

PATIENT-CENTERED SAFE OPIOID TAPERING RESOURCE GUIDE

For primary care providers

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Acknowledgement

This guide was developed by Cigna's clinician-based opioid taper workgroup, which includes clinicians with expertise in primary care, musculoskeletal surgery (orthopedic and spine), pain management, behavioral health, addictionology, and pharmacy. Its goal is to support primary care providers (PCPs) in their assessment and management of patients with pain. The guide focuses on safe, patient-centered tapering from opioids, and provides alternative and complementary treatment options based on the latest information from the Centers for Disease Control and Prevention (CDC), the Substance Abuse and Mental Health Services Administration (SAMHSA), the American Society of Addiction Medicine (ASAM), and the U.S. Department of Health & Human Services (HSS).

Overview

In recent decades, a dramatic increase in opioid medication prescriptions has been accompanied by an increase in opioid overdoses¹, with more than 33,000 opioid overdose deaths occurring in 2015² alone. Opioid misuse and addiction can happen fast, and it can be deadly. One in five people are at an increased risk of opioid addiction after taking opioids for just 10 days.

Higher prescribed opioid doses are associated with overdose risk³⁻⁵, opioid use disorder (OUD), depression, fracture, motor vehicle accident, and suicide⁶⁻¹⁰. Dose reduction, or drug discontinuation, or opioid tapering, may decrease these risks. Evidence-based guidelines recommend tapering when the risks outweigh the benefits^{11,12}.

Helping your patients to decrease or discontinue long-term opioid therapy (30 days or greater) can present a challenging clinical scenario, especially for patients on high doses (greater than 90 morphine equivalent doses [MEDs]), with moderate to severe chronic pain, and co-occurring mental health disorders, such as depression, anxiety, and post-traumatic stress disorder (PTSD)¹³. Some individuals who have been on opioids for years or decades may require years to taper their dose.

It is important to incorporate evidence-based protocols, validated assessments, alternative therapies, and non-pharmacologic treatment options, as well as maintain a therapeutic alliance with your patient. This will help to promote successful tapering, and decrease the risks related to opioid use, including overdose.

Purpose and scope

The purpose of this resource guide is to provide PCPs with evidence-based clinical tools to promote effective management of high-risk patients with pain who are taking opioids. The goal is to help decrease risks related to opioid use, and drive success in tapering opioid use safely and compassionately.

Please note: These guidelines are not intended for patients who are in active cancer treatment, acute care (hospitalized), receiving palliative care or end-of-life care, or have sickle cell disease.

This resource guide includes:

- Evidenced-based treatment guidelines for tapering opioids.
- Validated assessment tools¹⁴ to assess and determine referral needs.
- Management of opioid withdrawal symptoms.
- Care coordination and referral recommendations: Behavioral health, pain management specialists, and alternative services and therapies
- Considerations for managing OUD in pregnancy.
- Naloxone prescribing considerations.
- Substance use disorder (SUD) relapse prevention and recovery tips.
- Provider-patient communication tools and resources.

Assessment: Determine risk and treatment needs

Review patient history

To assess and determine the risk of overdose and the risks related to long-term opioid use, it's important to review the patient's history.

Pain management

- Assess what type of pain the patient has.
- Determine how long the patient has had this pain.
- Find out what has been done to address the pain. Evaluate what has been effective and what has not been effective.
- Use evidence-based pain and functional assessments, such as the Oswestry Low Back Pain Disability Questionnaire ([Exhibit C](#)) or The Veterans Rand 12-Item Health Survey (VR-12) ([Exhibit H](#)). Determine if a referral to a pain specialist is indicated.

Pharmacy

- Review medications and treatments (e.g., dose, length of time taking this medication), as well as all other medications that have already been tried and optimized, including high-risk medications (e.g., opioids, benzodiazepines, and sleep aids).
- Follow your state's prescription drug monitoring process (PDMP). Determine if non-opioid therapies have been optimized.
- For additional information, go to the PDMP Training and Technical Assistance Center website (PDMPAssist.org).

