clinic, cognitive behavioral therapist, physical/occupational therapist, acupuncturist.**

Rationale: It is important to develop a system of care that supports the patient-provider relationship, given the barriers that homeless patients face in obtaining treatment for chronic pain and the challenges that providers face in providing an appropriate combination of treatments in a safe and effective manner. Also important is developing a system of care that addresses the myriad needs of many homeless patients (e.g., medical, behavioral health, and social services) in a coordinated way.

Evidence: Recommendations are based on expert consensus of practitioners experienced in homeless health care with expertise in pain management and addiction medicine. Sources: Gersh et al., 2011; Griffith et al., 2010; ICSI, 2010; Passik, 2009 Jul; Tan et al., 2007

- **Goals** of optimal service delivery include meeting patient needs, promoting consistency in practice, and supporting staff that work with challenging patients. Base service delivery on individual patient needs. Recognize that a high percentage of patients are able to manage their pain with minimal interventions from clinical providers, while a smaller percentage of patients may need more intensive care. Consider using a decision tree to determine what types of services a particular patient needs. Recognize that therapeutic goals should focus not only on improved functioning and decreased centrality of pain, but also on meeting the patient's "hierarchy of needs" — housing, nutrition, supportive relationships, medical stabilization — which, if unmet, make appropriate pain management difficult. This may require use of a chronic pain "care manager," similar to those used for other chronic diseases such as diabetes or depression.

- **Integrated care** A "one-stop shopping" model of integrated care is ideal for homeless patients, enabling clinical care coordination to be maximized and triangulation minimized. Multiple return trips to receive different types of care result in more no-shows.

- **Multidisciplinary teams** Research has shown modest improvements in several outcomes with a collaborative care model of chronic pain management (Doorley et al., 2010; Gersh et al., 2011). Members of a multidisciplinary chronic pain management team may include a medical provider, nurse, social worker, psychologist, addiction specialist, and an eligibility or clerical worker. Include other specialists if resources permit — e.g., pharmacist, pain specialist, toxicologist/ clinical pathologist. (But beware of specialists who believe in only one treatment modality — e.g., pain specialists who only do injections/ nerve blocks, addiction specialists who only provide medication-free treatment.) Work with care providers from other agencies (e.g., mental health clinics, methadone treatment programs, residential and day treatment programs).

- **Group medical visits/ pain clinics** Consider use of group medical visits or special clinics for pain education, to manage medication refills, and to address the needs of challenging patients. Favor a multidisciplinary group model in treatment for chronic pain (Hammer in King & Wheeler, 2007, 121–128). This allows for more accurate diagnosis and treatment, particularly for patients with behaviors outside the treatment plan (Doorley et al., 2010). At each visit, all group participants should also have an individual encounter with a primary care provider — to prescribe/ dispense medications; assess for side effects, efficacy, and risk; address problematic events; and do urine drug tests, if warranted.

- **Non-pharmacologic treatment options** Given the increased challenges and risks of opioid treatment, the central role of behavioral approaches in management of chronic pain, and the benefits of non-pharmacologic treatments, identify and utilize strategies other than or in addition to opioids for effective pain management. Possibilities include: group visits run by an occupational therapist or behaviorist (Doorley, et al., 2010; Hammer in King & Wheeler, 2007, 121–128), concurrent addiction and chronic pain treatment, acupuncture, physical therapy, low-intensity stretching, meditation, yoga, and Xi Gong classes. Programs that offer these interventions often use creative, cost-effective strategies to help pay for them. For example:

  Physical therapy/ relaxation techniques Medicaid and Medicare provide some coverage for physical therapy services. If patients do not qualify for these programs or if service needs exceed coverage limits, seek assistance from large hospitals that offer some charity care. Use staff or community volunteers to provide instruction in low-impact stretching, medication, yoga, and Xi Gong, etc. (discussed above under Education, Self-Management).

  Acupuncture services When provided in a group setting, these services can be cost effective. One acupuncturist can treat a number of people within a treatment room simultaneously; the number of chairs available dictates the number of patients treated. Supplies (cotton, alcohol swabs and acupuncture needles) are inexpensive. It is not uncommon to provide as many as 50 treatments or more within 3–4 hours. If offered in a Federally Qualified Health Center, these services are reimbursable as "incident to" other treatments provided by the clinic. For example, if an acupuncturist charges $50–75 per hour for services, it is possible to realize a net profit in a group setting. An experienced acupuncturist can treat 5–7 chronic pain patients with ear and body points

in one hour. Most pain patients need multiple and frequent treatments. The group allows for this and minimizes the no-show effect on productivity. In addition, group treatment settings are well accepted by patients, including those with comorbid behavioral health issues (depression and anxiety). The group setting is ideal for patients with other comorbid conditions as well (e.g., diabetes).

Acupuncture services are available throughout the United States, particularly in urban areas where many homeless individuals reside. Through the influence of the National Acupuncture Detoxification Association (NADA) and Acupuncturists Without Borders, many practitioners are committed to providing low-cost community based services. Affiliating with such associations can be a useful collaboration. Public health service is a common goal within the acupuncture community. Rural areas are a challenge for any medical service, including acupuncture; but this challenge could be met using itinerant acupuncturists, similar to visiting nurses. Consider partnering with an acupuncturist to review resources and state licensing and practice laws to determine what is most feasible. Train local acupuncturists to practice in group settings.

Cognitive Behavioral Therapy CBT also lends itself well to group settings, as discussed above. To accommodate the special needs of homeless patients, vary the CBT protocol according to level of functioning and regularity of attendance at group meetings. It may take significantly longer for some patients to cover information from a typical protocol. Repetition of topics may also be necessary. To accommodate literacy limitations and avoid loss/ theft of written handouts, consider presenting most information orally. Assist with assignments during group sessions if the patient is unable to follow through with "homework." Consider timing medication refills to coincide with group sessions, to promote participation in CBT.

- **Policies and procedures** Systematize clinical practice for the benefit of patients and providers. Develop policies and procedures to manage homeless and other underserved patients with chronic pain across clinic/hospital systems, if possible, to improve safety, effectiveness, staff and patient satisfaction. (See Appendices P–R for policy examples). Use an external source of accountability and consequence — e.g., a community health network or consortium of safety-net providers. This can be helpful in maintaining the therapeutic relationship when the gap between the clinician's role and the patient's perceived need is greatest.

  Use patient-provider agreements, informed consent, and practice guidelines – to protect therapeutic relationships with patients, and to protect clinicians from professional and regulatory scrutiny when problems arise in the plan of care (e.g., irregular/unexpected drug screens, early refill requests, change in global function/self care, or other irregularities which may interfere with appropriate treatment of chronic pain). (See Appendices K–O.)

  Use monitoring/ tracking/ review mechanisms – to promote appropriate follow-up, identify repeated episodes of behaviors outside the treatment plan, review prescribing practices, and determine how best to manage care for particularly challenging patients:

- **Patient registries/ panel management** – to monitor completion of informed consent/ patient-provider agreements and other required aspects of care for all patients.
- **Case review mechanisms** – such as multidisciplinary committee, team review, peer review, or medical director review. Use structured formats for review (e.g., Appendices S–T). Use other forums to discuss difficult or high-risk patients (e.g., case conferencing by a multidisciplinary team following group visits).
- **Review of opioid prescribing practices** – especially those that are "outside the box" of mainstream prescribing practices — e.g., younger patients, conditions for which opioid use is controversial, using higher dosage, active mental health/substance abuse issues, contact with people who use opioids illicitly (Smith et al., 2009). Working in homeless health care often involves dealing with complex and unusual clinical situations. Consider consulting with an addiction medicine specialist or being certified yourself.

- **Pharmacy home** Establish a relationship with a pharmacy that can accommodate weekly (every seven day) medication pickups, either in bottles or pharmacy-filled medisets or bubble packs. Dispensing medications weekly provides a means to assure that the patient has received prescribed medications. If medications are lost or stolen, only seven days of medications at most would be lost, rather than a 30, 60 or 90 day supply.

OUTREACH AND ENGAGEMENT

Major Recommendations:

- **Focus on the pain, not the pill. Where pain medicines are sought, explore the patient's expectations, experience, and potential to benefit.**
- **Consider using a member of the care team other than the primary care provider (behavioral health counselor, acupuncturist, panel manager, occupational therapist, nurse, social worker, case manager) as the primary contact person for the patient, to lower potential access/ communication barriers.**

Rationale: Homeless patients often work with counselors, case managers, and/ or outreach workers who may explore pain issues when engaging the patient. These members of the care team often have more access to patients and are more accessible to them than medical providers. Early intervention and aggressive pain management may reduce the need for long-term treatment.

Evidence: Recommendations are based on expert consensus of practitioners experienced in homeless health care with expertise in pain management and addiction medicine. Sources: HCH Clinicians' Network, 2010

- **Outreach** is difficult if patients do not have a reason to come to the clinic/ point of service. Use group visits as a way to ensure that patients see the care team weekly or at least monthly, depending on the intensity of the program. Patients have reported high satisfaction with group medical visits (Doorley et al., 2010). Incentives such as healthy snacks, transportation vouchers, and scheduling medical refills to coincide with group visits can encourage regular attendance (Hammer in King & Wheeler, 2007, 121–128).

- **Engagement** Engage patients with chronic pain by focusing on the pain, not the pill. Evaluate the cause(s) of pain and the patient's desire for pain medication:
  - Is the individual feeling desperate or hopeless about his her chronic pain? Do demands for opiate medication look like pure drug- seeking, or is this more a cry for help than addiction?
  - Has the patient been treated by a clinician who is focused only on medication? Is the provider unfamiliar with or disinclined to use non- pharmacologic methods of pain management?
  - Has the patient tried a wide variety of non-pharmacological options but has not found one that is effective?
  - Is the patient taking the right medication and the appropriate dosage? Do prescription adjustments need to be made?
  - Have stressful psychosocial problems intruded on the patient's life recently? Have these stressors interfered with his/ her pain tolerance?
  - Does the individual have chronic pain issues with opioid or other substance dependence that are motivating demands for medication?

- **Point of contact** To facilitate engagement, consider using a member of the care team other than the primary care provider as the primary contact person for the patient — e.g., an addiction or mental health counselor, acupuncturist, panel manager, occupational therapist, nurse, social worker, or case manager. This can lower potential access and communication barriers. Other staff may be easier to reach than a primary care provider, and by discussing pain with someone other

than the person who prescribes medications, the patient may be more candid and open to other ways to manage pain. For individuals residing in medical respite facilities or supportive housing, consider designating a single point of contact for all communications about pain medications, to promote better coordination of care. This simplifies the process of addressing problems with an existing medical regimen for both patients and prescribers.

When multiple caregivers are separately involved in troubleshooting, pain patients may not receive a thorough evaluation or achieve adequate pain control, and are likely to become increasingly frustrated, as their treatment remains ineffective despite numerous conversations with clinical staff. Moreover, multiple attempts to seek change from various providers may be noted (accurately or erroneously) as "splitting" — i.e., playing one prescriber off against another and selectively providing or withholding information from each to obtain medications of choice (CareOregon, 2003, p.31). If the prescribing provider is inaccessible or lacks rapport with the client, consider establishing a two-person team whose members confer with each other and with the client before and after any pain regimen changes are made, to ensure that all client concerns are addressed. Educate all clinical staff to re-direct clients to designated point(s) of contact to discuss pain medication.

STANDARDS OF CARE

Major Recommendations:

- **Adapt clinical practices to optimize care for patients who are homeless or at risk of becoming homeless, considering the recommendations contained in this guide.**
- **Integrate service with advocacy to improve access for homeless people to a broader range of interventions for chronic pain management. Address structural causes of homelessness. Involve service providers and recipients to add credibility, help counteract staff burnout, and facilitate patient recovery.**

Rationale: Employ the same standards of care for patients who are homeless as for those with more resources – based on scientific evidence, expert opinion, and recommendations of practitioners with extensive experience working with homeless people. Involving direct service providers and patients in advocacy adds credibility to the positions presented, helps counteract staff burnout, and can facilitate patients' recovery process.

Evidence: Recommendations are based on expert consensus of practitioners experienced in homeless health care with expertise in pain management and addiction medicine. Sources: AMA, 2010; HCH Clinicians' Network, 2010

- **Clinical standards** Employ the same standards of care for patients who are homeless as for patients who have more resources – based on scientific evidence, expert opinion, and recommendations of practitioners experienced in working with homeless people. Adapt clinical practices to optimize care for patients who are homeless or at risk of becoming homeless, considering the recommendations contained in this guide.
- **Consumer involvement** Active involvement of patients in their own care is warranted as a basic principle of human rights – people should be involved in making decisions that affect their lives.
- **Prescription of controlled substances** The Federal Drug Enforcement Administration (DEA) regulates the prescription of controlled substances. States differ in medical and pharmacy laws. Many states require second opinions, patient-provider agreements, urine drug tests, etc., of clinical practices that prescribe chronic opioids for treatment of non-malignant pain. Check with your state medical, nursing, and pharmacy boards; refer to the model policy for use of controlled substances in the treatment of pain developed by the Federation of State Medical Boards (www.fsmb.org).
- **Licensure** Many states license acupuncturists and those that do not may have rules or regulations. Information about certification requirements in your state is available at www.acupuncture.com/statelaws/statelaw.htm. To learn about training opportunities, consult the National Acupuncture Detoxification Association (www.acudetox.com).
- **Integrated service and advocacy** Integrate service with advocacy to improve access for homeless people to a broader range of interventions for chronic pain management. Address the structural causes of homelessness. Advocacy is the educational process through which data, experiences, and insight are shared with those who craft public policy so that they may make informed decisions. Its aim is to educate policymakers about homelessness so that myths and stereotypes can give way to better-informed decision-making and resource allocation. Involving direct service providers and recipients in advocacy adds credibility to the positions presented, helps counteract staff burn-out, and can facilitate patients' recovery process.

TRANSITIONS IN CARE

Major Recommendations:

- **Confirm that long- and short-acting pain medications are prescribed by the hospital discharge team, and that at least a 7-day supply of medication is dispensed to the patient at discharge.**
- **Coordinate appropriate follow-up care for community provider(s) who will be prescribing medication before accepting the patient into a Medical Respite program following hospital discharge.**

Rationale: Homeless patients may transition to Medical Respite (convalescent) care following hospitalization. It is important to consider actions that will take place once a patient has left the hospital, including discharge planning and follow-up procedures to assure continuity of care, including appropriate pain control during the transition.

Evidence: Recommendations are based on expert consensus of practitioners experienced in homeless health care with expertise in pain management and addiction medicine. Sources: Jaco, 2011; Ciambrone & Edgington, 2009

Transition from Hospitals to Medical Respite/Recuperative Care:

- **Confirm that long-acting and short-acting pain medications are prescribed and dispensed for the patient upon discharge from the hospital**. At least a 7-day supply of pain medication should be dispensed at discharge.
- **Coordinate appropriate follow-up care with the provider who will be prescribing medication in the community** before accepting the patient into a Medical Respite program. If follow-up appointments with the provider are more than seven days after hospital discharge, consider the following measures to assure continuity in pain control:
  - Confirm with the established primary care provider that medication refills can be arranged via telephone or email prior to the appointment.
  - Additional days of medication, if needed, should be dispensed by the discharging hospital to the Medical Respite facility.
  - A second triplicate/secure prescription should be sent by the discharging hospital to the Medical Respite facility for any additional medications needed before the follow-up appointment.
  - One medication refill or more should be arranged for discharge pain medications.
  - The discharging hospital/medical team should schedule a follow-up appointment with their own team in the hospital clinic to bridge the gap between appointments.

For clients who need acute pain control in addition to chronic pain control:

- Confirm that the team treating the acute pain is in contact with the primary provider prescribing medication for chronic pain. This is particularly important for clients with existing opioid pain medication agreements.
- Identify which provider(s) will be continuing to assess and prescribe for the acute medical needs until they are resolved.

For clients with an opioid pain medication agreement:

- Confirm that the provider negotiating the contract is aware of acute medical needs and potential pain medication prescriptions.

CASE STUDY: INTEGRATED GROUP MEDICAL VISITS FOR CHALLENGING PATIENTS

Client Background: Mr. A is a 44-year-old chronically homeless male first seen at VHHP in 2005 with complaints of pain in his lower extremities. Mr. A's chronic pain began after a motorcycle accident in 1986 and a motor vehicle accident in 2004. Well-known on the public hospital campus, Mr. A was often found sleeping in a hallway at night and panhandling at a nearby McDonald's during the day. He frequently sought pain medications at the hospital emergency department, presenting 14 times to the Emergency Department in nine months prior to his participation in a chronic pain group. Although often seen in a wheelchair, Mr. A did not have any physical condition necessitating the use of one. In conversations with him, he would mention two fictitious characters which he had created for daily companionship. A neuropsychological assessment indicated that Mr. A might be exaggerating his psychological and medical problems.

Medical History: Mr. A has a history of hypertension, hepatitis C, hypothyroidism, and chronic venous insufficiency with secondary chronic lower extremity edema complicated by multiple episodes of cellulitis. His lower extremity edema was positional and worsened by sleeping in a wheelchair. Mr. A was non-adherent with his medications, often discarding pills or failing to refill prescriptions. Staff found that gaps in Mr. A's care were due to intermittent incarceration.

Psychosocial History: Mr. A was a foster child adopted at age seven. He has a history of child abuse and a known learning disability. Mr. A has an extensive history of alcohol abuse; until 2005, he drank two to three bottles of liquor a day.

Course of Treatment: Mr. A was seen at VHHP for several years without significant improvement in his health outcomes. Clinic visits often focused on his requests for pain medications and wheelchair certification. Providers were often suspicious of Mr. A's intentions. Due to his problematic behavior, he was recommended for the chronic pain group, which he was initially hesitant to attend. During his first few encounters, he attended for only five minutes and refused to engage in group discussions, with intermittent outbursts of anxiety. He sat by the door and abruptly left the session without explanation. The clinic team insisted that Mr. A continue to attend group sessions despite his complaints and excuses. Gradually, over several months, he attended more group sessions and stayed for longer periods.

Through participation in an intensive case management group, Mr. A obtained Social Security Income and transitioned to permanent housing. Several months later, he admitted to the pain group that he still slept in his wheelchair. Although he recognized the detrimental effect this had on his lower extremity edema, he confessed that sleeping in a bed was difficult because he had spent so many years sleeping upright in his wheelchair or on benches. He began to set weekly goals, using his action plan to make incremental changes. First, he simply parked his wheelchair next to his bed at night. Then he placed one of his legs on the bed while sitting in his wheelchair for a few hours each day, twice a week. Over the course of several months, Mr. A was able to place both legs on the bed for an extended period each day and slept in his bed one night a week. Within a year, Mr. A was sleeping in his bed five nights a week, with significant improvement in his edema.

Outcome: Mr. A's prior life experiences resulted in a set of behaviors in which guardedness and exaggeration became survival techniques for his life on the streets, even though they were counter-productive to his health. Meeting weekly with other chronic pain patients in a group where the message was always "come back just as you are" resulted in a dramatic relational shift in Mr. A's life. The structure and consistency which regular group visits provided eventually eroded Mr. A's guarded exterior. Over time, Mr. A became more open about past traumatic events, leading to the diagnosis of severe posttraumatic stress disorder. The team psychiatrist initiated medications which improved Mr. A's condition significantly. Mr. A began to trust the group and listen to its recommendations. He now walks into the pain group without using a wheelchair or walking device, and sleeps in his bed most nights of the week. He is actively engaged in his care, regularly brings his medication list to clinic encounters, and takes pain medications on an "as needed" basis. When a provider accidentally wrote a prescription for too few pain pills, Mr. A stretched the meds to last over the longer period without requesting additional medication through the clinic or the ED. Most recently, Mr. A began writing a book about his life experiences on the streets. At the time of this writing, he had completed over one hundred pages. In the nine months following enrollment in the chronic pain clinic, Mr. A reduced his ED utilization to two visits. As he learns a healthier, more adaptive model of interaction with others, his behavior changes bode well for maintaining permanent housing.

Sara L. Doorley, MD, Charles Preston, PhD, Viet Le, MD, PhD, Rebecca Shtulman, PhD, Libby Echeverria, MSW, and Cheryl J. Ho, MD, Valley Homeless Healthcare Program, San Jose, California, 2010

Excerpt, Innovations in Chronic Pain Management: New Models of Care. HCH Clinicians' Network *Homeless Health Care Case Report*, 6(1): 3–5.

CASE STUDY: MANAGING CHRONIC PAIN WITH COMORBID ADDICTION

Presentation: Mr. D first came to the syringe exchange outreach clinic at the Tom Waddell Health Center in San Francisco, 15 years ago. His clothes were disheveled, his hair matted from sweat and grime. Mr. D was apprehensive. He did not feel comfortable at the syringe exchange, and the younger crowd that hung around the park across the street intimidated him. During their first meeting he told Dr. Barry Zevin, that he had a painful leg ulcer and that he was hopeless, worn down, and suicidal. He was using heroin to cope and self medicate.

Background: On occasion, Mr. D would stop by the clinic and allow Dr. Zevin to perform dressing changes or review his medical history. After a number of visits, Mr. D became sufficiently comfortable to allow Dr. Zevin to be his primary care provider. Over time, Mr. D confided his interest and desire to find a way to stop his injection drug use and "cut down" on his use of other addictive substances. Dr. Zevin prescribed methadone for Mr. D's chronic pain. This helped the pain and helped Mr. D stop using heroin. An antidepressant was also prescribed, and his mood slowly began to improve. One day, Mr. D came to the clinic and declared that he had decided to follow-up on a referral to a surgery clinic at San Francisco General Hospital to save the viable tissue in Mr. D's poorly healing leg ulcer and decrease his chronic pain. Dr. Zevin had referred him to the surgery clinic a number of times, but until that day Mr. D. had not been receptive. The surgery significantly improved Mr. D's pain and function. Dr. Zevin observed him engaged in different activities around the city – "I even saw him riding his bike."

Developing a Pain Management Policy: Dr. Zevin sees many Mr. D's, To better address the complex needs of these patients, he and his colleagues were charged with developing an effective pain management policy. The concept behind the policy was simple: Develop a set of guidelines to help patients and providers work together around the issue of chronic pain and co-occurring addictions. The development of that policy was anything but easy, however.

"We had to craft a policy that was broad enough to deal with the varied concerns of our work force. Our task was to cast a very wide net that could make a safe, evidence-supported environment for everyone," said Zevin. The pain management policy they developed provides clear guidance on prescribing, medications that work for individuals with co-occurring pain and addictions, and options for alternative care. The policy is a tool for patients and providers to better meet their care needs.

Advocating for Consumers: Dr. Zevin thinks the best way to manage chronic pain with co-occurring use of addictive substances is to "focus on the patient." He encourages programs to incorporate a multidisciplinary team and focus on prevention, treatment, and care management. He believes that optimal pain management in patients with co-occurring substance dependence should be based on de-stigmatizing both homelessness and addiction, and focusing on the whole person and all of his/ her care needs.

"I want to make certain that I get across the idea that pain and a history of addiction are both really hard diagnoses – and that they are incurable but very treatable problems. I want my patients to know that they are not alone."

Dr. Zevin helps clients understand that their pain may require them to take potentially addictive substances and that he recognizes that their background disorder (substance use and addiction) is often in direct conflict with treatment. He lets his patients know that the "good news" is, there are tools to help them and he is willing to work with them over the "long haul."

Developing a chronic pain management treatment plan with a person who has a history of addiction requires careful attention to a variety of needs that may be in the background of the patient's life. Accordingly, Dr. Zevin always looks into the trauma, loss, and emotional pain that are often pervasive in the lives of homeless persons.

Wayne Centrone, MD, 2010
Excerpt, *Beyond Narcotics: Pain Management for People with Co-Occurring Chronic Pain and Addiction*
Prepared for the PATH Technical Assistance Center

Sources & Resources

PRIMARY SOURCES

Accessed 6/14/2011

Chou R, Fanciullo GJ, Fine PG, Adler JA, Ballantyne JC, Davies P, et al.; American Pain Society-American Academy of Pain Medicine (APS-AAPM) Opioids Guidelines Panel. Clinical Guidelines for the Use of Chronic Opioid Therapy in Chronic Noncancer Pain. *Journal of Pain*. 2009;10(2):113-130. http://www.jpain.org/article/S1526-5900%2808%2900831-6/fulltext

Berland DW, Rodgers PE, Green CR, Harrison RV, Roth RS; University of Michigan Health System (UMHS) Clinical Care Guidelines. *Managing Chronic Non-Terminal Pain – Including Prescribing Controlled Substances*. http://www.med.umich.edu/1info/fhp/practiceguides/pain.html

Institute for Clinical Systems Improvement (ICSI). *Assessment and Management of Chronic Pain*. 2009. http://www.icsi.org/guidelines_and_more/gl_os_prot/musculo-skeletal/

Labby D, Koder M, Amann T; prepared for CareOregon, Inc. *Opioids and Chronic Non-Malignant Pain: A Clinician's Handbook*. 2003. http://www.careoregon.org/Res/Documents/Providers/Opioids_Pain_Management.pdf

U.S. Department of Veterans Affairs, Department of Defense (VA/DoD). *Clinical Practice Guideline for Management of Opioid Therapy for Chronic Pain*. 2010. http://www.healthquality.va.gov/Chronic_Opioid_Therapy_COT.asp

Washington State Agency Medical Directors' Group (AMDG), Washington State Department of Labor and Industries. *Clinical Practice Guideline for Management of Opioid Therapy for Chronic Pain*. 2010. http://www.agencymeddirectors.wa.gov/Files/OpioidGdline.pdf http://www.agencymeddirectors.wa.gov/opioiddosing.asp

REFERENCES ON HOMELESS/ UNDERSERVED POPULATIONS

Accessed 6/14/2011

Aidala A, Cross JE, Stall R, Harre D, Sumartojo E. Housing status and HIV risk behaviors: implications for prevention and policy. *AIDS Behav.* 2005;9(3):251–65. http://www.ncbi.nlm.nih.gov/pubmed/16088369

Alford DP, Waldmann CA. Pain Management. In: O'Connell JJ, ed. *The Health Care of Homeless Persons: A Manual of Communicable Diseases and Common Problems in Shelters and on the Streets*. Boston Health Care for the Homeless Program; 2004:227-235. http://www.bhchp.org/BHCHP%20Manual/pdf_files/Part3_PDF/Pain_Management.pdf

American Medical Association. Continuing Education, Pain Management Series. Module 3: Barriers to pain management and pain in special populations. 2010. http://www.ama-cmeonline.com/pain_mgmt/printversion/ama_painmgmt_m3.pdf

Carlson T, Thompson L, Waldmann C, Post P; Traumatic brain injury in a homeless male. *Homeless Health Care Case Report*. HCH Clinicians' Network. 2008;4(1):1–10. http://www.nhchc.org/Publications/TBICaseRpt031008.pdf

Centrone W. *Beyond narcotics: pain management for people with co-occurring chronic pain and addiction*. Homelessness Resource Center, Substance Abuse and Mental Health Services Administration. 2010. http://homelessness.samhsa.gov/Resource/View.aspx?id=48557&AspxA

Doorley SL, Preston C, Le V, Shtulman R, Echeverria L, Ho CJ. Innovations in chronic pain management: new models of care. *Homeless Health Care Case Report*. Health Care for the Homeless Clinicians' Network. 2010;6(1):1–9. http://www.nhchc.org/CaseReports/ChronicPain_CaseReport_2010.pdf

Edens EL, Mares AS, Tsai J, Rosenheck RA. Does active substance use at housing entry impair outcomes in supported housing for chronically homeless persons? *Psychiatr Serv.* 2011;62:171–178. http://psychservices.psychiatryonline.org/cgi/reprint/62/2/171

Elder N, Johnston M, Joslyn M, Thompson L, Wismer B, Meinbresse M. *Pain Management Survey of Health Care for the Homeless Clinicians: Summary of Results*. Health Care for the Homeless Clinicians' Network, National Health Care for the Homeless Council. 2011. http://www.nhchc.org/Publications/FINAL_PainMngt_SummaryResults_Published.pdf

Griffith JM, Kushel M, Meinbresse M, Thompson L, Wismer B. *Pain Management: Working Toward Best Practices in Homeless Health Care Delivery.* Presentation, National HCH Conference 2010, San Francisco, CA. http://www.nhchc.org/2010conference/workshop31.html

Hammer H. Chapter 12: Group Medical Visits for Underserved Populations, 121–128. In: King TE, Jr & Wheeler MB, eds. *Medical Management of Vulnerable and Underserved Patients: Principles, Practice, and Populations*. New York, NY: McGraw-Hill Medical Publishing, 2007. http://www.amazon.com/Medical-Management-Vulnerable-Underserved-Patients/dp/0071443312#reader_0071443312

Health Care for the Homeless (HCH) Clinicians' Network, National Health Care for the Homeless Council. *Adapting Your Practice: General Recommendations for the Care of Homeless Patients*. 2010. http://www.nhchc.org/Publications/GenRecsHomeless2010.pdf

HCH Clinicians' Network. Delivering trauma-informed services. *Healing Hands*. Dec 2010;14(6):1–8. http://www.nhchc.org/Network/HealingHands/2010/DecHealingHandsWeb.pdf

HCH Clinicians' Network. Pain management: reducing disparities for homeless patients. *Healing Hands*. Oct 2004;8(5),1–6. http://www.nhchc.org/Network/HealingHands/2004/Oct2004HealingHands.pdf

HCH Clinicians' Network. Eliciting behavioral change: tools for HCH clinicians. *Healing Hands*. 2000;4(3),1–4. http://www.nhchc.org/Network/HealingHands/2000/hh.06_00.pdf

Highley JL. *Traumatic Brain Injury among Homeless Persons: Etiology, Prevalence and Severity* (B.J. Proffitt, Ed.). Nashville: Health Care for the Homeless Clinicians' Network, National Health Care for the Homeless Council, Inc. 2008. http://www.nhchc.org/TBIJune08final.pdf

Hopper EK, Bassuk EL, Olivet J. Shelter from the storm: trauma-informed care in homelessness services setting. *The Open Health Services and Policy Journal*. 2010;3:80–100. http://homeless.samhsa.gov/ResourceFiles/cenfdthy.pdf

Hwang SW, Colatonio A, Chiu S, Tolomiczenko G, Kiss A, Cowan L, Redelmeier DA, LevinsonW. The effect of traumatic brain injury on the health of homeless people. *CMAJ*. 2008; 179(8):779–84. http://www.cmaj.ca/content/179/8/779.full

Johnstone H, Marcinak J, Luckett M, Scott J. An evaluation of the treatment effectiveness of the Chicago Health Outreach Acupuncture Clinic. *Journal of Holistic Nursing.* 1994;12(2):171-83. http://www.ncbi.nlm.nih.gov/pubmed/8195574

Kushel MB, Evans JL, Perry S, Robertson MJ, Moss AR. No door to lock: victimization among homeless and marginally housed persons. *Arch Intern Med*. 2003;163(20):2492–9. http://archinte.ama-assn.org/cgi/reprint/163/20/2492.pdf

Larimer ME, Malone DK, Garner MD, Atkins DC, Burlingham B, Lonczak HS, Tanzer K, Ginzler J, Clifasefi SL, Hobson WG, Marlatt GA. Health care and public service use and costs before and after provision of housing for chronically homeless persons with severe alcohol problems. *JAMA*. 2009;301(13):1349–57. http://jama.ama-assn.org/content/301/13/1349.full

Matter R, Kline S, Cook KF, Amtmann D. Measuring pain in the context of homelessness. *Qual Life Res.* 2009;18(7):863–72. Epub 2009 Jul 7. http://www.ncbi.nlm.nih.gov/pubmed/19582592

Miaskowski C, Penko J, Guzman D, Mattson J, Bangsberg DR, Kushel MB. Occurrence and characteristics of chronic pain in a community-based cohort of indigent adults living with HIV infection. *J Pain,* 2011. Epub 2011 Jun 17. http://www.ncbi.nlm.nih.gov/pubmed/21684218

Moskowitz D, Thom DH, Guzman D, Penko J, Miaskowski C, Kushel MB. Is primary care providers' trust in socially marginalized patients affected by race? *J Gen Intern Med.* 2011. Epub 2001 Mar 12. http://www.ncbi.nlm.nih.gov/pubmed/21394422

National Coalition for the Homeless (NCH). *Fact Sheet on Mental Illness and Homelessness.* 2009. http://www.nationalhomeless.org/factsheets/Mental_Illness.html

National Medical Association (NMA). Managing pain: the challenge in underserved populations: appropriate use versus abuse and diversion. *J Natl Med Assoc*. 2004;96(9):1152–61. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2568463/pdf/jnma00178-0020.pdf

Perlman J, Parvensky J. *Denver Housing First Collaborative: Cost Benefit Analysis And Program Outcomes Report.* Colorado Coalition for the Homeless. 2006. http://www.shnny.org/documents/FinalDHFCCostStudy.pdf

Potter MB, Johnson YM, Zevin BD. Chapter 32: Chronic Pain Management in Vulnerable Populations. In: King TE, Jr and Wheeler MB, eds. *Medical Management of Vulnerable and*

Underserved Patients: Principles, Practice, and Populations. New York: McGraw-Hill Medical Publishing. 2007:331–340. http://www.amazon.com/Medical-Management-Vulnerable-Underserved-Patients/dp/0071443312#_

Sadowski LS, Kee RA, VanderWeele TJ, Buchanan D. Effect of a housing and case management program on emergency department visits and hospitalizations among chronically ill homeless adults: a randomized trial. *JAMA*. May;301(17):1771–1778. http://jama.ama-assn.org/cgi/content/full/301/17/1771

Shavers VL, Bakos A, Sheppard VB. Race, ethnicity, and pain among the U.S. adult population. *Journal of Health Care for the Poor and Underserved*. 2010;21(1):177–220. http://www.ncbi.nlm.nih.gov/pubmed/20173263

U.S. Dept. of Housing and Urban Development (HUD). *The Applicability of Housing First Models to Homeless Persons with Serious Mental Illness*. 2007. http://www.huduser.org/portal/publications/hsgfirst.pdf

Vijayaraghavan M, Penko J, Guzman D, Miaskowski C, Kushel M. Primary care providers' judgments of opioid analgesic misuse in a community-based cohort of HIV-infected indigent adults. *J Gen Intern Med*. 2011;26(4):412–8. http://www.ncbi.nlm.nih.gov/pubmed/21061084

Waldmann CA. Traumatic Brain Injury (TBI). In: O'Connell JJ, ed. *The Health Care of Homeless Persons: A Manual of Communicable Diseases and Common Problems in Shelters and on the Streets*. Boston Health Care for the Homeless Program. 2004:227–235. http://www.bhchp.org/BHCHP%20Manual/pdf_files/Part3_PDF/Brain_Injury.pdf

OTHER REFERENCES

Accessed 6/14/2011

Other practice guidelines:

Calistoga (CA): Council of Acupuncture and Oriental Medicine Associates (CAOMA), Foundation for Acupuncture Research. *Acupuncture and Electroacupuncture: Evidence-Based Treatment Guidelines*. 2004. http://www.guidelinecentral.com/CustomContentRetrieve.aspx?ID=1825714

Chou R, Qaseem A, Snow V, Casey D, Cross, Jr JT, Shekelle P, Owens DK. Diagnosis and Treatment of Low Back Pain: A Joint Clinical Practice Guideline from the American College of Physicians and the American Pain Society. *Annals of Internal Medicine*. 2007;47 (7):478–491. http://www.annals.org/content/147/7/478.full

Federation of State Medical Boards of the United States. *Model Policy for the Use of Controlled Substances for the Treatment of Pain*. 2004. http://www.fsmb.org/pdf/2004_grpol_Controlled_Substances.pdf

Lipman AG (Ed). *Pain Management for Primary Care Clinicians*. American Society of Health- System Pharmacists, Inc. ISBN: 1585281026. 2004. http://books.google.com/books?id=AjskVPLJhPsC&dq=isbn:1585281026

Registered Nurses Association of Ontario (RNAO). *Assessment and Management of Pain*. 2007. http://www.guideline.gov/summary/summary.aspx?doc_id=11507&nbr=005960&string=pain

Pharmacologic interventions:

Arnold L, Goldenberg D, Stanford S, Lalonde J, Sandhu H, Keck P, Welge J, Bishop F, Stanford K, Hess E, Hudson J. Gabapentin in the treatment of fibromyalgia: a randomized, double-blind, placebo-controlled, multicenter trial. *Arthritis & Rheumatism*, 2007;56(4):1336–44. http://www.ncbi.nlm.nih.gov/pubmed/17393438

Bohnert AS, Valenstein M, Bair MJ, Ganoczy D, McCarthy JF, Ilgen MA, Blow FC. Association between opioid prescribing patterns and opioid overdose-related deaths. *JAMA*. 2011;305(13):1315–21. http://jama.ama-assn.org/content/305/13/1315

Bossio MU. Opioid analgesics for chronic pain: responsibilities, implications and ramifications. *Pharmacology.* 2006;14(12):25. CE Offering http://nurse-practitioners-and-physician-assistants.advanceweb.com/Article/Opioid-Analgesics-for-Chronic-Pain-3.aspx

Chou R, Ballantyne JC, Fanciullo GJ, Fine PG, Miaskowski C. Research gaps on use of opioids for chronic noncancer pain: Findings from a review of the evidence for an American Pain Society and American Academy of Pain Medicine clinical practice guideline. *Journal of Pain.* Feb 2009;10(2):147–159. http://www.ncbi.nlm.nih.gov/pubmed/19187891

Chou R, Fanciullo GJ, Fine PG, Miaskowski C, Passik SD, Portenoy RK. Opioids for chronic noncancer pain: prediction and identification of aberrant drug-related behaviors: a review of the evidence for an American Pain Society and American Academy of Pain Medicine clinical practice guideline. *Journal of Pain*. Feb 2009;10(2):131–146. http://download.journals.elsevierhealth.com/pdfs/journals/1526-5900/PIIS1526590008008328.pdf

Compton P, Wu S, Schieffer B, Pham Q, Naliboff B. Introduction of a self-report version of the Prescription Drug Use Questionnaire and relationship to medication agreement noncompliance. *Journal of Pain and Symptom Management*. 2008;36(4):383–95. http://www.annals.org/content/152/11/712.abstract

DuPen A, Shen D, Ersek M. Mechanisms of opioid-induced tolerance and hyperalgesia. *Pain Manag Nurs*. 2007;8(3):113–121. http://www.medscape.com/viewarticle/562216

Finnerup N, Sindrup S, Staehelin JT. Recent advances in pharmacological treatment of neuropathic pain. *F1000 Med Rep.* 2010;2(52). http://f1000.com/reports/m/2/52

Ganzberg S. Pain Management Part II: Pharmacologic management of chronic orofacial pain. *Anesth Prog.* 2010;57:114–119. http://www.adsahome.org/PDFs/pain2.pdf

Lum PJ, Little S, Botsko M, Hersh D, Thawley RE, Egan JE, Mitty J, Boverman J, Fiellin DA. Opioid-prescribing practices and provider confidence recognizing opioid analgesic abuse in HIV primary care settings. *J Acquir Immune Defic Syndr*. 2011;56 Suppl 1:S91–7. http://journals.lww.com/jaids/Fulltext/2011/03011/Opioid_Prescribing_Practices_and_Provider.14.aspx#

Noble M, Treadwell JR, Tregear SJ, Coates VH, Wiffen PJ, Akafomo C, Schoelles KM. Long-term opioid management for chronic noncancer pain. *Cochrane Database Syst Rev.* 2010;(1):CD006605. http://www2.cochrane.org/reviews/en/ab006605.html

Smith HS, Kirsh KL, Passik SD. Chronic opioid therapy issues associated with opioid abuse potential. J *Opioid Manag.* 2009;5(5): 287–300. http://www.ncbi.nlm.nih.gov/pubmed/19947070

Non-pharmacologic interventions:

Bullock M, Culliton P, Olander R. Controlled trial of acupuncture for severe recidivist alcoholism. *Lancet.* 1989;1(8652):1435–9. http://www.ncbi.nlm.nih.gov/pubmed/2567439

Chou R, Huffmann LR; American Pain Society. Nonpharmacologic therapies for acute and chronic low back pain: a review of the evidence for an American Pain Society/American College of Physicians Clinical Practice Guideline. *Annals of Internal Medicine.* 2007;147(7):492–504. http://www.annals.org/content/147/7/492.long

Hollifield M, Sinclair-Lian N, Warner TD, Hammerschlag R. Acupuncture for posttraumatic stress disorder: a randomized controlled pilot trial. *J Nerv Ment Dis.* 2007;195(6): 504–13. http://www.ncbi.nlm.nih.gov/pubmed/17568299

Kelly RB. Acupuncture for pain. *Am Fam Physician.* 2009;80(5):481–4. http://www.aafp.org/afp/2009/0901/p481.html

Lee MS, Ernst E. Acupuncture for pain: An overview of Cochrane reviews. *Chin J Integr Med.* 2011;17(3):187–9. Epub 2011 Feb 27. http://www.ncbi.nlm.nih.gov/pubmed/21359919

Liang Z, Zhu X, Yang X, Fu W, Lu A. Assessment of a traditional acupuncture therapy for chronic neck pain: a pilot randomised controlled study. *Complement Ther Med.* 2011;19 Suppl 1: S26–32. Epub 2010 Dec 23. http://www.ncbi.nlm.nih.gov/pubmed/21195292

Lorig KR & Holman HR. Self-management education: history, definition, outcomes, and mechanisms. *Ann Behav Med.* 2003;26(1):1–7. http://www.ncbi.nlm.nih.gov/pubmed/12867348

Molton IR, Graham C, Stoelb BL, Jensen MP. Current psychological approaches to the management of chronic pain. *Curr Opin Anaesthesiol.* 2007;20(5):485–9. http://www.ncbi.nlm.nih.gov/pubmed/17873602

Osborne TL, Raichle KA, Jensen MP. Psychologic interventions for chronic pain. *Phys Med Rehabil Clin N Am.* 2006;17(2):415–433. http://www.med.nyu.edu/pmr/residency/resources/PMR%20clinics%20NA/PMR%20clinics%20NA_pain/Psychologic%20Interventions%20for%20Chronic%20Pain.pdf

Passik SD. Listing of non-pharmacologic options for treating chronic pain, Table 1. In: Issues in long-term opioid therapy: Unmet needs, risks, and solutions. *Mayo Clin Proc.* 2009; 84(7):594. http://www.mayoclinicproceedings.com/content/84/7/593.full.pdf+html

Tan G, Craine MH, Bair MJ, Garcia MK, Giordano J, Jensen MP, McDonald SM, Patterson D, Sherman RA, Williams W and Tsao JC. Efficacy of selected complementary and alternative medicine interventions for chronic pain. *J Rehabil Res Dev*. 2007;44(2):195–222. http://www.rehab.research.va.gov/jour/07/44/2/pdf/tan.pdf

Turk DC, Swanson KS, Tunks ER. Psychological approaches in the treatment of chronic pain patients — when pills, scalpels, and needles are not enough. *Can J Psychiatry.* 2008;53(4): 213–223. http://www.ncbi.nlm.nih.gov/pubmed/18478824

Comorbid substance use disorders:

Alford DP, Compton P, Samet JH. Acute pain management for patients receiving maintenance methadone or buprenorphine therapy. *Ann Intern Med*. 2006;144:127–134. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1892816/

Gourlay DL, Heit HA, Caplan YH. *Urine Drug Testing in Clinical Practice: The Art and Science of Patient Care, Edition 4*. California Academy of Family Physicians and PharamCom Group, Inc. 2010. http://www.familydocs.org/files/UDTMonograph_for_web.pdf

Gourlay DL, Heit HA. Universal precautions revisited: managing the inherited pain patient. *Pain Medicine*. 2009;10(82):S115–S123. http://www.ncbi.nlm.nih.gov/pubmed/19691682

Gourlay DL, Heit HA. Pain and addiction: managing risk through comprehensive care. *J Addict Dis.* 2008;27(3):23–30. http://www.ncbi.nlm.nih.gov/pubmed/18956526

Gourlay DL, Heit HA, Almahrezi. Universal precautions in pain medicine: a rational approach to the treatment of chronic pain. American Academy of Pain Medicine. *Pain Medicine.* 2005;6(2):107–112. http://onlinelibrary.wiley.com/doi/10.1111/j.1526-4637.2005.05031.x/full

Hansen L, Penko J, Guzman D, Bangsberg D, Miaskowski C, Kushel MB. Aberrant Behaviors with Prescription Opioids and Problem Drug Use History in a Community-Based Cohort of HIV Infected Individuals. *J Pain and Symptom Management.* 2011 (In Press).