Medical history

- Assess risks, such as respiratory disease, sleep apnea, or other comorbidities that may make the individual susceptible to opioid toxicity or respiratory distress, or conditions where safe opioid use has not been established, such as in pregnancy.
- If the patient is pregnant and you suspect SUD or OUD, see "[Management of substance use disorders in pregnancy](#)" on page 14.
- Evaluate overall nutritional intake (a poor diet contributes to inflammation) and nutritional supplements being taken (type, dosage, frequency considered for drug or nutrient interactions).

Oversedation risk

- Assess for risks of oversedation as evidenced by physical symptoms (e.g., nodding off, stupor, or overdose based on observation and family member or caregiver accounts).
- If present, taper the dose and educate the patient, family, and caregiver(s) on how to identify an overdose and use Naloxone.

Ability to control use of medications

- Assess the patient's ability to control use of medications and take them as prescribed via a urine toxicity screen and PDMP verification (to help you identify requests for early medication refills and unusual high-risk medication-fill patterns).
- If the patient has difficulty controlling use of the medications, consider adjusting, tapering, or stopping use based on risk.
- Provide education on how to identify an overdose and use Naloxone.

Behavioral

- Assess comorbid behavioral conditions (SUD or OUD).
- Access validated assessments to screen for risk, and support treatment plan and care coordination needs.
- Educate and make a referral to behavioral health (counseling, medication management, or both) if a patient has a positive screen for depression or anxiety.
 - ✓ [Patient Health Questionnaire \(PHQ\)-4](#)
 - ✓ [Generalized Anxiety Disorder-7 \(GAD-7\)](#)
 - ✓ [PHQ-9](#)
 - ✓ [SAMHSA Suicidal Assessment tool SAFE-T](#) if patient scores high on the PHQ-9
- Screen for mania or bipolar disorder.
 - ✓ [Mood Disorder Questionnaire \(MDQ\)](#)
- Screen for SUD or OUD. (If a patient has SUD or OUD, or risk factors for it, and there is a positive screen, consider tapering the opioid, along with medication-assisted treatment (MAT) or detoxification based on the risk, need, or both.)
 - ✓ [Opioid Risk Tool \(ORT\)](#)
 - ✓ Current Opioid Misuse Measure® (COMM)
 - ✓ [CAGE-AID](#)
- Determine if there is a history of overdose, suicide, or both
- Assess for co-occurring substance use (e.g., alcohol, cocaine, methadone)

Social and family support

- Review history, such as death, divorce, job loss, recent move, incarceration, homelessness, family and social support, and work and productivity.

Reminders

- ✓ When concerns exist specific to destabilizing a behavioral health condition (e.g., SUD) or a medical health condition (e.g., severe hypertension or unstable coronary artery disease [CAD]), consider seeking a specialist consultation and support prior to tapering.
- ✓ Spontaneous abortion and premature labor have been associated with opioid withdrawal during pregnancy. Refer to or consult with a specialist.
- ✓ When a patient's screen identifies him or her as being at a high risk, and the individual remains on opioids to treat pain, consider an increased level of monitoring.

When to taper, wean, or discontinue opioid treatment

Prior to tapering, engage patients in shared-decision making, including patient's values, goals, concerns, and preference. During the tapering process, use an interdisciplinary approach to support alternative and non-pharmacological and pharmacological management.

Tapering may be right for patients who:

- Have medical comorbidities that can increase risk (e.g., lung disease, sleep apnea, liver disease, renal disease, fall risk, advanced age, pregnancy). Use caution when there is chronic use of opiates.
- Are requesting a dosage reduction.
- Do not have a clinically meaningful improvement in pain and function (e.g., at least 30% improvement on the three-item Pain, Enjoyment, General Activity [PEG] scale).
- Are on dosages \geq 50 morphine milligram equivalent (MME) day, without benefit, OR taking opioids that are combined with benzodiazepines.
- Experience an overdose OR other serious adverse event involving opioids or other substances.
- Show early warning signs for overdose risk, such as confusion, sedation, or slurred speech.
- Do not adhere to the treatment plan OR exhibit unsafe behaviors (e.g., they ask for early refills, report the drugs as lost or stolen, buy or borrow opioids, do not obtain a urine drug screen [UDS], or the UDS is aberrant).
- Have an increased risk of SUD due to other concerns (e.g., aberrant behaviors, 30+ years of age, family history, personal history of SUD).
- Show signs of SUD (e.g., work or family problems related to opioid use, difficulty controlling use).
- Use other medications that increase risk (such as benzodiazepines).
- Have mental health comorbidities that can worsen with opioid therapy (e.g., PTSD, depression, anxiety).