Heit HA, Gourlay DL. Urine drug testing in pain medicine. *J Pain Symptom Manage.* 2004;27(3):260–267. http://download.journals.elsevierhealth.com/pdfs/journals/0885-3924/PIIS088539240300530X.pdf

Heit HA. The truth about pain management: The difference between a pain patient and an addicted patient. *Eur J Pain*. 2001;5 Suppl A:27–9. http://www.ncbi.nlm.nih.gov/pubmed/11798214

Jamison RN, Ross EL, Michna E, Chen LQ, Holcomb C, Wasan AD. Substance misuse treatment for high-risk chronic pain patients on opioid therapy: a randomized trial. *Pain*, 2010;150(3):390–400. http://www.ncbi.nlm.nih.gov/pubmed/20334973

Mitchell AM, Dewey CM. Chronic pain in patients with substance abuse disorder: general guidelines and an approach to treatment. *Postgrad Med*, 2008; 120(1):75–9. http://www.ncbi.nlm.nih.gov/pubmed/18467812

Olsen Y, Alford DP. Chronic pain management in patients with substance use disorders. *Adv Stud Med*. 2006;6(3):111–123. http://www.jhasim.com/files/articlefiles/pdf/XASIM_Master_6_3_pOlsen.pdf

Savage SR. Management of opioid medications in patients with chronic pain and risk of substance misuse. *Current Psychiatry Reports.* 2009;11:377–384. http://www.ncbi.nlm.nih.gov/pubmed/19785979

Starrels JL, Becker WC, Alford DP, Kapoor A, Williams AR, Turner BJ. Systematic review: treatment agreements and urine drug testing to reduce opioid misuse in patients with chronic pain. *Ann Intern Med.* 2010;152(11):712–20. http://www.annals.org/content/152/11/712.abstract

Weaver MF, Schnoll SH. Addiction issues in prescribing opioids for chronic nonmalignant pain. *Journal of Addiction Medicine. 2007;*1(1):2–10. http://journals.lww.com/journaladdictionmedicine/Abstract/2007/03000/Addiction_Issues_in_Prescribing_Opioids_for.2.aspx

Weaver MF, Schnoll SH. Opioid treatment of chronic pain in patients with addiction. *Palliat Care Pharmacother.* 2002;16(3):5–26. http://www.ncbi.nlm.nih.gov/pubmed/14640352

Whitehead AJ, Dobscha SK, Morasco BJ, Ruimy S, Bussell C, Hauser P. Pain, substance use disorders and opioid analgesic prescription patterns in veterans with hepatitis C. *J Pain Symptom Manage.* 2008;36(1): 39–45. Epub 2008 Mar 20. http://www.ncbi.nlm.nih.gov/pubmed/18358690

Ziegler PP. Addiction and the treatment of pain. *Substance Use & Misuse*. 2005:40;1945–1954. http://www.rsds.org/pdfsall/substance_use_abuse.pdf

Comorbid mental health disorders:

Finocchi C, Villani V, Casucci G. Therapeutic strategies in migraine patients with mood and anxiety disorders: Clinical evidence. *Neurological Sciences*. 2010;31 Suppl 1:S95–8. http://www.docguide.com/therapeutic-strategies-migraine-patients-mood-and-anxiety-disorders-clinical-evidence?tsid=5

Kroenke K, Bair MJ, Damush TM, Wu J, Hoke S, Sutherland J, Tu W. Optimized antidepressant therapy and pain self-management in primary care patients with depression and musculoskeletal pain: a randomized controlled trial. *JAMA.* 2009;301(20):2099–110. http://www.ncbi.nlm.nih.gov/pubmed/19470987

McWilliams LA, Cox BG, Enns MW. Pain prevalence of past year DSMIII-R psychiatric diagnoses from the National Comorbidity Survey. *Pain.* 2003;106(1): 127–133. http://www.painjournalonline.com/article/S0304-3959%2803%2900301-4/abstract

Menchetti M, Belvederi Murri M, Bertakis K, Bortolotti B, Berardi D. Recognition and treatment of depression in primary care: effect of patients' presentation and frequency of consultation. *J Psychosom Res.* 2009;66(4):335–41. Epub 2008 Dec 16. http://www.ncbi.nlm.nih.gov/pubmed/19302892

Wilsey BL, Fishman SM, Tsodikov A, Ogden C, Symreng I, Ernst A. Psychological comorbidities predicting prescription opioid abuse among patients in chronic pain presenting to the emergency department. *Pain Med.* 2008;9(8):1107–17. Epub 2008 Feb 5. http://www.ncbi.nlm.nih.gov/pubmed/18266809

Posttraumatic pain:

Nampiaparampil DE. Prevalence of chronic pain after traumatic brain injury: a systematic review. *JAMA.* 2008;13;300(6):711–9. http://www.ncbi.nlm.nih.gov/pubmed/18698069

Roden A, Sturman E. Assessment and management of patients with wound-related pain. *Nursing Standard.* 2009;23(45): 53–62. http://www.ncbi.nlm.nih.gov/pubmed/19678519

Assessment tools:

Krebs EE, Lorenz KA, Bair MJ, Damush TM, Wu J, Sutherland JM, Asch SM, Kroenke K. Development and initial validation of the PEG, a three-item scale assessing pain intensity and interference. *J Gen Intern Med.* 2009;24(6):733–8. Epub 2009 May 6. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2686775/pdf/11606_2009_Article_981.pdf

Nicolaidis C, Chianello T, Gerrity M. Development and preliminary psychometric testing of the Centrality of Pain Scale. *Pain Med.* 2011;12(4):612–7. Epub 2011 Mar 10. http://www.ncbi.nlm.nih.gov/pubmed/21392248

Smith PC, Schmidt SM, Allensworth-Davies D, Saitz R. A single-question screening test for drug use in primary care. *Arch Intern Med.* 2010;170(13):1155–60. http://www.ncbi.nlm.nih.gov/pubmed/20625025

Smith PC, Schmidt SM, Allensworth-Davies D, Saitz R. Primary care validation of a single-question alcohol screening test. *J Gen Intern Med.* 2009;24(7):783–8. Epub 2009 Feb 27. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2695521/pdf/11606_2009_Article_928.pdf

Tan G, Jensen MP, Thornby JI, Shanti BF. Validation of the Brief Pain Inventory for chronic nonmalignant pain. *J Pain.* 2004;5(2):133–7. http://www.ncbi.nlm.nih.gov/pubmed/15042521

Other:

Cole E. Pain management: classifying, understanding, and treating pain. *Hospital Physician.* 2002:23–30. http://www.turner-white.com/pdf/hp_jun02_pain.pdf

Dobscha SK, Corson K, Perrin NA, Hanson GC, Leibowitz RZ, Doak MN, Dickinson KC, Sullivan MD, Gerrity MS. Collaborative care for chronic pain in primary care: a cluster randomized trial. *JAMA.* 2009;301(12):1242–52. http://jama.ama-assn.org/content/301/12/1242.full.pdf+html?sid=0358fada-eba0-4f6b-9543-d689742dcf49

Elliott AM, Smith BH, Penny KI, Smith WC, Chambers WA. The epidemiology of chronic pain in the community. *Lancet.* 1999;354(9186):1248-52. http://www.ncbi.nlm.nih.gov/pubmed/10520633

Gersh E, Arnold C, Gibson SJ. The relationship between the readiness for change and clinical outcomes in response to multidisciplinary pain management. *Pain Med.* 2011;12(1):165–72. http://www.ncbi.nlm.nih.gov/pubmed/21223494

Imamura M, Cassius D, Fregni F. Fibromyalgia: From treatment to rehabilitation. *Eur J Pain.* 2009;3(2):117–122. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2907544/

Thompson JM, Chiasson R, Loisel P, Besemann LC and Pranger T. A sailor's pain: veterans' musculoskeletal disorders, chronic pain, and disability. *Can Fam Physician.* 2009;55(11):1085–1088. http://www.cfp.ca/cgi/content/full/55/11/1085

Wilsey BL, Fishman SM, Ogden C, Tsodikov A, Bertakis KD. Chronic pain management in the emergency department: a survey of attitudes and beliefs. *Pain Med.* 2008;9(8):1073–80. http://www.ncbi.nlm.nih.gov/pubmed/18266810

SUGGESTED RESOURCES

Accessed 6/14/2011

Ciambrone S, Edgington S. *Medical Respite Services for Homeless People: Practical Planning.* Nashville: Respite Care Providers Network, National Health Care for the Homeless Council, Inc. 2009. http://www.nhchc.org/Respite/FINALRespiteMonograph.pdf

Gregg J, Solotaroff R, Amann T, Michael Y, Bowen J. Health and disease in context: a community-based social medicine curriculum. *Acad Med.* 2008;83: 14–19. http://www.nhchc.org/Publications/Health_Disease.pdf

HCH Clinicians' Network, National Health Care for the Homeless Council. *Harm Reduction: Preparing for Change*. 2010. http://www.nhchc.org/harmreductionfactsheet_Apr10.pdf

HCH Clinicians' Network, National Health Care for the Homeless Council. Addiction on the streets: Clinical interventions. *Healing Hands*, 2006; 10(4):1–6. http://www.nhchc.org/Network/HealingHands/2006/Oct2006HealingHands.pdf

HCH Clinicians' Network, National Health Care for the Homeless Council. A comprehensive approach to substance abuse and homelessness. *Healing Hands*, 2003;7(5), 1–6. http://www.nhchc.org/Network/HealingHands/2003/hh-1003.pdf

Jaco, M. *Medical Respite Program Development Workbook*. Nashville: National Health Care for the Homeless Council, Inc. 2011. http://www.nhchc.org/Respite/FINALMedicalRespiteWorkBook.pdf

Kraybill K, Zerger S. *Providing Treatment for Homeless People with Substance Use Disorders: Case Studies of Six Programs*. National Health Care for the Homeless Council. 46 pages. 2003. http://www.nhchc.org/Advocacy/FactSheets/CA05RCaseStudies-FINAL5.pdf

McMurray-Avila M. *Organizing Health Services for Homeless People*, 2nd Edition. Nashville: National Health Care for the Homeless Council, Inc. ISBN: 0971165092. 2001. http://www.nhchc.org/Publications/Pagesfrom2ndedition-101901.pdf

Menchaca M, Martinez L, Stewart J, Treherne L, Vicic W, Audain G, Post P (Editor). *Adapting Your Practice: Treatment and Recommendations for Homeless Patients with HIV/AIDS*, 62 pages. Nashville: Health Care for the Homeless Clinicians' Network, National Health Care for the Homeless Council, Inc. 2008. http://www.nhchc.org/HIVguide2008.pdf

Morrison S. *Self Management Support: Helping Clients Set Goals To Improve Their Health*. Nashville: National Health Care for the Homeless Council. 2007. http://www.nhchc.org/SelfManagementSupport052907.pdf

O'Connell JJ (Editor). *The Health Care of Homeless Persons: A Manual of Communicable Diseases and Common Problems in Shelters and on the Streets*. Boston Health Care for the Homeless Program. 2004. http://www.bhchp.org/BHCHP%20Manual/index.html

O'Connell JJ, Zevin BD, Quick PD, Anderson S, Perret YM, Dalton M, Post PA (Ed.). *Documenting Disability: Simple Strategies for Medical Providers*. Nashville: Health Care for the Homeless Clinicians' Network, National Health Care for the Homeless Council, Inc. 82 pages. 2007. http://www.nhchc.org/DocumentingDisability2007.pdf

Post PA. *Defining and Funding the Support in Permanent Supportive Housing: Recommendations of Health Centers Serving Homeless People*. Prepared by the National Health Care for the Homeless Council for the Corporation for Supportive Housing. 2008. http://www.nhchc.org/PSHReport.pdf

WEBSITES

American Academy of Pain Management	www.painmed.org/
American Chronic Pain Association	www.theacpa.org/default.aspx
American Pain Society	www.ampainsoc.org/
American Society of Addiction Medicine	www.asam.org/
Emerging Solutions in Pain	www.emergingsolutionsinpain.com/
Federation of State Medical Boards	www.fsmb.org/
International Association for the Study of Pain	www.iasp-pain.org/
National Acupuncture Detoxification Association	www.acudetox.com/
National Alliance for Model State Drug Laws	www.namsdl.org/home.htm
National Health Care for the Homeless Council	www.nhchc.org/
National Institute on Alcohol Abuse & Alcoholism	http://pubs.niaaa.nih.gov/
National Institute on Drug Abuse	www.nida.nih.gov/
Pain and Policy Studies Group	www.painpolicy.wisc.edu/
Health Psychology Network, Boston University	www.healthpsychology.net/ChronicPain.htm
Up to Date: Overview, treatment of chronic pain	www.uptodate.com/contents/overview-of-the-treatment-of-chronic-pain

ABOUT THE HCH CLINICIANS' NETWORK

Founded in 1994, the Health Care for the Homeless Clinicians' Network is a national membership that unites care providers from many disciplines who are committed to improving the health and quality of life of people experiencing homelessness. The Network is engaged in a broad range of activities including publications, training, research and peer support. The Network is operated by the National Health Care for the Homeless Council whose efforts are supported by the Health Resources and Services Administration, member dues and private donations. The Network is governed by a Steering Committee representing diverse community and professional interests. Please visit our website at www.nhchc.org.

APPENDICES

A. Managing Pain in Patients with Co-occurring Substance Use Disorders: A Harm Reduction Addiction Medicine Perspective – Barry Zevin, MD, San Francisco Dept. of Public Health (SFDPH)

B. Chronic Pain Assessment and Treatment Plan, SFDPH

C. Centrality of Pain Measure – Christina Nicolaidis, MD, MPH, Oregon Health Science University, Portland, Oregon

D. Mental Health and Substance Abuse Screening Tools

E. Action Plan, Valley Homeless Health Care Program (VHHP), San Jose, California

F. Chronic Pain Recovery Program, Central City Concern, Portland, Oregon

G. Pain Medications: Frequently Asked Questions, SFDPH

H. Drug formulary, Albuquerque Health Care for the Homeless (HCH)

I. Non-opioid Medications for Management of Chronic Pain, Albuquerque HCH

J. Nurse Assessment Form: Refills for Controlled Substances, Tom Waddell Health Center (TWHC)

K. Patient-Provider Medication Agreement Forms, CareOregon

L. Low Literacy English Informed Consent and Patient-Provider Agreement, SFDPH

M. Low Literacy Chinese Informed Consent and Patient-Provider Agreement, SFDPH

N. Low Literacy Spanish Informed Consent and Patient-Provider Agreement, SFDPH

O. Patient Responsibilities for the Use of Chronic Controlled Substances, VHHP

P. Policy on Use of Controlled Substances in Chronic Pain Management, SFDPH

Q. Policy on Aberrant Drug-Related Behavior in the Use of Controlled Substances In the Treatment of Chronic Non-Malignant Pain, SFDPH

R. Urine Toxicology Screening Policy, TWHC

S. Provider Essential Elements for Presentation to Yellow Flag Committee, TWHC

T. Yellow Flag Committee: Template for Case Review and Guidelines, TWHC

Managing Pain in Patients with Co-occurring Substance Use Disorders:
A Harm Reduction Addiction Medicine Perspective

Barry Zevin, MD
Primary Care Provider and Addiction Medicine Specialist
San Francisco Department of Public Health

Introduction

The treatment of chronic pain in patients with co-occurring substance use disorders is challenging. There is no high quality evidence available to guide us in the use of opioid analgesics in this population. Current guidelines suggest consultation and co - management with addiction specialists. The following scenarios have been developed as helpful guidelines for some of the common clinical situations that arise. Individual cases require careful evaluation and decision making.

Pseudo-addiction

Patient presentation: Often seen in a patient with chronic pain with or without high opioid tolerance treated with inadequate doses of short acting opioid analgesic. Aberrant behaviors include taking more than prescribed, running out early, hoarding medications "just in case", going to multiple prescribers, thinking obsessively about pain and medication, etc.

Evaluation: Careful history and review of past patient records. Presence of past or current substance use disorder does not rule out the presence of pseudo-addiction. At times only a treatment trial will distinguish addiction from pseudo-addiction.

Interventions: Make or suggest this diagnosis and educate the patient as to how it may differ from or co-exist with an addiction disorder. Increase the dose of pain medication usually using long acting around the clock medications. See patient frequent for follow- up until dosing is stabilized (or until diagnosis of pseudo-addiction is seen to be wrong).

Important functional outcomes: Patient functional status improves progressively. Aberrant behaviors fade away. Patient reaches a stable dose of medication and dose escalation is no longer needed. (Occasional increases due to tolerance may be needed but this is rare once a stable, effective dose is achieved. Subsequent frequent requests for dose increases should be a red flag for worsening of the underlying condition or other problems.)

Follow-up: Initially frequent follow-up and functional assessments. Patients may be initially resistant to non-pharmacological interventions but when stable dosing of meds is achieved and trust in treatment is restored, patients may be much more willing to follow through.

Uncontrolled substance use

Patient presentation: Patient presents in clinic frequently in an intoxicated state or is reported to have altered consciousness or to be intoxicated by other caregivers. Patient has a history of overdoses requiring treatment. Invariably functional status is deteriorating.

Evaluation: Evaluate the patient for underlying causes of the clinical presentation and come to a working diagnosis of the problem(s). Usually this is attributable to uncontrolled drug use due to an addiction disorder but not infrequently another disorder is present. Important examples that may change intervention would include patients with cognitive disorders who overdose because they cannot remember that they already took their medication dose or people with mania or impulse control disorders who overuse their medications and may respond to psychiatric treatment.

Interventions may also differ depending on the patient's pattern of substance use. Common scenarios include oversedation due to use of benzodiazepines or alcohol, sedation due to withdrawal or "crashing" after a period of cocaine or methamphetamine use or "run", sedation due to excessive opioids or combinations of the above.