Prior to tapering, weaning, or discontinuing opioid treatment

- Address both pain and OUD in patients with chronic pain** who have developed OUD from opioid analgesic therapy. The risk of overdose and other adverse events may increase if you either taper the opioid analgesic or continue to prescribe the opioid without providing OUD treatment. Refer to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) for OUD criteria.
- Assess for clinical red flags that warrant a medical specialist referral or additional diagnostics, including:**
 - ✓ Progressive numbness or weakness
 - ✓ Progressive changes in bowel or bladder function
 - ✓ History of cancer
 - ✓ Unexplained weight loss
 - ✓ Signs of infection (e.g., fever, recent skin or urinary infection, immunosuppression, IV drug use)
- Address treatment and support for conditions that complicate pain management before initiating the taper** (e.g., PTSD, suicidal thoughts, depression, anxiety, bipolar disorder).
 - ✓ If an OUD is present, MAT may be appropriate. Treatment options include opioid agonist therapy (OAT) – buprenorphine/Naloxone (Suboxone®) or methadone maintenance Extended Release (ER) Injectable Naltrexone (Vivitrol®)
 - ✓ If an OUD is suspected, recommend a behavioral evaluation to further assess treatment needs.

- Frame the conversation around tapering as a safety issue and shared decision approach.** See “[The BRAVO Protocol](#)” on page 8.
- Discuss a reasonable taper timeline.** Agree to a start date, a completion date, and a shared plan.

Example of a *slow* taper:

Current opioid: Morphine SR 120 mg two times per day (bid)
 Calculate total daily opioid dose: Total daily dose- 240 mg per day
 Calculate daily opioid dose reduction – typically 5-10%

5%= 12 mg
 10%= 24 mg

Reduce dose every two to four weeks, depending on your patient’s response and tolerance to the taper.

Example of *rapid* taper:

Current opioid: Morphine SR 120 mg bid-
 Taper/reduction plan: Decrease morphine SR 120 mg bid to 90 mg bid x 3 days, 60 mg bid x 3 days, then 30 mg bid x 3 days, then 15 mg bid x 3 days, then 15 mg every bedtime (qhs) x 3 days, then stop.

*If multiple drugs are involved, determine where the highest risk lies and begin tapering that agent first. **Assure that the support system, including behavioral supports, are in place for the patient.***

- Determine the rate of taper based on the degree of risk** (e.g., 5-10 percent decrease per month to promote successful taper).
- Incorporate a [pain flare-up management plan](#)** to support the patient’s shifting pain levels during the taper (see Resources and tools below).
- Provide information to the patient and establish **behavioral supports before starting the taper.**

Resources and tools

- PEG Scale** – To assess pain and function (baseline and follow up), go to the Washington State Agency Medical Directors’ Group website (AgencyMedDirectors.wa.gov > Assessment Tools > [Pain, Enjoyment of Life, General Activity \(PEG\)](#)).
- Pain flare-up management plan** – Go to the U.S. Department of Veterans Affairs website (VA.gov) > Health Care > More Information and resources: Veteran’s programs for health and wellness > Health Needs & Conditions > Health Topics A-Z > P > Pain Management > Veterans/Public > Self-Management > Resources > [Flare-Up Management and Planning](#) (PDF).
- The Bravo Protocol** – See the next page or visit the Oregon Pain Guidance Clinic (OregonPainGuidance.org > Pain Treatment guidelines > Tapering – Guidance & Tools > BRAVO Overview > BRAVO Detailed Guidelines: [BRAVO Protocol for Tapering – Detailed Description](#)

The BRAVO Protocol

B = Broaching the Subject

- ✓ Suggesting an opioid taper can trigger anxiety.
- ✓ Identify this feeling for patients, normalize it, and express empathy.
- ✓ Make clear that the opioid taper was carefully considered, was not impulsive, and is not punitive.

R = Risk – Benefit Calculator

- ✓ Consider the risks of long-term opioid therapy, and weigh against the benefits in this patient.
- ✓ Is MED > 90 mg? Are there medical comorbidities? Are there side effects? Is there a lack of functional improvement? Is there a lack of significant pain relief despite dose increases?
- ✓ Is there dangerous co-prescribing, such as benzodiazepines? If there is, what do you taper first?

A = Addiction Happens

- ✓ Misuse of opioids in long-term opioid therapy is common, and can predict subsequent addiction.
- ✓ Physical dependence, withdrawal, and tolerance by themselves do not define addiction.
- ✓ Addiction refers to behaviors associated with opioid use. Think of the four c's: Control, compulsion, craving, and continued use (despite consequences).
- ✓ Normalize the concept of addiction to medications prescribed for pain, and reassure patients that there are effective treatments.

V = Velocity Matters

- ✓ Tapering too fast is the most common mistake physicians make.
- ✓ It's OK to take breaks in the taper schedule, but never go backward during the taper.
- ✓ Validate the patient's experience of opioid withdrawal, which may initially increase body pain. Pain from withdrawal will resolve, and doesn't mean any underlying condition is worsening.
- ✓ Use other medications to mitigate some of the symptoms of withdrawal.

O = Other Strategies for Coping with Pain

- ✓ Teach patients these three dialectical behavioral techniques:
 1. **STOP:** Stop, Take a breath, Observe internal and external experiences, and Proceed mindfully.
 2. **Opposite action skills:** Act opposite to a negative emotional urge when pursuing values or goals.
 3. **Radical acceptance:** Accept reality as it is, and not as you wish it would be.

How to taper, wean, and discontinue opioids

Tapering plans should be *individualized and minimize symptoms of opioid withdrawal, while maximizing pain treatment* with non-pharmacological therapies and non-opioid medications. It's important for your patient to be part of the planning process to buy in and adhere to an agreed-upon plan. To help ensure his or her understanding, have the patient repeat the plan back to you.

When undertaking an opioid taper plan, keep in mind that although there may be a taper schedule in place, you may need to deviate from it (e.g., pause), or adjust the rate, intensity, or duration of the taper, depending on how your patient is responding to it, including pain, function, withdrawal symptoms, and other life events.

The CDC recommends decreasing the original dose by 10 percent each week as a reasonable starting point. Some patients who have taken opioids for a long time may find that a slower taper (such as 5-10 percent each month) is easier. Once the smallest available dose is reached, you can extend the interval between doses. You may stop opioids when your patient is taking them less than once per day. For longer-acting drugs and more stable patients, use a slower taper plan. For shorter-acting drugs and less stable patients, use a faster taper plan.

For additional information, refer to the [CDC Pocket Guide: Tapering Opioids for Chronic Pain \(see Resources and tools below\)](#).

General approach:

- Determine opioid formula** (short vs. long acting).
- Establish dosing interval** (scheduled and consistent dosing is preferred to dosing as needed, to manage pain and decrease withdrawal symptoms).
- Use a MED calculator** to help plan your tapering strategy. Examples include:
 - ✓ CDC Opioid Prescribing Guideline Mobile App.
 - ✓ Oregon Conversion Calculator (Oregon Pain Guidance) Online MED calculation tool.
- Establish rate of taper** based on your patient's health history, preferences and risk factors.
- Proactively consider adjuvant medications**, such as antidepressants, gabapentin, nonsteroidal anti-inflammatory drugs (NSAIDs), clonidine, and anti-nausea/antidiarrheal agents.
- Adjust the rate and duration of the taper** according to the *patient's response* (i.e., pain, function, and withdrawal symptoms).
- Don't reverse the taper.** However, you may slow or pause the rate while monitoring and managing withdrawal symptoms.
- Frequent follow up.** See the patient frequently during the process, and stress the importance of behavioral supports.
- Consider UDS, pill counts, and PDMP to help determine adherence.

Caution: Reducing the dose immediately or rapidly over a few days or weeks may result in severe withdrawal symptoms and is best carried out in a medically-supervised setting.