Interventions: Recommend that the patient seek substance abuse treatment and inform them that controlled medication will no longer be prescribed. Depending on the severity of the problem this may be an immediate action or a contingency based action. If the situation does not change, stop the prescription and give the patient alternative treatment options for example: non-medication based treatment, enrollment in methadone maintenance for opioid dependence, etc. Tapering off a medication in this scenario is unlikely to be safer or more effective than just stopping abruptly. If the patient is thought to be at high risk for opioid withdrawal, offer the patient assistance with a referral for methadone detoxification or buprenorphine detoxification. Abuse of benzodiazepines or alcohol is frequently a problem in this scenario. Referral to a medically supported detoxification for these potentially dangerous withdrawal syndromes should be a high priority. Whether to continue prescribing opioid analgesics during this time or also attempt opioid detoxification needs to be an individualized case by case decision. The risk of fatal overdose remains high even when the prescription opioid analgesic is stopped therefore attempts to work with patients (and family / community members) on overdose prevention strategies should be done if possible. In general, do not give a prescription to a patient who is altered / intoxicated at the time of a visit. Ask them to come back in for a re-assessment when they are not altered. Be very cautious and consider not prescribing for a patient who has had an overdose in the time since the last visit unless a clear plan can be made to increase safety.

Important functional outcomes: Patient safety. Expect anger and resentment and refocus the patient on concerns for health and safety.

Follow up: Attempt to maintain a treatment relationship with the patient. Attempt to maintain hope that positive change is possible.

<u>Cocaine use with diversion of prescribed opioids</u>

Patient presentation: Patient presents with continued cocaine use. Functional status is usually deteriorating due to uncontrolled cocaine or methamphetamine use. Prescribed substance is absent from urine toxicology screening when it should be present. The patient may minimize the importance of cocaine.

Evaluation: Review with the patient the history, treatment plan and functional goals established at the start of treatment or at the most recent review. Use urine toxicology screening strategically (see "questions to ask at the time of UTOX") and consult with the toxicology lab to understand test results.

Interventions: Use motivational interviewing and other techniques in working with the patient to make positive change. Refer the patient to an addiction specialist onsite or in the community for further evaluation. Suggest treatment for stimulant dependence. Consider contingency of only continuing to prescribe controlled substances if the patient enters a residential treatment program or other setting where dispensing of the prescribed controlled substance is controlled. Stop prescribing if the patient cannot follow through. Consider restarting at a later date if the situation changes. If the patient never or rarely has the prescribed substance detected in urine toxicology screening, then tapering of medications is unnecessary and they should be stopped abruptly.

Important functional outcomes: Improved functional outcomes

Follow-up: Attempt to maintain a treatment relationship with the patient. Attempt to maintain hope that positive change is possible. If the patient is participating in a substance abuse treatment program, obtain consents to speak with the treatment program staff and stay engaged in the patient's care during substance abuse treatment.

Cocaine use with appropriate use of prescribed opioid

Patient presentation: Patient presents with continued cocaine use but improving functional status. The prescribed medication is present in urine toxicology screens.

Evaluation: Review with the patient the history, treatment plan and functional goals established at the start of treatment or at the most recent review. Consider reviewing the DSM-IV definition of substance abuse and dependence with the patient. Particularly review "loss of control" type issues and issues related to pain management. (e.g., the scenario of a patient going on a binge and walking 10 miles when they have chronic knee pain and then reporting that the pain is exacerbated)

Interventions: Counsel the patient on the health benefits of stopping cocaine and continue to offer help. Use motivational interviewing and education about the nature of addiction. If benefits of pain management appear to outweigh the risks, then continue prescribing with careful monitoring for deterioration in functioning and other aberrant behaviors.

Important functional outcomes: Maintaining current functioning, careful monitoring for functional deterioration.

Follow-up: Close and frequent follow-up is especially important in this scenario. Using a team with all members aware of a patient's functional goals will be helpful as an early warning system of problems that may arise. Referral to a harm reduction oriented substance use counseling program could be very helpful. Referral to traditional abstinence based counseling program may not work.

Diversion / misuse due to loss of control of use of prescribed opioid

Patient presentation: In patients whose primary substance use problem has been opioid dependence, loss of control in handling the prescribed medication is frequently a problem. Common scenarios include borrowing from the future for perceived need now, "lending" medication to others in need, being victimized and robbed.

Evaluation: Careful non-judgmental history taking. Rule-out pseudo-addiction as these patients can have very high tolerance to opioids.

Interventions: Change to more frequent dispensing (e.g. weekly), using a pharmacy that will divide up the number of pills dispensed to the patient from a single prescription or by writing multiple prescriptions indicating "fill on or after" dates, use of medi-sets, requests for a patient to return for pill counts, etc. Avoid as needed / rescue dosing of short acting medications. If medications are to be used PRN, make an explicit plan that the patient take medication prior to an anticipated pain inducing activity. If the patient is diverting medication to a partner or spouse, work with your patient in engaging the partner in care. Some patients have such severe loss of control issues that they will not be able to properly take prescribed opioids without daily observed dosing. Referral for residential treatment may be one option for this unfortunately as other options are generally not available.

Important functional outcomes: Stabilization in medication taking with increase in control.

Follow up: Close follow-up. Use pharmacy staff as part of team if possible.

Patients committing or responsible for criminal acts

Patient presentation: Patient steals prescription pad, forges or alters prescription, is physically violent toward staff or provider or engages in drug dealing in clinic or the vicinity of clinic.

Evaluation: Assure staff and patient safety, confirm occurrence with involved staff, pharmacy and others involved.

Interventions: Follow clinic protocols for dealing with abusive / violent patients; make a police report when appropriate and stop prescribing controlled substances. If problems are caused by an underlying illness such as a mental health disorder, acute intoxication or chronic substance dependency, attempt to refer or treat the patient for these problems.

Important functional outcomes: Clinic safety, provider safety, patient safety

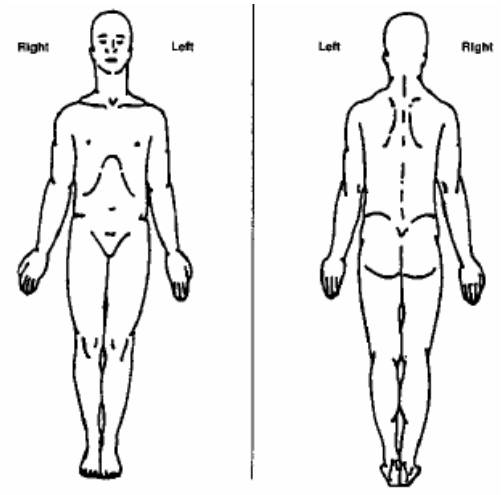
Follow up: Work with the clinic administrative staff and risk management to ensure appropriate documentation.

Using UTOX, Functional Assessment, and Subjective Pain Outcomes In Diagnosing Outcomes of Pain Management

Possible Dx	Expected pain meds in UTOX	Illicit stimulants in UTOX	Illicit (non prescribed) opioids in UTOX	Functional improvement	Pain management subjectively acceptable	Interventions (See details above)
Pseudo-addiction	+/-	-	+/-	-	-	Improve pain management (inc doses, long acting meds, etc)
Uncontrolled stimulant use	-	+	-	- (may have no signs of opioid withdrawal when it might be expected)	+/-	Stop opioid rx'ing or set contingency/ Substance abuse treatment
Controlled stimulant use	+	+	-	+	+	Substance abuse counseling. Treatment, closer monitoring
Uncontrolled opioid use	+/-	+/-	+/-	- (may have signs of opioid intoxication or withdrawal)	-	Changing dosing logistics / may need methadone maintenance

PAIN MODULE (PROVIDER/BEHAVIORIST)

Shade in areas of pain. Put X on area that hurts most.



Duration of pain_____

Circle all words which apply to pain.

Aching	Sharp	Penetrating
Throbbing	Tender	Nagging
Shooting	Burning	Numb
Stabbing	Exhausting	Miserable
Gnawing	Tiring	Unbearable

Mark number that best describes pain on average.

0	1	2	3	4	5	6	7	8	9	10

(0=no pain) (10=pain as bad as you can imagine)

What makes pain feel better (e.g., heat, medicine, rest)? How much (minimal, moderate, significant)?

_____
_____
_____

What makes pain worse (e.g., walking, standing, lifting)? How much (minimal, moderate, significant)?

_____
_____
_____

List current treatments or medications for pain.

Treatment/Medication (dose/duration)_____
Treatment/Medication (dose/duration)_____
Treatment/Medication (dose/duration)_____
Treatment/Medication (dose/duration)_____
Treatment/Medication (dose/duration)_____

Degree of relief from current treatments and medications.

_____complete
_____incomplete but adequate
_____incomplete and not adequate

Adverse effects from current treatments and medications.

_____falls
_____oversedation
_____overdose requiring emergency services
_____constipation
_____itching
_____nausea/vomiting
_____other

List past medications for pain.

Medication (dose/duration)_____
Problems: _____ineffective pain relief/improvement, _____adverse effect:_____
Medication (dose/duration)_____
Problems: _____ineffective pain relief/improvement, _____adverse effect:_____
Medication (dose/duration)_____
Problems: _____ineffective pain relief/improvement, _____adverse effect:_____
Medication (dose/duration)_____
Problems: _____ineffective pain relief/improvement, _____adverse effect:_____
Medication (dose/duration)_____
Problems: _____ineffective pain relief/improvement, _____adverse effect:_____

Diagnostic tests (e.g., x-ray, CT, MRI, EMG/NCV) and specialty visits (test or specialist/date/results):

1._____
2._____
3. _____
4. _____
5. _____

FUNCTION MODULE (BEHAVIORIST)

In the last month, how much has pain interfered with your daily activities? Use a scale from 0-10, where 0 is "no interference" and 10 is "unable to carry on any activities"?

0	1	2	3	4	5	6	7	8	9	10

Physical Activities/Mobility:

O Walking
O Standing
O Taking public transportation
O Chores
O Work-physical labor
O Work-sedentary
O Sexual activity
O Reaching
O Grasping
O Manipulating objects
O Ability to bathe, groom, dress self
O Recreational/leisure activities

Daily Functioning:
O Sleep
O Appetite
O Concentration
O Emotions
O Other _____

Social Functioning:
O Interacting with friends, family
O Interacting with spouse, partner, significant other
O Interacting in work setting
O Interacting in public setting (clinic, agencies, school, etc)

MENTAL HEALTH MODULE (BEHAVIORIST)

Psychiatric History (symptoms, Dx, suicidal behavior, family Hx mental health Dx)
_____

Hx Traumatic Events:
O childhood abuse
O sexual abuse
O intimate partner violence
O other _____
O interpersonal violence/assault
O war/combat trauma
O traumatic loss

If yes to any of the above, any of the following in the past month:
O nightmares about the event or thought about it when you didn't want to?
O tried hard not to think about it or went out of your way to avoid situations that reminded you of it?
O were constantly on guard, watchful, or easily startled?
O felt numb or detached from others, activities, or your surroundings?

Psychiatric medications (Hx, current)_____
Hospitalizations_____
Suicidal Ideation/Threats/Attempts_____
Therapy/counseling/support group (Hx, current)
_____

SUBSTANCE USE MODULE (BEHAVIORIST)

Drug	Amt/Frequency	When/How Long	Last Use	Route
Cigarettes				
ETOH				
Amphetamines				
Cocaine/Crack				
Heroin				
Marijuana				
Other:				

Periods of abstinence and why_____
Prior substance abuse treatment Hx_____
Consequences associated with use (incarcerations, impact on relationships, job…)
_____
Are you or others around you concerned about your substance use?_____

NON-PHARMACOLOGIC TREATMENT MODULE (BEHAVIORIST)

(P=planned, C=completed, R=refused, N=not indicated)

__ PT/OT; warm packs/cold packs
__ acupuncture
__ massage
__ physical activity
__ rest
__ stress management (breathing/relaxation)
__ mindfulness
__ cognitive behavioral therapy (CBT)
__ other: _____

PHYSICAL EXAM (PROVIDER)

See noted dated_____

ASSESSMENT MODULE (PROVIDER/BEHAVIORIST)

Pain-related diagnoses (check all that apply)

- ❑ AIDS
- ❑ Amputation
- ❑ Arthritis , inflammatory
- ❑ Arthritis, DJD
- ❑ Arthritis, Post Traumatic
- ❑ Cancer
- ❑ Compression fractures
- ❑ CVA/post stroke
- ❑ Dental problems
- ❑ Fracture
- ❑ Gout
- ❑ Headache
- ❑ Hepatitis C
- ❑ Joint replacement/pinning
- ❑ Lower back disorder
- ❑ Neuropathy
- ❑ Osteoporosis/osteopenia
- ❑ Postoperative
- ❑ Pressure ulcers/skin lesions
- ❑ Shingles /PHN
- ❑ Other musculoskeletal
- ❑ Venous Stasis / ulcers
- ❑ Unspecified
- ❑ Other (describe):
- ❑ _____
- ❑ _____

Level of pain control

_____none/minimal
_____poor/inadequate
_____adequate
_____excellent

Functional status

_____at goal functioning
_____not at goal functioning

Mental health/substance use **[develop measures – diagnosis, treatment, impact]**

Agreement violations

- ❑ Requests for refill of controlled substances earlier than expected
- ❑ Requests for refill of controlled substances later than expected
- ❑ Requests for repeated dose escalations beyond an initial 3 month treatment period
- ❑ Requests for a specific/brand name controlled substance/dose
- ❑ Report of lost, stolen, damaged prescriptions/medications
- ❑ Missing appointments with provider
- ❑ Presenting to clinic intoxicated or under the influence of drugs
- ❑ Presenting to clinic with signs or symptoms of withdrawal
- ❑ History of overdose of controlled substances
- ❑ Not adhering to the treatment plan, including adjuvant therapies, diagnostic tests and specialty consultations
- ❑ Request for pill count is refused or there is a pill count discrepancy
- ❑ Toxicology screening is refused or altered (see appendix)
- ❑ Toxicology screening indicates that prescribed medications are absent
- ❑ Toxicology screening demonstrates illicit drug use
- ❑ Toxicology screening demonstrates use of non-prescribed controlled substances
- ❑ Obtaining controlled substances from another provider
- ❑ Abusive or threatening behavior towards staff
- ❑ Physical violence toward staff
- ❑ Altering or stealing a prescription
- ❑ Declining functional status despite appropriate therapy
- ❑ Arrest for selling prescription controlled substances
- ❑ Controlled substance dose reduction in a hospital/other supervised setting due to over sedation

TREATMENT GOALS MODULE (PROVIDER/BEHAVIORIST)

Function

_____physical function adequate
_____improve physical function
Physical function goals_____

_____social function adequate
_____improve social function
Social function goals_____

Pain control

_____adequate pain control to meet function goals
_____inadequate pain control to meet function goals
_____palliative care if not able to achieve functional goals_____

Mental health

_____no mental health issues
_____active mental health issues
Mental health goals (e.g., assessment, therapy, medication)
_____

Substance use

_____no substance use issues
_____active substance use issues
Substance use goals (e.g., harm reduction, moderation, abstinence, treatment, 12 step program)
_____

TREATMENT PLAN MODULE (PROVIDER/BEHAVIORIST)

Visit frequency_____

Designated pharmacy_____

Diagnostic tests

_____not indicated
_____see progress note dated_____
_____list:_____

Consultation

_____not indicated
_____see progress note dated_____
_____list:_____

Pharmacologic therapy

_____continue current medications
_____add/increase medications due to inadequate response
List:_____
_____stop/taper off medications
List:_____

Non-pharmacologic therapy

_____see progress note dated_____
_____list: _____physical activity
_____coping/stress management
_____other

[include buckets in pain pathway]

- ❑ Pain Self-management Group
- ❑ Pain Class (time limited didactic model)
- ❑ Cognitive-Behavioral Interventions (time limited up to 6 sessions)
- ❑ Seeking Safety Group (adapted for co-occurring PTSD/chemical dependency/chronic pain

- ❑ Addiction Medicine Consultation
- ❑ Substance Abuse Treatment Referral
- ❑ Pain Group Visit (ongoing)
- ❑ 1:1 Motivational Interviewing Interventions
- ❑ Pain Group (1 time visit with all patients of 1 provider for orientation to P&P, form filling out, etc)
- ❑ Mental Health referrals
- ❑ Pain specialist referral
- ❑ Mental Health treatment (delivered in primary care setting)
- ❑ Everything Else

DOCUMENTATION CHECKLIST

- ❑ Initiation or continuation of prescribed controlled substances for the treatment of this patient's condition is justified.
- ❑ Informed Consent for Long-Term Controlled Substance Therapy for Chronic Pain signed on:
- ❑ Patient-Provider Agreement for Long-Term Controlled Substance Therapy for Chronic Pain signed on:
- ❑ Medication list in LCR up-to-date with current and discontinued medications noting reasons for changes
- ❑ Clinical Alert for controlled substances therapy entered/updated
- ❑ Pain Management Registry Code (338.99) entered into LCR problem list

The Centrality of Pain Scale

Please rate how strongly you agree or disagree with each of these statements about your chronic pain on your current pain regimen. Think about how your pain has affected your life over the past month.

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
1. Pain controls my life.	☐1	☐2	☐3	☐4	☐5
2. I am able to live a full life despite my pain.	☐5	☐4	☐3	☐2	☐1
3. My pain defines who I am.	☐1	☐2	☐3	☐4	☐5
4. I have control over my pain most of the time.	☐5	☐4	☐3	☐2	☐1
5. I think about pain all the time.	☐1	☐2	☐3	☐4	☐5
6. My pain consumes all of my energy.	☐1	☐2	☐3	☐4	☐5
7. My life revolves around my pain.	☐1	☐2	☐3	☐4	☐5
8. Pain is a constant struggle for me.	☐1	☐2	☐3	☐4	☐5
9. I can deal with my pain.	☐5	☐4	☐3	☐2	☐1
10. Pain greatly interferes with my life.	☐1	☐2	☐3	☐4	☐5

 For info, contact nicolaid@ohsu.edu

Nicolaidis, C., Chienello, T., Gerrity, M. "The Development and Initial Psychometric Assessment of the Centrality of Pain Scale." *Pain Medicine.* In press. Article first published online: 10 Mar 2011.

Mental Health and Substance Abuse Screening Tools

Conditions	Screening tools	Comment
Mental Health	Mental Health Screening Form III	Public domain instrument used to screen for a range of psychiatric conditions – takes about 5 minutes to administer
Depression	PHQ-9 Beck Depression Inventory (BDI)	Depression is strongly associated with severity of pain. Antidepressants have efficacy in relieving pain independent of their effect on depression.
Anxiety	Beck Anxiety Inventory (BAI)	21-question multiple-choice self-report inventory used for measuring the severity of anxiety (frequently associated with chronic pain)
Bipolar Mood Disorder	Mood Disorders Questionnaire (MDQ) Primary Care MoodCheck	Bipolarity should be ruled out in homeless patients with a history of depression.
Posttraumatic Stress Disorder (PTSD)	PC-PTSD	4-item screening test - if positive, should be followed up with longer screening test. PTSD is strongly associated with chronic pain and high prevalence of PTSD in homeless populations.
Interpersonal violence	Posttraumatic Diagnostic Scale Modified for Use with Extremely Low Income Women HITS(Hurt, Insulted, Threatened, Screamed)	Available from National Center on Family Homelessness: 181 Wells Ave, Newton Centre, MA 02459; Tel: 617-964-3834; Fax: 617-244-1758 dawn.moses@tbhf.org See also: Melnick & Bassuk, 2000 HITS has been validated for use with both male and female patients in primary care practice settings.
Substance use **Alcohol abuse** **Other drug abuse**	NM-ASSIST Single-Question Alcohol Screening Test CAGE, AUDIT-C Single-Question Test for Drug Use DAST	NIDA modification of WHO ASSIST– screens for tobacco, alcohol and drug use disorders Detects unhealthy alcohol use Differentiates alcohol abuse from dependence Screens for illegal drug use and nonmedical use of prescription drugs 20-question self-test for drug use/abuse, not including alcohol use
Opioid misuse/ abuse/ behaviors outside treatment plan	Screener and Opioid Assessment for Patients with Pain (SOAPP), Revised SOAPP (SOAPP-R), Opioid Risk Tool (ORT), Current Opioid Misuse Measure (COMM)	A few studies have shown these tests are somewhat effective in predicting current or future behaviors outside the treatment plan (Chou et al, 2009 Feb). May lack discriminant capacity in high risk populations
Cognitive deficit	Montreal Cognitive Assessment (MOCA) Mini-Mental Status Examination (MMSE)	May be useful for ruling out certain cognitive impairments 11-item questionnaire that can be answered in 10 minutes; widely used for adults; tests orientation, attention, immediate and short-term recall, language, and ability to follow simple verbal and written commands.
Traumatic brain injury	Traumatic Brain Injury Questionnaire (TBIQ) Repeatable Battery for the Assessment of Neuro-Psychological Status (RBANS)	Assessment for history and symptoms of traumatic brain injuries Simplified tool used to assess neuropsychological status

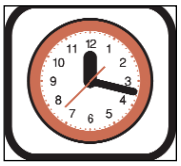
* Pilot *

Best time of day to call:
Telephone #:

Name:_____ Date:_____

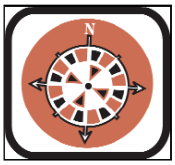
Main Goal for better health:_____
_____

What will you do over the next few weeks?



When will you do it? (what time of day)

How will you do it?



Where will you do it?

How often will you do it?

Things could make it hard to achieve my goals are:

My plan for overcoming difficulties is:

Who can help you with your goals?

On a scale of 1 to 10, how confident are you that you will achieve your goal?

1	2	3	4	5	6	7	8	9	10
not confident									very confident

What did you do since your last visit to better your health?

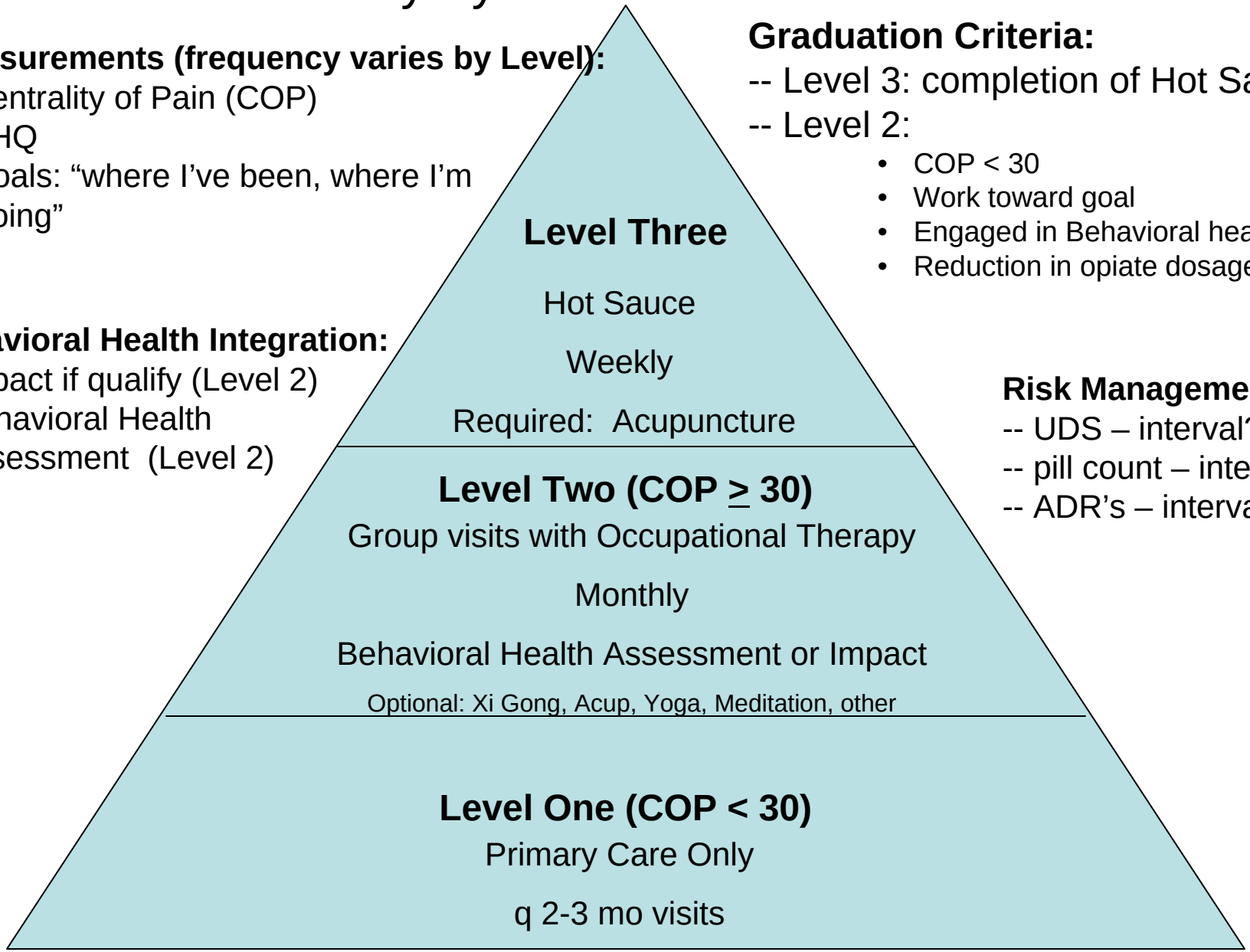
_____
_____
_____

Chronic Pain Recovery Pyramid

Measurements (frequency varies by Level):
-- Centrality of Pain (COP)
-- PHQ
-- Goals: "where I've been, where I'm going"

Graduation Criteria:
-- Level 3: completion of Hot Sauce
-- Level 2:
- COP < 30
- Work toward goal
- Engaged in Behavioral health
- Reduction in opiate dosage

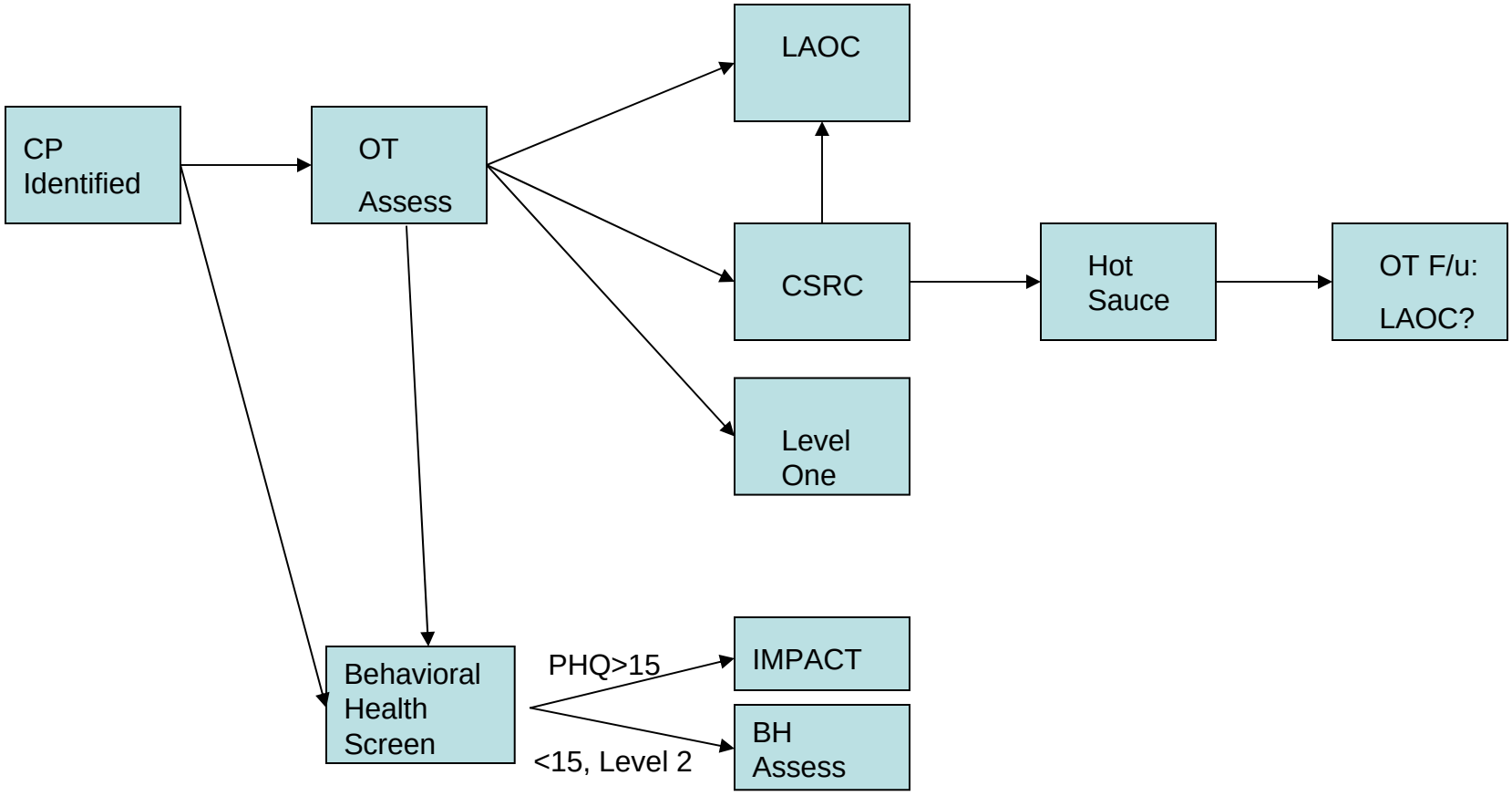
Behavioral Health Integration:
-- Impact if qualify (Level 2)
-- Behavioral Health Assessment (Level 2)



Risk Management
-- UDS – interval?
-- pill count – interval??
-- ADR's – interval?

Chronic Pain Recovery Program Initiation

Road Map



PAIN MEDICATIONS FAQ

Q1: How do I find out the scheduling of controlled substances and the regulations for transmittal of controlled substances prescriptions?

A1: *Lexi-comp Online* provides information on the classification of controlled substances (CII-CV). For your convenience, a list of SFGH formulary agents (opioid analgesics and benzodiazepines), their respective classifications, and regulations for transmittal of controlled substances prescriptions are summarized on the following table:

DEA CONTROLLED SUBSTANCES SCHEDULE	Secure form required?	FAX acceptable?	eFAX acceptable?	CONTROLLED SUBSTANCES ON CHN/SFGH FORMULARY
Schedule II	**YES**	**No**	**No**	❖ Codeine ❖ Fentanyl ❖ Hydromorphone ❖ Methadone ❖ Meperidine ❖ Morphine ❖ Oxycodone (immediate release) ❖ Oxycodone 5mg + Acetaminophen 325mg (Percocet)
Schedule III	Yes, if prescription is not sent via fax, or called into the pharmacist	Yes, **ONLY after printed copy of prescription is signed by the prescriber, then sent via fax**	**No**, prescription must be signed and dated by prescriber per DEA regulations	▪ Codeine 30mg + Acetaminophen 300mg (Tylenol with Codeine #3) ▪ Codeine 60mg+ Acetaminophen 300mg (Tylenol with Codeine #4) **Inpatient discharge orders only; NON-FORMULARY FOR OUTPATIENTS:** ▪ Hydrocodone 5mg + Acetaminophen 500mg (Vicodin) ▪ Buprenorphine 2mg + Naloxone 0.5mg (Suboxone)
Schedule IV	Yes, if prescription is not sent via fax, or called into the pharmacist	Yes, **ONLY after printed copy of prescription is signed by the prescriber, then sent via fax**	**No**, prescription must be signed and dated by prescriber per DEA regulations	❖ Alprazolam ❖ Clonazepam ❖ Lorazepam ❖ Flurazepam ❖ Temazepam ❖ Triazolam **Inpatient discharge orders only; NON-FORMULARY FOR OUTPATIENTS:** ❖ Diazepam
Schedule V	Yes, if prescription is not sent via fax, or called into the pharmacist	Yes, **ONLY after printed copy of prescription is signed by the prescriber, then sent via fax**	**No**, prescription must be signed and dated by prescriber per DEA regulations	▪ Codeine phosphate 12 mg + Acetaminophen 120mg per 5mL ▪ Codeine phosphate 30 mg + Acetaminophen 160mg per 5mL (compounding required)

Q2: Under what circumstances am I allowed to prescribe methadone to someone I know has an addiction?

A2: The presence of substance abuse does not preclude appropriate treatment with opioid analgesics, including methadone, but strict boundaries, which may include more frequent assessments, prescribing or dispensing for shorter periods of time (e.g., weekly), requests to return to the clinic (or pharmacy) for pill counts, random urine drug testing, a treatment agreement and referral to a recovery program, need to be in place to increase the success of treatment of chronic pain. According to the US Code of Federal Regulations, controlled substances can be prescribed for the treatment of pain including patients with a history of substance misuse or addiction. It should be noted that these controlled substance prescriptions are to be used for pain only and not for detoxification of an active substance addiction. Such distinction should be clearly indicated on the patient's medical records.

(California Academy of Family Physicians, Urine drug testing in clinical practice, edition 3, 2006, http://www.familydocs.org/mint/pepper/orderedlist/downloads/download.php?file=http%3A//www.familydocs.org/files/UDTmonograph.pdf)

Q3: Is there a limitation on the number of pills I can prescribe in a single prescription?

A3:
CHN Limitations: 30-day supply per prescription

Medi-Cal Limitations:

Drug	**Restrictions**
Hydromorphone	None
Hydrocodone/Acetaminophen(5/500)	Restricted to a maximum dispensing quantity of 90 tablets or capsules and a maximum of three (3) dispensings in any 75-day period.
Tylenol #2	Acetaminophen 300 mg and codeine phosphate 30 mg: Restricted to a maximum dispensing quantity of 60 tablets or capsules and a maximum of three (3) dispensings in any 75-day
Tylenol #3	Acetaminophen 300 mg and codeine phosphate 30 mg: Restricted to a maximum dispensing quantity of 45 tablets or capsules and a maximum of three (3) dispensings in any 75-day period.
Morphine (IR/SR)	Restricted to a maximum dispensing quantity of 90 tablets or capsules and a maximum of three (3) dispensings in any 75-day period. Note that for sustained released morphine, only Kadian is covered
Oxycodone (IR)	Restricted to a maximum dispensing quantity of 90 tablets or capsules and a maximum of three (3) dispensings in any 75-day period.
Oxycodone/Acetaminophen (5/325, 5/500)	No restriction

Q4: Where can I find a reliable table of equi-analgesic doses with guidelines for switching from one opioid to another?

A4: Pain Medication Pocket Tool is available from the American Caner Society (http://www.cancer.org/downloads/PRO/Pain_Management_Pocket_Tool.pdf)

Q5: If I know a patient has previously diverted a controlled substance, under what circumstances can I continue to medicate that patient's pain with opioid analgesics?

A5: A history of substance abuse diversion does not preclude appropriate treatment with opioid analgesics but there may be a need for strict boundaries, which may include random urine drug testing, and high risk patients can also be requested to return to the clinic for pill counts. It is important to understand the characteristics of the testing procedure as many drugs are not reliably detected by urine drug testing and drug levels may not correlate with dose taken. Inappropriate negative test results may not be indicative of diversion as maladaptive behavior, such as bingeing, may lead to a patient running out of medication early. Possible reasons for unexpected negative results need to be discussed with the patient.

(California Academy of Family Physicians, Urine drug testing in clinical practice, edition 3, 2006, http://www.familydocs.org/mint/pepper/orderedlist/downloads/download.php?file=http%3A//www.familydocs.org/files/UDTmonograph.pdf)

Q6: What do I do for a patient who is receiving opioids for pain but urine drug testing is positive for something else (i.e., cocaine or others)?

A6: Depending on the drug test, it may be indicative of concurrent substance addiction. Tests for cocaine have lower cross-sensitivity with other substances and a positive test is highly predictive of cocaine use. Tests for amphetamines/methamphetamine are highly cross-reactive and may show positive results due to ingestions of sympathomimetics such as pseudoephedrine and ephedrine which can be found in over the counter cold remedies. Tests for opiates are very sensitive for morphine and codeine but are less sensitive to semi-synthetic or synthetic opioids such as oxycodone, oxymorphone, buprenorphine, fentanyl and methadone. A positive test of opiates may not include the specific drug of interest because it lacks specificity and a negative result does not predict reliable the absence of opiate use. If a patient is found to have concurrent substance addiction, referral to a recovery program should be made.

(California Academy of Family Physicians, Urine drug testing in clinical practice, edition 3, 2006, http://www.familydocs.org/mint/pepper/orderedlist/downloads/download.php?file=http%3A//www.familydocs.org/files/UDTmonograph.pdf)

Q7: Which illicit and licit drugs are picked up in the urine drugs of abuse screen (at SFGH lab) and which are not?

A7: SFGH drug of abuse screen picks up cocaine, opiates (codeine, morphine, hydrocodone, hydromorphone), oxycodone (including oxymorphone), methamphetamines, amphetamines, estacy, benzodiazepines, barbiturates, and methadone (metabolite and parent compound assays). Phencyclidine (PCP) is not tested routinely but available upon request. Tetrahydrocannabinol (THC) testing is not available and does not contribute to acute toxic symptoms.

Drug of abuse screen (http://labmed.ucsf.edu/sfghlab/data/tests/97.html) are available 24x7 with a 1-2 hour turnaround and comprehensive drug of abuse screen takes 1-2 days. The comprehensive screen covers many more drugs than what is listed above and is recommended if screening test result does not explain the symptoms or presentation that is present.

(Alan Wu, MD, Toxicology Chief)

Q8: How many days prior to the urine Drugs of Abuse Screen can a person have ingested a substance and expect to have a positive result (may be different for different drugs and for different quantities of drugs)?

A8: Please see chart below

Drug of Abuse:	**Drug Detection Period (Approximate Guidelines)**
Amphetamines	2 – 4 days
Barbiturates	1 – 3 days (Phenobarbital, 2 weeks)
Benzodiazepines	Up to two weeks
Cocaine Metabolite	2 – 3 days
EDDP (Methadone metabolite)	2 - 4 days
Methadone	2 – 4 days
Opiates	2 – 3 days
Oxycodone	1 - 3 days
Phencyclidine (PCP)	3 – 8 days

(Drug of Abuse Screen Urine, Clinical Laboratory Manual, SFGH, http://labmed.ucsf.edu/sfghlab/data/tests/97.html)

Q9: Can I prescribe controlled substances to someone who's actively using illegal drugs (e.g. cocaine, speed)?

A9: There is no law or regulation prohibiting this. Patients with active abuse or dependence on alcohol, sedative hypnotics (benzodiazepines, methocarbamol, Soma, others) or other opioids are at high risk of overdose, misuse, or victimization and great care should be used in prescribing opioid analgesics. Patients with stimulant abuse or dependence are at high risk of misuse and diversion and require monitoring such as tox screens and pill counts. When possible referral of these patients to substance abuse specialists such as substance abuse counselors or addiction medicine physicians will help in their being able to benefit from medical care.

Q10: Can I write a prescription for controlled substances for a patient who is being seen in clinic by a nurse but not by me?

A10: California law does not specify the requirement for such situation. Ultimately, a prescription for a controlled substance to be effective must be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his or her professional practice. At a minimum, the prescriber should have a throughout understanding of the patient's medical conditions and the prescription should be given for the treatment of one of these medical conditions other than for the treatment of substance abuse.

Q11: Can I write 3 one-month scripts for controlled substances at 1 visit and see a patient who is stable every 3 months?

A11: Yes. A practitioner may provide individual patients with multiple prescriptions for the same schedule II controlled substance to be filled sequentially. The combined effect of these multiple prescriptions is to allow the patient to receive, over time, up to a 90-day supply of that controlled substance. The individual practitioner must provide written instructions on each prescription indicating the earliest date on which a pharmacy may fill each prescription. Prescriptions should not be post-dated and be "dated as of, and signed on, the day when issued." All controlled substance prescriptions are valid for a period of 6 months.

(Q&A - Issuance of Multiple Prescriptions for Schedule II Controlled Substances. http://www.deadiversion.usdoj.gov/faq/mult_rx_faq.htm. Accessed on March 13, 2009)

Q12: What are the major drug interactions that can lower the effectiveness (pain relief) of opioids, especially methadone?

A12: Major inducers of CYP450 include amprenavir, barbiturates, carbamazepine, efavirenz, lopinavir/ritonavir, nevirapine, phenytoin, rifampin, rifampin+isoniazid can lower the effectiveness of methadone, potentially inducing methadone withdrawal. Symptoms and signs of withdrawal due to these interactions may take about a week to show. Methadone dose may need to be increased and more frequent dosing may be necessary.

Interferon-alfa in combination with ribavirin may produce side effects that mimic opioid withdrawal symptoms.

Other opioids:

Morphine – drug-drug interactions are rare

Codeine – quinine decreases its conversion to morphine, which can decrease the analgesic effect of codeine. It is also metabolized by CYP2D6. Therefore CYP2D6 inhibitors such as bupropion, celecoxib, cimetidine, and cocaine can reduce its conversion to morphine thereby reducing its analgesic effect. CYP2D6 inducers such as dexamethasone and rifampin may speed up conversion and increase analgesia with codeine.

Hydrocodone – it has been suggested that hydrocodone is a prodrug requiring conversion by CYP2D6 for it to exhibit its analgesic effect. Therefore, CYP2D6 inhibitors may reduce its analgesic effectiveness.

Oxycodone – it is metabolized by CYP2D6 and therefore inhibitors can lower its analgesic effect while inducers can decrease pain relief.

Hydromorphone – no significant drug-drug interactions.

(Trescot AM, Datta S, Lee M, Hansen H. Opioid pharmacology. *Pain Physician* 2008;11: S133-S153)

Q13: Why do I get a call from the pharmacy after e-Faxing a controlled substance prescription?