Resources and tools

- CDC Pocket Guide: Tapering Opioids for Chronic Pain** – Go to [CDC.gov](https://www.cdc.gov) > More > Injury, Violence & Safety > Opioid Overdose Prevention > Information for Providers > Guideline Resources > Clinical Tools > [Pocket Guide: Tapering Opioids for Chronic Pain](#).
- Opioid Conversion Calculator (Oregon Pain Guidance) Online MED calculation tool** – Go to OregonPainGuidance.org > Tools > Opioid Conversion Calculator > [MED calculator](#).

❑ **CDC Opioid Prescribing Guideline Mobile App** – Go to [CDC.gov](https://www.cdc.gov) > More > Injury, Violence & Safety > Opioid Overdose Prevention > Information for Providers > Guideline Resources > [Mobile App](#). You can also view a [PDF](#).

Management of opiate withdrawal

Opioid withdrawal syndrome refers to the wide range of symptoms that occur after stopping or dramatically reducing the dose of opioid drugs after heavy and prolonged use. For short-acting opioids, such as heroin and oxycodone, symptoms usually emerge within 12 hours of the last opioid use, peak within 24-48 hours, and diminish over three to five days. For long-acting opioids, withdrawal symptoms generally emerge within 30 hours of the last exposure, and may last up to 10 days.

Although distressing, opioid withdrawal syndrome is rarely life-threatening. However, abrupt discontinuation of opioids is not recommended because it may precipitate withdrawal, lead to strong cravings, and result in a failed taper and potential relapse.

Consider using the Clinical Opiate Withdrawal Scale (COWS) assessment to better monitor and manage patient’s withdrawal symptoms during the opioid taper process. (See Exhibit A).

Stage	Grade	Physical signs and symptoms	Treatment options
Early withdrawal (8-24 hours after last use)	1	Lacrimation, rhinorrhea, diaphoresis, yawning, restlessness, insomnia	Antihistamine or trazadone
	2	Piloerection, myalgia, arthralgia, abdominal pain	<ul style="list-style-type: none"> • NSAIDs or acetaminophen for muscle and joint pain • Loperamide or bismuth subsalicylate for abdominal cramping
Fully developed withdrawal (1-3 days after last use)	3	Tachycardia, hypertension, tachypnea, fever, anorexia	<ul style="list-style-type: none"> • Clonidine for autonomic symptoms • Ondasetron or H2 blocker for nausea
	4	Diarrhea, vomiting, dehydration, hypotension	<ul style="list-style-type: none"> • Loperamide for diarrhea • Oral rehydrating solutions
Post-acute withdrawal syndrome (PAWS)	NA	Mood swings, anxiety, irritability, anhedonia, fatigue, poor concentration, insomnia	<ul style="list-style-type: none"> • Assessment of behavioral health comorbidities • Relaxation techniques • Self-care • Relapse prevention strategies

Resources and tools

❑ **ASAM National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use: Tapering Opioids for Chronic Pain** – Go to [ASAM.org](https://www.asam.org) > Resources > Clinical Resources > the ASAM National Practice Guideline > [National Practice Guideline](#).

Intervention and treatment

Behavioral health referral considerations

Outpatient

You may want to consider **cognitive behavioral therapy**, **referring the patient to a psychiatrist**, or both in cases where there is:

- Higher opioid doses or longer-term opioid use requiring behavioral intervention.
- Polypharmacy with narcotics (opioids with benzodiazepines or other sedatives).
- Active addiction, history of addiction, or a SUD requiring intervention (e.g., (MAT).
- A positive behavioral health assessment screen (e.g., depression – PHQ-4 and PHQ-9; anxiety – GAD-7) or other behavioral health diagnosis.
- Limited improvement, continued pain, fear avoidance affecting recovery, or no behavioral health treatment.
- Disability or pending disability.
- MAT for patients with OUD or SUD

Do not attempt to initiate tapering with patients who have an OUD or SUD, as it may increase the risk for potential overdose or suicide. Instead, a referral for MAT is recommended. This therapy is recommended for patients who need and want to quit their use of opiates, including heroin. It uses FDA-approved medications, in combination with counseling and behavioral therapies, to provide a "whole-patient" approach to the treatment of OUD or SUD. Refer to the DSM-5 for OUD criteria.

Three medications are commonly used to treat opioid addiction:

- Methadone** – clinic-based opioid agonist that does not block other narcotics while preventing withdrawal; daily liquid dispensed only in specialty regulated clinics
- Naltrexone** – office-based, non-addictive opioid antagonist that blocks the effects of other narcotics; daily pill or monthly injection
- Buprenorphine** – office-based opioid agonist or antagonist that blocks other narcotics while reducing withdrawal risk; daily dissolving tablet, cheek film, or six-month implant under the skin

Note: It is important that the patient achieves abstinence through a medically supervised opioid withdrawal or other means. SAMHSA has developed the MATx mobile app for providers, which allows immediate access to vital information about MAT for OUD.

Benefits of MAT

MAT has proven to be effective in helping patients curb opioid cravings. It decreases opioid use, opioid-related overdose deaths, criminal activity, and transmission of infectious disease for patients with a SUD. MAT increases social functioning and treatment retention. Patients with OUD or SUD who are treated with medication are more likely to remain in therapy compared with those who did not receive medication.

Inpatient detoxification

You may want to consider inpatient detoxification for patients who need:

- Around-the-clock intensive, psychiatric, medical, and nursing care, including continuous observation and monitoring.
- Acute management to prevent harm or significant deterioration of functioning, and ensure the safety of the individual or others.
- Medications to be prescribed and frequently adjusted, as indicated, to assure that the individual has a safe and effective withdrawal from alcohol, sedative-hypnotic medications, or opiates.

- ❑ Daily monitoring of medication effects and side effects to assure a safe taper and withdrawal.

Resources and tools

- ❑ **SAMHSA: Mental Health and Substance Use Disorders** – Go to the SAMHSA website (SAMHSA.gov) > Find Treatment > [Learn More: Mental Health and Substance Use Disorders](#).

Recovery and relapse prevention

Symptoms or triggers to use	Relapse prevention tips
<ul style="list-style-type: none"> • Withdrawal symptoms (e.g., anxiety, nausea, physical weakness) • Post-acute withdrawal symptoms (e.g., anxiety, irritability, mood swings, poor sleep) • Poor self-care (stress management, eating, sleeping) 	<p>See Management of Opiate Withdrawal (see page 10).</p>
<ul style="list-style-type: none"> • People (old friends who use drugs) • Places (where the patient used drugs or used to buy them) • Things (that were part of using drugs or that remind the patient of using them) • Uncomfortable emotions (Hungry, angry, lonely, tired [HALT]) 	<ul style="list-style-type: none"> • Play the tape of what happens when using drugs. • Talk to someone who isn't using drugs for support. • Go to a meeting or a recovery group, or speak with your counselor, doctor, or a trusted advisor. • Improve self-care – get good sleep, eat nutritious food, and increase activity level.
<ul style="list-style-type: none"> • Relationships and sex (can be stressful if anything goes wrong) • Isolation (gives patient too much time to be with their own thoughts) • Pride and overconfidence (the patient thinks he or she doesn't have a drug or alcohol problem, or that it is behind them) 	<ul style="list-style-type: none"> • Go to a meeting or a recovery group, or speak with your sponsor or counselor, doctor, or a trusted advisor. It's important to build a clean and sober recovery network. • Create a daily structure focused on maintaining recovery, and schedule time with someone you trust (e.g., your sponsor or a support person engaged in successful recovery). • Go to counseling (highly recommended to support relapse prevention).

Overdose prevention: Naloxone

Naloxone prescribing considerations

Naloxone is a medication approved by the U.S. Food and Drug Administration (FDA) to prevent overdose by opioids. SAMHSA and the CDC provide guidance on when providers should consider including Naloxone as part of a patient's opioid prescription, such as when the patient:

- Takes high doses of opioids (greater than or equal to 50 MME).
- Has a comorbid condition that may make them at risk for an overdose (e.g., breathing disorders, pregnancy, prior overdose, mental health conditions).
- Is currently using a benzodiazepine.
- Is completing mandatory opioid detoxification or abstinence programs.