A13: DEA regulations do NOT permit electronic signatures on controlled substances prescriptions sent through a direct e-prescribing link or via e-Fax. You may continue to use the LCR to generate Schedule III through Schedule V controlled substances prescriptions. However, the LCR prescription should be printed, manually signed, then sent via Fax to the pharmacy of the patient's choice. If not manually signed but sent via e-Fax, DEA regulations require the pharmacist to call the provider to verify the prescription, and this may delay treatment for your patient. One alternative to printing, manually signing and sending the prescription via Fax to the pharmacy is to write for controlled substances on a secure prescription form, and then give the form to the patient to present at the pharmacy. Another alternative is to call the prescription for Schedule III though V controlled substances into the pharmacy.
Schedule III through Schedule V prescriptions previously sent to pharmacies using the LCR e-Fax function. Ordering Schedule II controlled substances remains unchanged, and use of secure prescription forms are required for these agents. Please also see Q1 on this FAQ.

Figure 1 ***Albuquerque HCH formulary medications***

Formulary Medications	Type of pain					
	Muskuloskeletal	**Neuropathic**	**Fibromyalgia**	**Headache**	**Post-herpatic neuralgia**	**Dental**
Analgesics						
Acetaminophen	325mg-1000mg q 4-6h		25mg-1000mg q 4-6h	25mg-1000mg q 4-6h		25mg-1000mg q 4-6h
Aspirin	325mg-650mg q 4 h			325mg-650mg q 4 h		325mg-650mg q 4 h
Ibuprofen	300mg-800mg TID-QID			300mg-800mg TID-QID		300mg-800mg TID-QID
Naproxen	250MG-500MG BID			250MG-500MG BID		250MG-500MG BID
Piroxicam	20MG DAILY			20MG DAILY		20MG DAILY
Tricyclic Antidepressants						
Amitriptyline		25mg-50mg HS	25mg-50mg HS	25mg-50mg HS	25mg-50mg HS	
Doxepin		10mg- 100MG HS	10mg- 100MG HS	10mg- 100MG HS	10mg- 100MG HS	
Anti-seizure						
Gabapentin		300mg-1200mg TID	300mg-1200mg TID	300mg-1200mg TID	300mg-600mg TID	
Carbamazepine		200mg-400mg BID		200mg-400mg BID		
Lamotrigine		up to 400mg/day		up to 400mg/day		
Valproic acid		250mg-500mg BID		250mg-500mg BID		
Calcium Channel Blockers						
Amlodipine				5mg-10mg day		
Verapamil				80mg TID		
Beta Blockers						
Metoprolol				25mg-125mg BID		
Propranolol				80mg-240mg/day div		
Muscle relaxants						
Baclofen	10mg-20mg TID-QID		10mg-20mg TID-QID			
Cyclobenzaprine	5mg-10mg TID		5mg-10mg TID			
SNRI's						
Duloxetine	60mg daily	60mg daily	60mg daily		60mg daily	
Triptans						
Sumatriptan				Max of 200mg/day		

H

Non-opioid Medications for the Management of Chronic Pain
Albuquerque Health Care for the Homeless, Inc.

TYPE OF PAIN	MEDICATIONS
Musculoskeletal/ myofascial pain **Musculoskeletal** pain – affects bones, muscles, ligaments, tendons, and nerves; can be acute (having a rapid onset with severe symptoms) or chronic (long-lasting), localized in one area or widespread **Myofascial** pain – caused by abnormal stress on the muscles; a chronic condition that affects the fascia (connective tissue that covers the muscles). Myofascial pain syndrome can be confused with fibromyalgia and may accompany it. Unlike fibromyalgia, myofascial pain tends to occur in trigger points, as opposed to tender points, and typically there is no widespread, generalized pain.	■ **Acetaminophen** Can be used alone or in combination with NSAIDs for exacerbations. Use with caution or avoid in patients with hepatic or renal impairment, alcohol abuse, dehydration or malnutrition. ■ **Non-steroidal anti-inflammatory (NSAIDs)** Use with caution in patients with hepatic or renal impairment, chronic alcohol use, asthmatics and the elderly. Use the least frequently dosed option as NSAIDs should be taken with food.
Neuropathic pain – a complex, chronic pain state that usually is accompanied by tissue injury. With neuropathic pain, the nerve fibers themselves may be damaged, dysfunctional or injured	■ **Gabapentin** Can be dosed up to 3,600mg per day for neuropathic pain. Use with caution in patients with chronic alcohol use, depression, suicide risk or renal impairment. Monitor closely in patients taking methadone, barbiturates, benzodiazepines and antisiezure medications. ■ **Tricyclic antidepressants** Dosed once daily at bedtime due to drowsiness caused. Use with caution in patients with hepatic impairment, schizophrenia, bipolar disorder, alcohol abuse, suicide risk and the elderly. Should be used in caution with patients taking MAOIs, haloperidol, dopamine, cimetidine and erythromycins. May cause photosensitivity; counsel patients to avoid excess sun exposure. ■ **Duloxetine** Use 60mg once daily if possible, may increase to 60mg twice daily in rare cases. Caution in patients with hepatic impairment, alcohol abuse, seizure history, suicide risk, dehydration and the elderly. Avoid use in combination with MAOIs and use cautiously in patients taking antidepressants, triptans, haloperidol and antiarrhythmics.
Post-herpatic neuralgia (PHN) – the most common complication of herpes zoster or shingles, broadly defined as any pain that remains after healing of herpes zoster lesions or rash, usually after a three month period.	Medications used to treat neuropathic pain are also used to treat post-herpatic neuralgia: ■ **Antivirals** Used to shorten severity and duration of flare. Use with caution in patients with renal or hepatic impairment or in patients taking nephrotoxic medications. May cause diarrhea and vomiting, leading to dehydration. May cause photo sensitivity; patients should be counseled to avoid sun exposure. ■ **Oral corticosteroids** Used to decrease inflammation and severity of outbreak. Caution if active infection of any type, hypertension, psychiatric disorder, immunosuppressed, seizure disorder, hepatic/ renal impairment, or if elderly. Should be taken with food, for short duration only.
Fibromyalgia – A common syndrome in which people experience long-term, body-wide pain and tender points in joints, muscles, tendons, and other soft tissues. Fibromyalgia has also been linked to fatigue, sleep problems, headaches, depression, anxiety, and other symptoms.	■ Many of the medications used to treat other types of pain are also used to treat pain caused by fibromyalgia, including: **gabapentin, tricyclic anti-depressants, acetaminophen and Duloxetine** ■ **Muscle relaxants** Used in conjunction with other agents to decrease muscle and joint pain. Should be used with caution in patients with hepatic impairment, seizure disorder, psychosis, urinary retention and the elderly. Avoid use or monitor treatment in patients taking anticholinergics, CNS depressants, MAO inhibitors, barbiturates and benzodiazepines. May cause irritability and photosensitivity.

Chronic headache/ migraines	■ **Analgesics** – Aspirin, NSAIDs and acetaminophen can be used short term for symptomatic pain relief. ■ **Triptans** (5HT1 Agonists) Used as rescue treatment for acute migraine attacks, may repeat once in 2 hours if needed. Should be taken as soon as possible after migraine onset. Caution with seizure disorder, hepatic impairment, hypertension and the elderly. Monitor therapy or avoid use in patients taking SSRI's or SNRI's due to risk of serotonin syndrome. Avoid use in patients taking MAOIs or bromocriptine. Counsel patients that they may experience tachycardia, vision changes, flushing and sedation. ■ **Calcium channel blockers** Used as prophylaxis to prevent migraine attacks. May be used in conjunction with prednisone. May cause hypotension, edema and bradycardia. Use cautiously in patients with hepatic or renal impairment, hypotension and the elderly. ■ **Anti-seizure medications** (gabapentin, valproic acid, topiramate) Used to limit the severity and frequency of attacks in patients suffering from chronic migraine. Caution in patients with hepatic or renal impairment, dehydration, depression or seizure disorder. Monitor treatment in patients taking antihypertensives, immunosuppressants and warfarin. May cause drowsiness, nausea, tremor, insomnia and photosensitivity. ■ **Beta blockers** – Used as prophylaxis in patients with chronic migraines. Use with caution in patients with bradycardia, asthma, hepatic impairment, diabetes and heart failure. Caution in patients taking cimetidine, Celebrex, insulin or using cocaine. Counsel patients on possible photosensitivity, drowsiness, depression and dyspnea. ■ **Tricyclic antidepressants** Sometimes used as prophylaxis against migraines and to treat pain associated with chronic migraines.
Dental Pain	■ **Analgesics** Aspirin, acetaminophen and NSAIDs are used for short term relief of dental pain. Caution if recent tooth extraction due to increased risk of bleeding.

TWHC Nurse Assessment Form
Refills for Controlled Substances

BP____/____, P=, RR=
__alert __nodding off __agitated __etoh on breath

Current Problems and Concerns:

Medication(s):

Rx written by: _____
Rx given to pt by: _____
Rx updated in LCR by: _____

Last Refill? Date Due?

Is patient early or late? __Yes __No
If yes, why:

When was the patient's last appointment?
MD/NP: RN:

What was the plan last appointment and has it been followed up on?

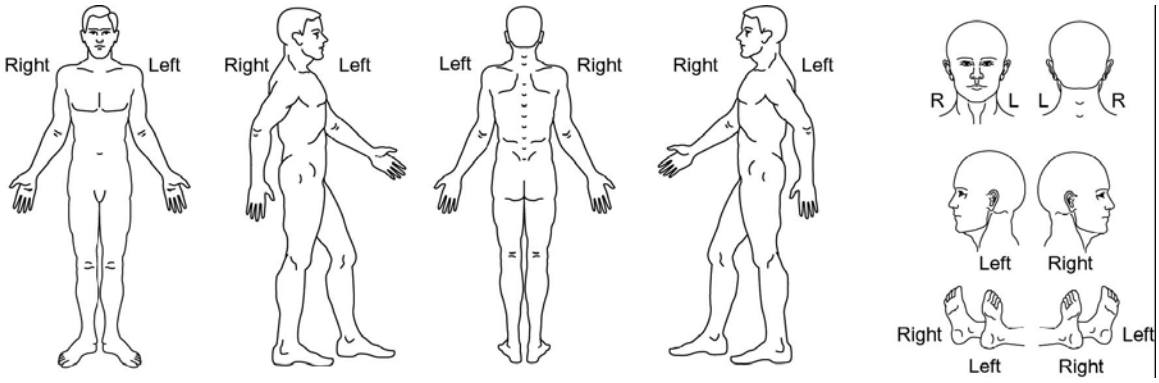
Has the patient had a utox in the last year? ___Yes ___No
If no, get urine sample and complete the form

When is next scheduled appointment?
MD/NP: RN:

Does the patient's chart contain the following forms (if not completed, make sure there's a blank in front of chart)

- Informed Consent ___Yes ___No
- Patient-Provider Agreement (current within one year) ___Yes ___No
- Assessment and Treatment Plan (current within one year) ___Yes ___No

Location of Pain:



Analgesia

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

1. What was your pain level at its worst (since last visit)? (circle number)
0 1 2 3 4 5 6 7 8 9 10

2. What was your average pain level (since last visit)? (circle number)
0 1 2 3 4 5 6 7 8 9 10

3. Are you able to do day-to-day activities (dressing, bathing, shopping)?
___Yes ___No

Adverse Effects

1. Is patient experiencing any of the following side effects from current pain reliever(s)?

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

Other adjunctive pain treatment therapies in use:

Interest in other pain therapies (physical therapy, acupuncture, ??)

Signature of RN_____

SECTION 3:
MEDICATION CONTRACTS

Although not required by Oregon law, medication contracts should be considered for patients on long-term opioid therapy. Medication contracts can improve provider-patient relations by allowing expectations to be made explicit and communicated. Depending on the context, they can emphasize provider concerns regarding appropriate medication use and/or patient concerns that their reports of pain be accepted and acted upon.

- Contracts should not be used in a way that violates the patient's right to respectful care, the right to medical care for pain, or the right to make decisions about their care.
- Written and signed medication contracts can be modified for the individual patient. Examples of both a comprehensive and a basic contract follow.

Pain Patient's Bill of Rights

Pain patient "Bill of Rights" statements have been issued by a number of organizations. They emphasize that the person in pain has:

1. The right to considerate and respectful care that accepts and acts upon their reports of pain.
2. The right to have their pain thoroughly assessed and addressed no matter what its cause or severity.
3. The right to be fully informed concerning the diagnosis and prognosis of their condition, the proposed treatments, and the benefits, risks and costs of each.
4. The right to participate in decisions about pain management, including the right to refuse specific treatments.
5. The right to privacy concerning their medical care.

For more information consult the American Pain Foundation at www.painfoundation.org or the American Academy of Pain Management at www.aapainmanage.org.

Medication Contract

I, _____, have agreed to use the following medications as part of my treatment for chronic pain. I understand that these medications may not eliminate my pain but may reduce it and improve what I am able to do each day.

MEDICATION	DOSE	DIRECTIONS	QUANTITY PER MONTH

I understand the following guidelines for continuing pain treatment under the care of _____

1. I understand that I have the following responsibilities:
   - I will take medications at the dose and frequency prescribed.
   - I will not increase or change how I take my medications without the approval of this health care provider.
   - I will arrange for refills at the prescribed interval ONLY during regular office hours. I will not ask for refills earlier than agreed, after-hours, on holidays or on weekends.
   - I will obtain all refills for these medications only at _____ pharmacy (phone number: _____), with full consent for my provider and pharmacist to exchange information in writing or verbally.
   - I will not request any pain medications or controlled substances from other providers and will inform this provider of all other medications I am taking.
   - I will inform my other health care providers that I am taking these pain medications and of the existence of this contract. In event of an emergency, I will provide this same information to emergency department providers.
   - I will protect my prescriptions and medications. I understand that lost or misplaced prescriptions will not be replaced.
   - I will keep medications only for my own use and will not share them others. I will keep all medications away from children.
   - I agree to participate in any medical, psychological or psychiatric assessments recommended by my provider.

continued on back

- I will actively participate in any program designed to improve function, including social, physical, psychological and daily activities.

2. I will not use illegal or street drugs or another person's prescription. If I have an addiction problem with drugs or alcohol and my provider asks me to enter a program to address this issue, I agree to follow through. Such programs may include:
   - 12-step program and securing a sponsor
   - Individual counseling
   - Inpatient or outpatient treatment
   - Other:_____

If in treatment, I will request that a copy of the program's initial evaluation and treatment recommendations be sent to this provider and will not expect refills until that is received. I will also request written monthly updates be sent to verify my continuing treatment.

3. I will consent to random drug screening to assure I am only taking prescribed drugs. I understand that a drug screen is a laboratory test in which a sample of my urine or blood is checked to see what drugs I have been taking.

4. I will keep all my scheduled appointments. If I need to cancel my appointment, I will do so a minimum of 24 hours before it is scheduled.

5. I understand that this provider may stop prescribing the medications listed if:
   - I do not show any improvement in pain or my activity has not improved.
   - I develop rapid tolerance or loss of improvement from the treatment.
   - I develop significant side effects from the medication.
   - My behavior is inconsistent with the responsibilities outlined above, ***which may also result in being prevented from receiving further care from this clinic***.

Signed: _____ Date: _____

Provider: _____ Date: _____

Medication Contract

I, _____, agree to the following rules and conditions regarding refills of prescribed medications.

The medication(s) covered by this agreement include:

MEDICATION	DOSE	DIRECTIONS	QUANTITY PER MONTH

1. I will limit my dose of medications to the dose prescribed. I will discuss any future changes in my dose with my provider.
2. I am responsible for my medications. Lost, misplaced or stolen prescriptions will not be replaced.
3. Refills will be made only at the prescribed level. No early refills will be authorized.
4. No refills with be authorized after-hours, on holidays or on weekends.
5. I will obtain all refills for these medications only at _____ pharmacy (phone number:_____).
6. I will request all refills through my primary care clinic during these hours:
   _____.
7. I understand that my provider may stop prescribing opioids or change the treatment plan if I do not show any improvement in pain from opioids or my level of activity has not improved.
8. Other: _____
9. I understand that failure to comply with any of these conditions or failure to make regular follow-up appointments with my primary care provider may result in termination of prescriptions for the medications listed above. ***It may also result in being prevented from receiving any further care.***

Signed: _____ Date: _____

Provider: _____ Date: _____

Getting the Best Result from Opioid Pain Medication: A Partnership Agreement

The greatest success in chronic pain management comes when there is a partnership based on mutual respect between patient and health care provider.

As patient and health care provider, we respect each other's rights and accept our individual responsibilities.

The health care provider understands that it is important for patients with pain to know that the provider will:

- Listen and try to understand the patient's experience living with pain.
- Accept the patient's reports of pain and response to treatment.
- Thoroughly assess the patient's pain and explore all appropriate treatment options, including those suggested by the patient.
- Explain what is known and unknown about the causes of the patient's pain.
- Explain the meaning of test results or specialty visits/consultations, and what can be expected in the future.
- Explain the risks, benefits, side effects and limits of any proposed treatment.
- Respect the patient's right to participate in making pain management decisions, including the right to refuse some types of treatment.
- Make sure that the patient has access to acute care, even when the provider is not personally available.
- Not allow the patient to be treated disrespectfully by other providers or staff because of the patient's use of opioids for pain.

The patient understands that it is equally important for providers that their patients on opioid pain medications will:

- Take medication only at the dose and time/frequency prescribed.
- Make no changes to the dose or how the medication is taken without first talking to the provider.
- Not ask for pain medications or controlled substances from other providers. The patients will also tell every provider all medications they are taking.
- Arrange for refills only through the provider's clinic during regular office hours. Not ask for refills earlier than agreed upon.

continued on back

- Protect their prescriptions and medications, keeping all medicines away from children.
- Keep medications only for their own use and not share them with others.
- Be willing to be involved in programs that can help improve social, physical, or psychological functioning as well as daily or work activities.
- Be willing to learn new ways to manage their pain by attempting step-by-step behavior and lifestyle changes in their daily life.

We agree that the provider may stop prescribing the medication or the patient may decide to stop taking the medication if there is no improvement in pain or activity, there is loss of improvement from the medication, or there are significant side effects from the medication.

We both realize and have discussed that there can be limitations to opioid therapy. We acknowledge that it may not be helpful or only partially helpful and that it is only one part of the treatment of chronic pain.

We agree to work together in an active partnership, learning from both successes and failures, to find the most effective ways to control pain and improve functioning.

Patient: _____ Date: _____

Provider: _____ Date: _____

Informed Consent for
Long-Term Controlled Medicines for Chronic Pain

I, _____, and _____,
(Patient) (Provider)
have decided to use controlled medicines to treat_____

_____.
(symptom, cause)

Reasons for using these medicines and what to expect:
This form tells me what may happen when I use controlled medicines for my chronic (on-going) pain. Controlled medicines, like opioids (like codeine, fentanyl, methadone, morphine, oxycodone, Percocet, Vicodin), may reduce my pain.

They may also improve my ability to do daily activities.
My provider and I have decided that I should take controlled medicines because other treatments have not helped enough.

- My symptoms may get better.
- My symptoms may not go away completely.
- I may need more tests to pick the best treatment.
- My provider may change my treatment. This is to make sure my treatment is the best for me.

I understand that there are risks with this treatment. Some risks are:

Risk of misuse or use by others:

- Opioids and other controlled medicines are powerful medicines.
- They can be dangerous if not taken the way my provider tells me to.
- It is important that no one but me take my medicines.
- They can cause overdose (taking too much) or death.

Side-effects:

- My medicines may have side effects.
- I should not drive or use heavy machinery until I know how the medicine affects me.
- It is important that I tell my provider if I am taking other medicines.
- Some medicines can be harmful if I take them with opioids.
- Some medicines may have Tylenol in them. High levels of Tylenol can damage my liver.

Some side effects of these medicines are:

- Feeling drowsy or tired
- Constipation
- Upset stomach
- Itchy skin
- Slow or shallow breathing
- Feeling “slowed down”
- Overdose--I may stop breathing and I could die if I take too much of this medicine
- effects on my bones, my mood and my sexual function

Women Only: It is important to talk to my provider if I am pregnant or want to get pregnant.
If I take these medicines when I am pregnant, the baby may be born dependent on them.
The risk of birth defects is low.

Side effects that I may have from the use of other (non-opioid) prescribed controlled medicines include:
_____
_____

Physical Dependence:
My body may become dependent on these medicines. This is normal.
I may go through withdrawal if I cut back or stop these medicines all at once ("going cold turkey").
Symptoms of opioid withdrawal include:

- stomach pain
- feeling nervous
- diarrhea
- pain
- racing heart
- feeling shaky
- runny nose
- upset stomach.

These symptoms are uncomfortable. They will not cause serious harm. They can be treated.

- Most of the time, medicines should be cut back slowly over time.
- I should talk to my provider if I stop taking my medicines.
- Restarting these medicines after stopping for a while can cause an overdose which could lead to my death.

Other withdrawal symptoms from stopping other (non-opioid) medicines are:

_____
_____

Tolerance/Worsening of pain:
My body may become "used-to" or tolerant to these medicines.

Opioid medicines may cause my body to feel more pain. If this happens, higher doses of the medicines may not help. My medicines may then be changed, lowered, or stopped.

Addiction:
Opioids can cause drug addiction.
The risk is higher for people with a history of addiction.

It is important to tell my provider about my personal and family history of addiction or substance use.

_____
_____
_____
_____
_____
_____
_____
_____

I understand this form. I have been able to ask questions about these medicines and have them answered. I have been offered a copy of this form.

I agree to the treatment of my condition with controlled medicines.

Patient Signature: **X**_____

Witness Signature: _____ Date: _____/_____/_____

Patient-Provider Agreement for
Long-Term Controlled Medicines for Chronic Pain

I, _____, and _____,
(Patient) (Provider)

have decided to use controlled medicines to treat:_____
_____.
(symptom, cause)

Purpose
The purpose of this agreement is to make clear what I can expect when I am prescribed controlled medicines (like codeine, fentanyl, methadone, morphine, oxycodone, Percocet, Vicodin) as part of the treatment of my pain. It describes what I can expect from my provider and what my provider expects of me.

My Provider's Responsibilities
It is my provider's responsibility to assess my pain and to create and monitor a treatment plan that is safe and appropriate for my condition. My provider is also responsible for making sure that my treatment follows the law about controlled medicines. This includes making sure that I do not misuse the medicines that are prescribed for me and/or that others do not get a hold of or use my medicines.

My Responsibilities

I, _____understand and agree to the following:
(Patient)

- My treatment plan may include other things besides medications like: diagnostic tests, group visits or specialty visits. I agree to follow the treatment plan that my provider and I have agreed to.
- Only I will take these medicines. I will not share, give away, lend, sell or trade these medicines. I will not let others use my medicines.
- I will only take these medicines as directed.
- My prescriptions may not be refilled early. I may run out of medicines if I take more than my provider tells me to.
- I can only refill prescriptions during regular clinic hours and according to the refill policy of my clinic.
- I will guard my medicines like my money or jewelry. Lost, stolen or damaged medicines or prescriptions may not be replaced.
- I will not seek controlled medicines from other places without talking to my provider. This includes urgent care and the emergency department. I will tell my provider right away if I get a prescription for other controlled medicines.
- My pharmacy records may be reviewed.
- I will behave respectfully towards all staff. I will not be abusive or rude.
- I have been advised not to use illegal drugs or unprescribed controlled medicines. I may be asked to do drug testing at any time.
  - If my drug test shows illegal drugs or unprescribed controlled medicines, my medicines may be stopped or I may need to go to substance use treatment in order to continue getting controlled medicines.
  - If my drug test does not show that I am using my prescribed medicines, my provider may stop these medicines.

Patient-Provider Agreement for
Long-Term Controlled Medicines for Chronic Pain

- Any medical treatment starts on a trial basis. My prescription may be stopped. This would happen if there are no signs that the medicines are helping me or if there are signs of harm or misuse.
- I will talk to my provider if I am pregnant or want to get pregnant.
- I will tell my provider if I am taking other medicines.
- I will tell my provider about my personal and family history of addiction or substance use.
- I understand the possible risks and benefits of these medicines.
- Other Terms:_____
  _____
  _____
  _____
- If I break this agreement, my provider may stop prescribing controlled medicines for me.
- This agreement will be reviewed at least once a year. It may also be reviewed if I change providers or break the agreement.

I understand this form. I have been able to ask questions about this agreement and have them answered. I have been offered a copy of this form.

I am signing this form because I want to. I accept all of its terms.

Patient: **X**_____

Provider: _____

Date: _____/_____/_____

使用長期受管制藥物治療慢性疼痛之

知情同意書

本人，_____，與_____，

(病人) (醫生)

決定使用受管制藥物，治療_____

_____

(症狀，病因)

使用上述藥物的原因及預期效果:

此表告知我，如果我使用受管制藥物來治療我的慢性 (目前) 疼痛，可能會產生什麼後果。受管制藥物，例如鴉片類物質 (諸如可待因、芬太尼、美沙酮、嗎啡、氧可酮、Percocet、Vicodin 等) 可能減輕我的疼痛。

這些藥物亦可能改善我的日常活動能力。

由於其他治療沒有對我產生足夠療效，我的醫生和我斷定我應該服用受管制藥物。

- 我的症狀可能會有所改善。
- 我的症狀可能不會完全消失。
- 我可能需要更多試驗，從中選擇最佳治療方法。
- 我的醫生可能會變更我的治療方法。目的是確保為我採用最佳治療方法。

我理解此治療方法可能有一些危險。其中一些危險包括:

誤用或被他人使用:

- 鴉片類物質和其他受管制藥物的藥效很強。
- 如果我未按醫生指示的方法服藥，則可能導致危險。
- 務必保證其他人不可服用我的藥物，只有我本人可以。
- 可能導致用藥過量或死亡。

副作用:

- 我的藥物可能有副作用。
- 除非我知道這些藥物會對我產生什麼影響，否則我不應駕車和操作重型機械。
- 如果我正在服用其他藥物，我應告訴醫生，這一點至關重要。
- 有些藥物如果與鴉片類物質同時服用，可能造成傷害。
- 有些藥物可能含有泰諾 (Tylenol)。Tylenol 含量高可能損害我的腎臟。

這些藥物可能產生以下一些副作用:

- 感覺困倦或者疲憊
- 便秘
- 胃部不適
- 皮膚發癢
- 呼吸困難
- 感覺「行動越來越遲緩」
- 用藥過量，如果我服用此藥過量，可能會停止呼吸，甚至死亡。
- 影響我的骨骼、情緒和性功能

僅對婦女而言:如果我已懷孕或想要懷孕，則務必告訴醫生，這很重要。

如果我在懷孕期間服用這些藥物，我的孩子出生後可能對這些藥物產生依賴性

產生天生缺陷的風險較低。

服用其他 (非鴉片類) 處方管制藥物可能對我產生副作用，其中包括:

_____

_____

生理依賴性:
我的身體可能逐漸對這些藥物產生依賴性。這是正常的。
如果我減服或突然完全停服這些藥物 (突然終止)，我可能要經歷一個戒藥過程。
戒除鴉片類藥物的症狀包括:

- 胃部不適
- 感覺緊張
- 腹瀉
- 疼痛
- 心博過速
- 感覺虛弱顫抖
- 流鼻涕
- 胃部不適。

這些症狀令人不舒服。不會導致嚴重傷害。但可以治癒。

- 大多數情況下，應該逐漸緩慢地減少藥量。
- 如果我停止服藥，我應告訴我的醫生。
- 停服一段時間後重新開始服用這些藥物可能導致用藥過量，繼而導致我死亡。

停服其他 (非鴉片類) 藥物的其他戒藥症狀包括:

_____
_____

耐藥性/疼痛加劇:
我的身體已逐漸「習慣」這些藥物或者產生耐藥性。

鴉片類藥物可能導致我的身體感覺更疼痛。如果發生這種情況，則加大服藥劑量可能於事無補。因此可能更換用藥、減少劑量或者停止服藥。

成癮:
鴉片類藥物可導致藥物成癮。
對於有藥物成癮史的人士，成癮風險更大。

務必告知我的醫生有關我本人及家庭的藥物或物質使用成癮史。

_____
_____
_____
_____
_____
_____
_____
_____

我理解此表內容。我一直有機會就這些藥物提出疑問並已得到解答。
我已獲得此表的一份副本。

我同意使用受管制藥物治療我的病症。

醫生簽名: **X** _____

見證人簽名:_____ 日期:_____/_____/_____

M-2

使用長期受管制藥物治療慢性疼痛之

醫患協議

本人，_____，與 _____，
(病人) (醫生)

決定使用受管制藥物，治療

_____

_____

(症狀，病因)

目的

本協議的目的是，述明當醫生就治療我的疼痛為我開立受管制藥物 (例如可待因、芬太尼、美沙酮、嗎啡、氧可酮、Percocet、Vicodin 等) 時我能期望什麼。並說明我可期望醫生做什麼以及醫生期望我做什麼。

醫生的責任

我的醫生有責任評估我的疼痛，制定並監督執行適合我的安全治療方案。我的醫生有責任確保我的治療符合有關受管制藥物的法律。包括確保我不會誤用為我開立的藥物，確保他人無法獲得或使用我的藥物。

我的責任

我，_____理解並同意以下內容:
<病人>

- 我的治療方案可能包括藥物以外的內容，例如:診斷性測驗、會診或專科門診。我同意遵從我的醫生和我一致同意的治療方案。
- 只有我本人可以服用這些藥物。我不可與他人共用、贈送、借予或出售這些藥物。我不會允許他人使用我的藥物。
- 我只會依照指示服藥。
- 我的處方藥可能不會很早獲得補充供應。如果我的服藥劑量超過醫囑用量，我可能用完藥物。
- 我只能在診所正常工作時間並依照診所的補藥政策獲得處方藥的補充供應。
- 我會像守衛我的錢物或珠寶一樣守衛我的藥物。丟失、被盜和損壞的藥物或處方藥可能不會獲得償還。
- 未經與醫生商量，我不會從其他地方尋求受管制藥物。這些地方包括緊急護理部或急診室。如果我得到其他受管制藥物的處方，我會告知我的醫生。
- 我的藥房紀錄可能會被查閱。
- 我會禮貌對待工作人員。不會辱罵或無禮對待他們。
- 我已被告知不得使用毒品或無處方的受管制藥物。我可能隨時被要求去做藥物檢測。
  - o 如果我的藥物檢測表明我的藥物是毒品或無處方的受管制藥物，我可能被停藥，或者需要接受藥物使用治療，方可繼續獲得受管制藥物。
  - o 如果我的藥物檢測表明，我並未服用我的處方藥物，我的醫生可能會停發這些藥物。

使用長期受管制藥物治療慢性疼痛之

醫患協議

- 任何醫療治療皆從試驗開始。我的處方可能會被終止。當沒有跡象顯示這些藥物對我療效，或者有跡象顯示這些藥物可能對人有害或被誤用，在這種情況下，處方將被終止。
- 如果我已懷孕或想要懷孕，我會告訴醫生。
- 如果我正在服用其他藥物，我會告訴醫生。
- 我會告知我的醫生有關我本人及家庭的藥物或物質使用成癮史。
- 我理解這些藥物的潛在風險和益處。
- 其他條款:
  _____
  _____
  _____
  _____
- 如果我違反此協議，我的醫生可能會停止為我開立受管制藥物。
- 本協議至少每年覆核一次。如果我更換醫生或違反協議，本協議亦可能被覆核。

我理解此表內容。我一直有機會就此協議提出疑問並已得到解答。
我已獲得此表的一份副本。

本人出於自願簽署本協議。本人接受此協議所有條款。
病人: X _____

醫生:_____

日期:_____/_____/_____

Consentimiento Informado para

Administración de Medicamentos Controlados a Largo Plazo Para el Dolor Crónico

Yo, _____, y _____, hemos decidido usar medicamentos
(Paciente) (Proveedor)

Controlados para tratar: _____.
(síntoma, causa)

Razones para el uso de estos medicamentos y lo que se puede esperar:
Este formulario me informa lo que puede pasar cuando utilizo medicamentos controlados para aliviar mi dolor crónico (continuo). Los medicamentos controlados, tales como los opioides (como la codeína, fentanilo, metadona, morfina, oxicodona, Percocet y Vicodin) pueden reducir mi dolor.

También pueden mejorar mi capacidad de realizar las actividades diarias.
Mi proveedor y yo hemos decidido que debo tomar medicamentos controlados porque otros tratamientos no me han ayudado lo suficiente.

- Mis síntomas pueden mejorar.
- Es posible que mis síntomas no desaparezcan por completo.
- Es posible que necesite más pruebas para elegir el mejor tratamiento.
- Mi proveedor puede cambiar mi tratamiento. Esto es para asegurarme de que mi tratamiento sea el mejor para mí.

Entiendo que hay riesgos con este tratamiento. Algunos riesgos son:

Riesgo de que se les dé un uso incorrecto o que los usen otras personas:

- Los opioides y otros medicamentos controlados son medicamentos muy potentes.
- Pueden ser peligrosos si no los tomo como me lo indicó mi proveedor.
- Es importante que nadie más que yo tome los medicamentos.
- Pueden ocasionar una sobredosis (tomar demasiado) o la muerte.

Efectos secundarios:

- Mis medicamentos me pueden causar efectos secundarios.
- No debo conducir ni manejar maquinaria pesada hasta que de qué forma me afecta el medicamento.
- Es importante que le informe a mi proveedor si estoy tomando otros medicamentos.
- Algunos medicamentos pueden ser dañinos si los tomo con los opioides.
- Algunos medicamentos pueden contener Tylenol. Los niveles altos de Tylenol pueden dañar mi hígado.

Algunos efectos secundarios de estos medicamentos son:

- sensación de somnolencia o cansancio
- estreñimiento
- malestar estomacal
- picazón en la piel
- respiración lenta o poco profunda
- sensación de "lentitud"
- sobredosis: si tomo demasiado de este medicamento podría dejar de respirar y podría morir
- efectos en mis huesos, mi estado de ánimo y mi función sexual

Mujeres únicamente: es importante hablar con mi proveedor si estoy embarazada o quiero quedar embarazada.

Si tomo estos medicamentos durante el embarazo, el bebé podría nacer con dependencia de ellos. El riesgo de que ocurran defectos congénitos es bajo.

Los efectos secundarios que podría tener por el uso de otros medicamentos controlados (no opioides) con receta médica incluyen:

_____
_____

Dependencia física:
Mi cuerpo se puede volver dependiente de estos medicamentos. Esto es normal.
Puedo sufrir de abstinencia si reduzco o suspendo súbitamente estos medicamentos (parar en seco).
Los síntomas de abstinencia de los opioides incluyen:

- dolor de estómago
- sensación de estar nervioso
- diarrea
- dolor
- corazón acelerado
- sensación de temblor
- secreción nasal
- malestar estomacal.

Estos síntomas son incómodos. No causarán un daño grave. Pueden tratarse.

- La mayoría de las veces, los medicamentos deberían reducirse gradualmente.
- Debo hablar con mi proveedor si dejo de tomar mis medicamentos.
- El reinicio de estos medicamentos después de dejarlos por un tiempo podría causarme una sobredosis que me podría causar la muerte.

Otros síntomas de abstinencia por suspender otros medicamentos (no opioides) son:

_____
_____

Tolerancia/aumento del dolor:
Mi cuerpo se puede llegar a "acostumbrar" o volverse tolerante a estos medicamentos.

Los medicamentos opioides pueden causar que mi cuerpo sienta más dolor. Si esto ocurre, es posible que las dosis más altas del medicamento funcionen. Entonces, me podrían cambiar, reducir o suspender los medicamentos.

Adicción:
Los opioides pueden causar adicción a las drogas. El riesgo es mayor en personas que tienen antecedentes de adicción.

Es importante informarle a mi proveedor sobre mi historial personal y familiar de adicción o de uso de sustancias.

_____
_____
_____
_____
_____
_____
_____
_____

Entiendo este formulario. He podido hacer preguntas sobre estos medicamentos, las cuales me fueron respondidas.
Se me ha ofrecido una copia de este formulario.

Estoy de acuerdo con el tratamiento de mi condición con medicamentos controlados.

Firma del paciente: **X** _____

Firma del testigo: _____ Fecha: _____

N-2

Acuerdo Paciente-Proveedor Para el Uso de Medicamentos Controlados a Largo Plazo Para el Dolor Crónico

Yo, _____, y _____, hemos decidido usar medicamentos
(Paciente) (Proveedor)

controlados para tratar: _____.
(síntoma, causa)

PROPÓSITO

El propósito de este acuerdo es poner en claro lo que puedo esperar cuando me receten medicamentos controlados (como codeína, fentanilo, metadona, morfina, oxicodona, Percocet y Vicodin) como parte de mi tratamiento para el dolor. Describe lo que puedo esperar de mi proveedor y lo que mi proveedor espera de mí.

LAS RESPONSABILIDADES DE MI PROVEEDOR

Es la responsabilidad de mi proveedor evaluar mi dolor y crear y supervisar un plan de tratamiento que sea seguro y apropiado para mi condición. Mi proveedor también es responsable de asegurarse de que mi tratamiento se apegue a la ley sobre medicamentos controlados. Esto incluye asegurarse de que yo no haga mal uso de los medicamentos que se me receten y de que otras personas no obtengan ni usen mis medicamentos.

MIS RESPONSABILIDADES

Yo, _____entiendo y estoy de acuerdo con lo siguiente:
(Paciente)

- Mi plan de tratamiento puede incluir otras cosas además de medicamentos, tales como: pruebas de diagnóstico, visitas de grupo o visitas a especialistas. Acepto seguir el plan de tratamiento que mi proveedor y yo hemos acordado.
- Mi plan de tratamiento puede incluir otras cosas además de medicamentos, tales como: pruebas de diagnóstico, visitas de grupo o visitas a especialistas. Acepto seguir el plan de tratamiento que mi proveedor y yo hemos acordado.
- Sólo yo tomaré estos medicamentos. No voy a compartir, regalar, prestar, vender o intercambiar estos medicamentos. No permitiré que otros usen mis medicamentos.
- Sólo voy a tomar estos medicamentos según lo indicado.
- Mis recetas médicas no se pueden reponer antes de tiempo. Me puedo quedar sin medicamentos si tomo más de lo que mi proveedor me ha indicado.
- Sólo puedo reponer mis recetas médicas durante el horario regular de la clínica y de acuerdo con la política de reposición de mi clínica.
- Guardaré mis medicamentos como mi dinero o mis joyas. No se podrán reemplazar las recetas o los medicamentos perdidos, robados o dañados.
- No buscaré medicamentos controlados en otros lugares sin antes hablar con mi proveedor. Esto incluye la atención de urgencia y en el departamento de emergencia. Informaré a mi proveedor de inmediato si me recetan otros medicamentos controlados.

- Mis registros de farmacia podrán ser revisados.
- Me comportaré de manera respetuosa con todo el personal. No me comportaré de manera abusiva ni grosera.
- Me han aconsejado no usar drogas ilegales ni medicamentos controlados que no me hayan recetado. Se me puede pedir hacer pruebas de detección de drogas en cualquier momento.
  - Si mi prueba de drogas muestra el uso de drogas ilegales o de medicamentos controlados no recetados, mis medicamentos serán suspendidos y es posible que tenga que someterme a un tratamiento por abuso de sustancias para poder continuar recibiendo los medicamentos controlados.
  - Si mi prueba de drogas muestra que no estoy usando mis medicamentos recetados, mi proveedor puede suspender estos medicamentos.
- Cualquier tratamiento médico empieza como una prueba. Mi receta médica puede ser suspendida. Esto podría pasar si no hay signos de que los medicamentos me estén ayudando o si hay signos de daño o mal uso.
- Hablaré con mi proveedor si estoy embarazada o quiero quedar embarazada.
- Informaré a mi proveedor si estoy tomando otros medicamentos.
- Informaré a mi proveedor sobre mi historial personal y familiar de adicción o de uso de sustancias.
- Entiendo los posibles riesgos y beneficios de estos medicamentos
- Otros términos:

_____
_____
_____

- Si no cumplo con este acuerdo, mi proveedor puede dejar de recetarme los medicamentos controlados.
- Este acuerdo será revisado por lo menos una vez al año. También puede ser revisado si cambio de proveedor o dejo de cumplir con el acuerdo.

Entiendo este formulario. He podido hacer preguntas sobre este acuerdo, las cuales me fueron respondidas.
Se me ha ofrecido una copia de este formulario.

Estoy firmando este formulario porque deseo hacerlo. Acepto todos sus términos.

Paciente: **X** _____

Proveedor: _____

Fecha: _____

N-4

Puentes Pain Clinic
Patient Responsibilities for the Use of Chronic Controlled Substances

I, _____, understand and I will receive a controlled substance as part of my care at the Valley Homeless Healthcare Program / Puentes Clinic.

The purpose of the consent/agreement form is to educate you about the process about effective pain management. We hope to foster an open, trusting, and collaborative relationship between you and your pain treatment team.

I am aware that this medicine has the potential for addiction, abuse, or dangerous consequences if taken improperly. By agreeing to take opioid medications for chronic pain management, I understand that I have several important responsibilities. These responsibilities are as follows:

Initials		
_____	1.	I will take all medications as prescribed by my provider.
_____	2.	I understand that the providers at the Puentes Clinic will be the only people to write my pain prescription.
_____	3.	I will not sell these medications, or share them with others.
_____	4.	I understand that early refills will not be provided and that refills will not be available nights, weekends, or by telephone. It will be my responsibility to obtain my prescription refills in person from the provider during clinic hours before they run out.
_____	5.	If an emergency occurs or I get hospitalized and some other doctor must prescribe medication, I will inform the Puentes Clinic as soon as possible.
_____	6.	I will use only one pharmacy to fill prescriptions.
_____	7.	My providers at Puentes Clinic have my permission to speak with the pharmacy about prescriptions at any time. If I choose to change pharmacies at any time, I will first notify my provider.
_____	8.	I will give Puentes Clinic permission to communicate with any of my other providers about my health care (medical, mental, addiction, etc.).
_____	9.	I agree not to use alcohol, illegal drugs, or take other's prescription medications while taking this medication. I will fully inform my provider of any current or prior use of medications, alcohol, or illegal drugs. I agree to undergo urine or blood tests if my doctor requests.

I understand that if I fail to meet all the agreements of this contract, the Puentes Clinic providers and staff will review the conditions of my care and may decide to stop or hold the prescription of this medicine.

Patient Name _____ Date _____

Provider Name _____ Date _____

Nurse Name _____ Date _____

Clinic Day: _____

Pharmacy: _____

Date	Medication	Strength	Frequency	# of Pills	Refills

COMMENTS (add date):

COMMUNITY ORIENTED PRIMARY CARE 16.35Community Oriented Primary Care
Policy Number: 16.35

USE OF CONTROLLED SUBSTANCES IN CHRONIC PAIN MANAGEMENT

1. Purpose:

The purpose of this policy is to define minimum standards for the use of controlled substances in chronic pain management within the Community Health Network (CHN) - Community Oriented Primary Care (COPC) clinics. This document outlines the procedure by which clinics assess chronic pain, develop and monitor individualized treatment plans and document pain management in the medical record that include the use of controlled substances.

2. Statement of Policy:

I. It is the policy of COPC that all that all providers follow an approach to the use of controlled substance in chronic pain management that:

A. conforms to standards of practice set by the Medical, Nursing and Pharmacy Boards of California;

B. promotes the safe, adequate, appropriate and effective management of chronic pain that optimizes patients' functional status, addresses the risks, benefits and side effects of therapy and attempts to minimize patient misuse of prescribed medications;

C. facilitates sharing of information and coordination of care of patients with chronic pain within the CHN and with other safety net sites (e.g., the San Francisco Community Clinic Consortium (SFCCC) through the use of a shared electronic medical record (EMR).

3. Procedure:

I. Initial Pain Assessment- Providers will perform and document an initial comprehensive biopsychosocial pain assessment that follows Medical Board of California guidelines. The evaluation should include:

A. Assessment of the pain and any prior diagnostic evaluation
B. Impact of pain on physical and psychological functioning
C. History of prior pain treatment
D. Assessment of coexisting medical and/or mental health conditions
E. Substance use history
F. Documentation of the presence of one or more recognized medical indications for the use of a controlled substance
G. Relevant physical exam, including musculoskeletal and neurologic exam if indicated

II. Treatment Plan Objectives - Providers will design and document an individualized treatment plan in consultation with the patient that outlines:

A. Any planned diagnostic evaluations and/or specialty consultation (including mental health referral)
B. Any and all prescribed therapeutic modalities (e.g., medications, physical therapy, acupuncture)
C. Treatment goals by which the plan will be evaluated, such as level of pain relief, improved physical and psychosocial functioning and/or improved quality of life

III. Informed Consent - Providers will document their discussion with the patient of the risks, benefits and side effects of prescribed treatment(s) and how these issues will be monitored and addressed.

IV. Pain Management Agreement - Providers will complete and include in the medical record a pain management agreement that is signed by the provider and the patient that outlines components of the treatment plan and situations in which the plan may be reviewed, altered or discontinued.

V. Periodic Review - Providers will perform and document a periodic reassessment of chronic pain that focuses on the patient's progress toward the Treatment Plan Objectives (see above) on an annual basis (or more frequently as deemed necessary by the provider) to determine the appropriateness, continuation or modification of the treatment plan.

VI. Documentation in the Electronic Medical Record (EMR) -
Providers will use the EMR to:

A. Keep an up-to-date medication list that includes all current and previously prescribed medications noting the reason(s) for medication changes and discontinuations
B. Enter a clinical alert in the EMR that indicates that a pain management agreement has been signed and that current and previously prescribed pain medications are documented in the medication list in the EMR (this may include any special circumstances or considerations regarding the patient's pain management history and/or treatment plan)
C. Form: COPC will disseminate template forms that outline the minimum standards for executing Initial Pain Assessment, Treatment Plan Objectives, Informed Consent, Pain Management Agreement and Periodic Review. Clinics may adopt these forms as is or adapt them to suit site-specific purposes as long as the revisions preserve the minimum standards set out in the templates.

VII. Site specific policy - Each COPC site will develop individualized policies and procedures as appropriate to address:

A. Creation and maintenance of chronic pain registries
B. Monitoring for patient misuse of controlled substances that may include the use of urine toxicology screening and/or prescription monitoring programs (e.g., CURES reports)
C. Situations or conditions that constitute grounds for suspension or termination of the pain management agreement (i.e., "contract breaks")

4. Attachment:

Chronic Pain Assessment and Treatment Plan Sample Template
Informed Consent Chronic Pain Meds Sample Template
Pain Medications FAQ09 Final
Patient Provider Agreement Chronic Pain Meds Sample Template
Low Literacy Informed Consent for Long-Term Controlled Medicines - English
Low Literacy Informed Consent for Long-Term Controlled Medicines - Chinese
Low Literacy Informed Consent for Long-Term Controlled Medicines - Spanish

5. **Signed by:**
   Michael Drennan, MD, Medical Director, Primary Care Service; Barbara Garcia, MPA, Deputy Director, SFDPH; Sheila Kerr, RN, MS, Nursing Director, Primary Care Service

6. **Approval date:**
   This policy was originally approved by Primary Care Quality Improvement Committee on October 16, 2009.

COMMUNITY ORIENTED PRIMARY CARE 16.36Community Oriented Primary Care
Policy Number: 16.36

ABERRANT DRUG-RELATED BEHAVIOR IN THE USE OF CONTROLLED SUBSTANCES IN THE TREATMENT OF CHRONIC NON-MALIGNANT PAIN

1. Purpose:

The purpose of this policy and procedure is to define minimum standards for monitoring for, responding to and documenting potential aberrant-drug related behavior in the setting of chronic pain management with controlled substances within the Community Health Network (CHN) Community Oriented Primary Care (COPC) clinics.

2. Statement of Policy:

It is the policy of the COPC that all providers/clinics follow a uniform approach to monitoring for and responding to potential aberrant drug-related behavior in the setting of chronic pain management with controlled substances.

3. Definitions:

(Adapted from American Pain Society-American Academy of Pain Medicine Opioid Treatment Guidelines. *J Pain*, 10:130, 2009 and http://www.ampainsoc.org/advocacy/opioids2.htm)

Aberrant drug-related behavior: A behavior outside the boundaries of the agreed on treatment plan between provider and patient. These behaviors may be due to abuse, diversion, misuse and pseudo- addiction. (See "Monitoring for Aberrant Drug-Related Behaviors" for more details.)

Abuse: Any use of an illegal drug, or the intentional self-administration of a medication for a non-medical purpose such as altering one's state of consciousness leading to clinically significant impairment or distress.

Addiction: Behaviors that include one or more of the following: 1) impaired control over drug use; 2) compulsive use; 3) continued use despite harm; 4) craving.

Diversion: The intentional transfer of a controlled substance from legitimate distribution and dispensing channels. This may be done due to other underlying addictive disorders, for pure profit motive, or for some type of altruistic purpose.

Misuse: Use of a medication (for a medical purpose) other than as directed or as indicated, whether willful or unintentional, and whether harm results or not.

Physical Dependence: A typical response that can occur with persistent use of a drug manifested by one or more of the following: 1) increasing tolerance to the effect of a drug; 2) a drug class specific withdrawal syndrome that occurs with abrupt discontinuation, rapid dose reduction, or decreasing blood level of the drug, and/or administration of an antagonist; 3) continued use of a drug to avoid withdrawal.

Pseudo-addiction: Behaviors that may occur when pain is undertreated. Patients with unrelieved pain may become focused on obtaining medications and may otherwise seem inappropriately "drug seeking." Even such behaviors as illicit drug use and deception can occur in the patient's efforts to obtain relief. Pseudo addiction can be distinguished from true addiction in that the behaviors resolve when pain is effectively treated.

Tolerance: A typical response in which continued use of a drug leads to a decrease of one or more of the drug's effects over time sometimes requiring the use of increased amounts of the drug to achieve the desired effect.

Withdrawal: A syndrome manifested by either of the following: 1) the characteristic withdrawal syndrome for the substance; 2) the same (or closely related) substance is taken to relieve or avoid withdrawal symptoms.

4. Background:

The primary goal of chronic pain management is safe and effective treatment that optimizes pain control and functional status while minimizing side effects and aberrant-drug related behavior.

The management of chronic pain with controlled substances within COPC is complicated by the high prevalence of co-occurring substance use, mental health issues and/or other psychosocial stressors among individuals with chronic pain. These factors increase the likelihood of aberrant drug-related behaviors that may indicate abuse, diversion, misuse and/or pseudo-addiction. Unfortunately, there is a relative lack of scientific evidence to guide how to address such concerns. Nevertheless, providers can implement a rational, consistent, non-judgmental approach to monitoring for and responding to aberrant drug-related behaviors.

The goal of this policy and procedure is to help maximize benefits and minimize harms of treating chronic pain with controlled substances as well as to ensure a consistent approach throughout the COPC.

5. Procedure:

A. MONITORING FOR ABERRANT DRUG-RELATED BEHAVIORS

Providers will monitor for and document any aberrant drug related behavior as part of the standard initial and periodic assessment of chronic pain as outlined in the COPC Policy and Procedure for the Use of Controlled Substances in Chronic Pain Management. The following are tools that should be used to assist in monitoring for aberrant drug related behavior.

1. Aberrant Behavior Checklist:

The following are examples of aberrant drug-related behaviors that providers should monitor for:

- Requests for refill of controlled substances earlier than expected
- Requests for refill of controlled substances later than expected
- Requests for repeated dose escalations beyond an initial 3 month treatment period
- Requests for a specific/brand name controlled substance/dose
- Report of lost, stolen, damaged prescriptions/medications
- Missing appointments with provider
- Presenting to clinic intoxicated or under the influence of drugs
- Presenting to clinic with signs or symptoms of withdrawal
- History of overdose of controlled substances
- Not adhering to the treatment plan, including adjuvant therapies, diagnostic tests and specialty consultations
- Request for pill count is refused or there is a pill count discrepancy

- Toxicology screening is refused or altered (see appendix)
- Toxicology screening indicates that prescribed medications are absent
- Toxicology screening demonstrates illicit drug use
- Toxicology screening demonstrates use of non-prescribed controlled substances
- Obtaining controlled substances from another provider
- Abusive or threatening behavior towards staff
- Physical violence toward staff
- Altering or stealing a prescription
- Declining functional status despite appropriate therapy
- Arrest for selling prescription controlled substances
- Controlled substance dose reduction in a hospital/other supervised setting due to oversedation

2. Urine Toxicology Screening:

All patients receiving controlled substances for the treatment of a chronic pain condition shall undergo urine toxicology screening within three months of initiation of therapy and at least annually thereafter to monitor for use of prescribed and non-prescribed controlled substances and illicit substances. Ideally, this is a random, unannounced screen. The purpose of this testing will be explained to the patient at the initiation of therapy and each time the testing is done. Testing will always include a brief questionnaire and documentation by the staff (See Appendix).

It is important that providers understand how to interpret the results of urine toxicology screening, especially in the absence of the prescribed substance and/or the presence of metabolites (See Appendix).

3. Pill counts:

For those individuals for whom urine toxicology screening is not feasible (e.g., patients with anuria or neurogenic bladder) and/or those for whom some level of drug diversion is suspected (e.g. presence of both prescribed drug and illicit substance in urine toxicology screening), providers may use pill counts as a way to monitor patient use of the prescribed medication(s).

4. CURES reports:

The CURES program generates a report of all controlled substances prescriptions filled by a patient in the last 3 to 12 months in California. Providers should consider using this tool if there is concern that a patient may be obtaining prescriptions from multiple prescribers.

B. ADDRESSING ABERRANT DRUG-RELATED BEHAVIOR

The occurrence of aberrant drug-related behavior always suggests the need for re-evaluation and perhaps a change in therapy. Providers should formulate a differential diagnosis when evaluating suspected aberrant drug-related behaviors that include: self-treatment of poorly controlled pain (pseudo addiction), inaccurate toxicology screening results (see appendix), drug abuse or addiction, co-occurring mental health/psychosocial issues and/or diversion. The response to aberrant drug-related behavior reflects a clinical judgment about its seriousness, its cause or causes, the likelihood that behaviors of this type will recur, and the

clinical context. (Adapted from American Pain Society-American Academy of Pain Medicine Opioid Treatment Guidelines, 2009)

1. **Initial Episode of Aberrant Drug-Related Behavior:**
   Each occurrence of aberrant behavior should trigger a timely documented review by the provider of the treatment plan and the patient-provider agreement. Depending upon the type of behavior noted, the response may range from "closer monitoring" to "discontinuing the prescription." (See below. See appendix for various scenarios and recommended responses.)

2. **Multiple Episodes of Aberrant Drug-Related Behavior:**
   Every health center is required to have a mechanism to perform a documented review by the medical director/designee, provider peer or treatment team whenever there is 1 or more episodes of aberrant behavior on 3 separate occasions within 1 year.

3. **Discontinuation of Prescribed Controlled Substances:**
   Discontinuation of controlled substances should be strongly considered when there is a clear and consistent pattern of aberrant drug-related behavior (excluding pseudo-addiction) despite repeated provider interventions. In general, should the provider decide to discontinue controlled substances, the medications should be tapered to avoid withdrawal unless there is reasonable evidence that the patient is not taking the controlled substance.

6. **Attachment:** Links to attachments here

7. **Signed by:**
   Michael Drennan, MD, Medical Director, Primary Care Service; Barbara Garcia, MPA, Deputy Director, SFDPH; Sheila Kerr, RN, MS, Nursing Director, Primary Care Service

8. **Approval date:**
   This policy was originally approved by Primary Care Quality Improvement Committee on October 16, 2009

Edwin M. Lee
Mayor

San Francisco Department of Public Health
Community Oriented Primary Care
Tom Waddell Health Center/
Homeless Programs
50 Ivy Street
San Francisco, CA 94102
Telephone: (415)-355-7400
FAX: (415)-355-7407

TITLE: URINE TOXICOLOGY SCREENING

STATEMENT OF POLICY

1. Nursing staff (RN, MEA) is responsible for obtaining a urine toxicology screening test on all patients who are prescribed controlled pain medications.
2. All patients who are taking controlled pain medications will need a urine toxicology screening at least once every year.
3. Nursing staff must first obtain informed verbal consent prior to urine being tested.
4. This policy serves as a standing order for nurses to perform urine toxicology screening on patients taking controlled pain medications.

RELEVANT DATA

Urine toxicology screens cannot be performed legally without express verbal consent by the patient. The conditions of admission do not cover or imply consent for toxicology screening.

EQUIPMENT

1. Toxicology Slip
2. Specimen Container

PROCEDURE

1. Nursing staff will obtain verbal consent for urine toxicology screens using the Urine Toxicology Screening and Consent form on all patients who are prescribed controlled pain medications who are due for their annual drug screen or if ordered y the provide (See Appendix A).

a. Screening Questions:
   1. When was your last dose of pain medication?
   2. Have you taken any other medications for pain in the past week?
   3. Have you used any other drugs or non-prescribed medications in the past week?
   4. Is there anything else you would like us to know?

2. After informed verbal consent is obtained, ask patient to urinate (at least 50 ml) into a specimen cup. The laboratory requires 50 ml to complete a thorough screening.
3. Label specimen appropriately with patient's name, medical record number, and the date.
4. Complete appropriate lab slips, and attach to specimen. Place in lab basket for

messenger pick up.
5. Document urine obtained and sent to lab in Urine Toxicology Screening and Consent form.
6. If patient refuses to give consent, mark “Refused” in the form and inform medical provider.

Appendix:
A: Urine Toxicology Screening & Consent Form

Reference:
SFGH Labor and Delivery Policy Number 20.3: Toxicology Screening in Labor and Delivery (03/09)

Adapted by:
Carlos M. Salazar, RN, PHN, MSN, Nurse Manager

Approval:

_____
Barbara Wismer, MD, MPH
Medical Director, Primary and Urgent Care

_____
Deborah Borne, MD, MSW
Medical Director, Community and Homeless Services

Date Adopted: 1/11
Reviewed: 1/11
Revised: 1/11/11

COPC Approval: Pending

P:\My Documents\TWHC Policies & Procedures1/11/11

Tom Waddell Health Center

Urine Toxicology Screening and Consent

Patient Label

I. Screening Questions:

1. When was your last dose of pain medication?
   - ☐ Today Time:_____
   - ☐ Yesterday Time:_____
   - ☐ Date:_____

2. Have you taken any other medications for pain in the past week?
   - ☐ No
   - ☐ Yes: Name of other meds:_____
     Most Recent Date Taken:_____

3. Have you used any other drugs or non-prescribed medications in the past week?
   - ☐ No
   - ☐ Yes: Name of other meds:_____
     Most Recent Date Taken:_____

4. Is there anything else you would like us to know?

II. Patient Consent:

"As part of your Controlled Substance Patient-Provider Agreement, your provider is requesting a urine toxicology screen. Can you please provide me with at least 50 cc. of urine in this cup?"

- ☐ Verbal consent given by patient; Urine collected & sent to lab
- ☐ Patient refused: Refer to Medical Provider

Notes:

Screener's Signature:	Provider's Signature:
Screener's Name:	Provider's Name:
Date:	Date:

Provider's Essential Elements for Presentation to the Yellow Flag Committee

Tom Waddell Health Center, San Francisco Department of Public Health

- What "red flags" brought the client's name to this committee?
- Length of time client has been coming to TWHC, where seen before TWHC?
- Other community providers? (Mental Health, Case Managers)
- Medical History, including diagnosis for opiate prescriptions
- Mental Health History – hospitalizations, suicidality, therapy history, medical history
- Substance use – including periods of sobriety, treatment
- History of cognitive impairments, head injuries?
- Education, Health Literacy
- Social history – housing, emotional supports, financial resources
- Family history
- History of incarcerations
- What does the Provider think is going on?
- What is the client's (and the clinic's) potential for constructive change?

Template for Yellow Flag Committee

Are there any other questions for the presenter?

Safety Concerns – Will continued prescribing of controlled substances put the staff at risk? The client? Other TWHC clients?, or the public (through diversion or aberrant behavior of client)?

Can a care plan be devised to eliminate or greatly decrease safety concerns?

Ciient Functionality – Is client's life moving forward, improving (Look at client's behavior in clinic, money management, medical status, hygiene, housing status, ability to keep appointments, establish relationships, life goals).

Substance Abuse issues – Have prescribed opiates accelerated or decreased client's drug use? Does client continue to ask for higher opiate doses, or specific opiates? What do UA toxs look like? Do you think client may be undermedicated or diverting?

Mental Health – Is it stabilizing or worsening as a result of controlled substances?

What is this cleint's and team's potential for constructive change?

Yellow Flag Committee Guidelines

Purpose: To seek Team Assistance in managing clients whose use of prescribed opiates has become problematic for the client, the staff at TWHC and other clients.

Primary Care Provider presents the client and formulates a question for the panel to consider. If the client's name is brought to the committee by someone other than the provider, the provider must still be present. As many members as possible who are part of the client's Primary Care Team should be present. The team must be multi-disciplinary, including RN, SW, HCW, MEA, Eligibility, etc. There should be about 6 people on the team – a varying mix is o.k. as long as at least 4 people are present. Committee members will periodically rotate (Q3-4 mos). They can be appointed as necessary by administration. One team member will facilitate the meeting – another will write up the recommendation . The Primary Provider should come prepared (see "Essential Elements") , able to state the goals of treatments for the client being reviewed.

The initial question (i.e. "Should I keep prescribing narcotics for this client?") will lead to the key issues for the committee to discuss. Key issues for Review (see Template):

1. Safety concerns – for staff, client, and other clients of TWHC, diversion to the community.
2. Client functionality – is client getting better or worse with narcotic prescriptions?
3. Substance Abuse issues and connection to narcotics
4. Mental Heatlh – stabilizing, worsening with prescriptions?
5. Is client keeping critical appts – at TWHC, or specialty clinics?
6. Is client maintaining housing (or pursuing getting it)?
7. What is the potential for constructive change?
8. Any other questions of the PMD?

After a review of these issues the committee will formulate a recommendation based on the goals of treatment. The recommendation may involve:

1. Suggested changes to prescribing plan (Weekly meds, pill counts, etc.)
2. Change in frequency of visits
3. Monitoring of client's over-all functionality
4. Behavioral plan (not necessarily a contract).
5. Another review by the committee , or a review by the client's Primary Care Team.
6. Addiction med consult with Dr. Zevin
7. Case conference with client's outside providers (SOM MH, ie).
8.

The Committee's final report will be concise and useful:

Example:

GOAL	PLAN
Decrease etoh in-take	Attend Harm Reduction Groups
Take Oxycontin as prescribed	Weekly pills counts, UA Tox

The recommendation will be placed in the chart. A F/U time to review client's progress will be scheduled before the meeting is over.

TWHC staff will become familiarized with this new committee as it will will be discussed in discipline meetings. Potential pitfalls are scheduling, lack of buy-in by staff, insufficient training of staff. Administration might want to trouble shoot these issues before introducing topic to the whole clinic.