Other considerations to prescribe Naloxone include when the patient:

- Is over the age of 65.
- Lives in a household where there are other people at risk of overdose, such as children or someone with a SUD.
- Has difficulty accessing emergency medical services (e.g., due to distance, remoteness, lack of transportation, homelessness, or no phone service).
- Recently received substance use treatment, was incarcerated, or had a period of abstinence with a history of drug abuse.
- Has a history of suicide attempt(s) or overdose.
- Has a concurrent prescription or is taking over-the-counter medications such as:
 - ✓ Antipsychotics
 - ✓ Antiepileptics
 - ✓ Muscle relaxers
 - ✓ Hypnotics
 - ✓ Antihistamines

For elderly patients, review the BEERS medication list for possible drug interactions.

Note that the CDC guidelines advocate co-prescribing Naloxone for anyone who is taking a daily MME of 50 mg or more, and have risk factors for a possible opioid overdose. In your risk-management plan for those on high-dose chronic opioid therapy, consider the value of co-prescribing Naloxone, and educating the patient on how to use it in the home.

When Naloxone is prescribed, it is important to educate the patient's caregivers and support system on the safe administration of Naloxone in case an overdose occurs and to prevent overdose death.

Resources and tools

- SAMHSA: Medication-assisted treatment** – Go to [SAMHSA.gov](https://www.samhsa.gov) > Programs > Medication-Assisted Treatment > [Medication for Opioid Overdose Naloxone](#).

Management of substance use disorders in pregnancy

Considerations for pregnant women with OUD

- ❑ Make a referral for SUD treatment to safely monitor and manage the patient and fetus.
- ❑ Consider pharmacotherapy, which is preferable to medication withdrawal, followed by drug-free psychosocial treatment to decrease the rate of a potential relapse.
- ❑ Counsel the woman about options with a shared-decision approach. For example, the choice of pharmacotherapy (methadone versus buprenorphine) is often a shared decision.
- ❑ Conduct a pretreatment maternal evaluation, which should include:
 - ✓ Detailed psychosocial history.
 - ✓ Screening for hepatitis C, sexually transmitted diseases, and other infections.
 - ✓ Sonographic examination of the fetus.
- ❑ Determine if additional steps need to be taken after initial stabilization and initiation of pharmacotherapy.
- ❑ Evaluate the need for outpatient antepartum fetal testing, such as a non-stress test and biophysical profile. It may not be needed when a woman demonstrates good compliance by a negative UDS, and shows no standard indications for fetal surveillance.
- ❑ Consider additional fetal surveillance when there is evidence of recidivism, polysubstance use, or there are other indications such as preeclampsia or fetal growth restriction. It is reasonable to test one to two times per week during the third trimester.
- ❑ Recommend an ultrasound to assess fetal growth between 28 and 32 weeks of gestation. Growth is more likely to be a concern in women who have ongoing illicit drug use. A clinical suspicion of fetal growth restriction (such as lagging fundal height) may indicate the need for an ultrasound examination and management of the pregnancy in the same manner as for any pregnancy complicated by impaired fetal growth.
- ❑ Do not treat acute intrapartum and postpartum pain with additional doses of methadone or buprenorphine. During labor and after the birth, administer pain control in women with OUD in a similar way that you would for women without this disorder. However, do not administer mixed agonist and antagonist opioid analgesics, such as pentazocine, nalbuphine, and butorphanol, as they may displace methadone from the mu receptor and precipitate acute withdrawal.
- ❑ Closely monitor postpartum women, as they are at a particularly high risk of an opioid use relapse due to multiple stressors. As in all postpartum women, it's important to screen for depression and offer postpartum contraception.

Addendum: Additional tools and resources

Non-opioid strategies for chronic pain

Covered services

The services listed below are considered medically necessary when the service is available in the applicable benefit plan document, and the criteria in the coverage policy is met:

Medical condition	Medical interventions covered	Behavioral health interventions covered
Chronic back pain	<ul style="list-style-type: none"> • Spinal manipulation • Massage • Acupuncture • Multidisciplinary rehabilitation physical therapy • Surgical intervention (e.g., lumbar fusion) • Chiropractic services • Epidural injections • Facet joint injections • Sacroiliac injections • Mechanical traction in the clinic setting • Electrical stimulation • Trigger point injections • Radiofrequency joint ablation for facet mediated pain • Spinal cord stimulation • Nutritional evaluation and counseling 	<ul style="list-style-type: none"> • Cognitive behavioral therapy (CBT) delivered alone or as a component of an integrated, multimodal, and interdisciplinary pain management program <p>CBT encourages customers to adopt an active, problem-solving approach to cope with the many challenges associated with chronic pain. Specific modalities include:</p> <ul style="list-style-type: none"> ○ Relaxation training ○ Cognitive restructuring ○ Behavioral activation ○ Biofeedback <ul style="list-style-type: none"> • Group and supportive therapy • Behavioral services for caregivers
Chronic neck pain	<ul style="list-style-type: none"> • Acupuncture • Physical therapy • Chiropractic services • Mechanical traction in the clinic setting • Surgical therapy (e.g., cervical fusion, IVD) • Nutritional evaluation and counseling 	Same as above
Knee osteoarthritis	<ul style="list-style-type: none"> • Acupuncture • Surgical intervention • Unloading or offloading knee braces • Nutritional evaluation and counseling 	Same as above
Hip osteoarthritis	<ul style="list-style-type: none"> • Acupuncture • Surgical Intervention • Nutritional evaluation and counseling 	Same as above
Fibromyalgia	<ul style="list-style-type: none"> • Acupuncture • CBT • Multidisciplinary rehabilitation • Nutritional evaluation and counseling 	Same as above
Chronic headache	<ul style="list-style-type: none"> • Acupuncture • Spinal manipulation • Biofeedback • Nutritional evaluation and counseling 	Same as above

Services not covered

The services listed below are excluded from coverage. They are considered experimental investigational or unproven, not medically necessary, or both.

Medical condition	Medical interventions <i>not</i> covered	Behavioral health interventions <i>not</i> covered
Chronic back pain	<ul style="list-style-type: none"> • Low-level laser • Yoga • Mindfulness-based stress reduction • Epidural adhesiolysis • Axial/spinal decompression therapy • Extracorporeal shock wave therapy • Home traction • Mechanical devices (e.g., Medex, Cybex) • Patient-operated spine unloading devices 	Hypnotherapy
Chronic neck pain	<ul style="list-style-type: none"> • Low-level laser • Alexander technique • Home traction 	Hypnotherapy
Knee osteoarthritis	<ul style="list-style-type: none"> • Ultrasound therapy • Pulsed electromagnetic therapy 	Hypnotherapy
Hip osteoarthritis	<ul style="list-style-type: none"> • Tai chi • Qigong 	Hypnotherapy
Fibromyalgia	<ul style="list-style-type: none"> • Massage therapy • Yoga • Tai chi • Mindfulness-based stress reduction • Biofeedback • Nutrition supplements 	Hypnotherapy
Chronic headache	<ul style="list-style-type: none"> • Massage therapy • Yoga • Tai chi • Mindfulness-based stress reduction • Biofeedback • Nutrition supplements 	Hypnotherapy

Validated assessments

We recommend using validated assessment tools to help evaluate a customer’s functional status and address multidisciplinary treatment needs.

Pain and functional assessments

- Functional Status and Pain Screening Tools for Low Back Pain fact sheet (See [Exhibit B.](#))
- Oswestry Disability Index (ODI) (See [Exhibit C.](#))
- Keele STarT Back Screening Tool (See [Exhibit D.](#))
- Visual Analog Scale (VAS) for pain (See [Exhibit E.](#))
- Verbal Rating Scale (VRS) for pain (See [Exhibit F.](#))
- Numeric Rating Scale (NRS) (See [Exhibit G.](#))
- The Veterans Rand (VR-12) Online Health Survey (See [Exhibit H](#))

Behavioral assessments

Resource	Link
Behavioral Screening Tools for Depression, Anxiety, and Substance Abuse fact sheet	See Exhibit I.
PHQ-4	OregonPainGuidance.org > Tools > Assessment Tools: PHQ-4
PHQ-9	Center for Quality Assessment and Improvement in Mental Health website (CQUAIMH.org) > STABLE Measures & Toolkit > Toolkit > Depression screening > Patient Health Questionnaire-9
GAD-7 questionnaire	SAMHSA-HRSA Center for Integrated Health Solutions (Integration.SAMHSA.gov) > Clinical Practice > Screening Tools > Anxiety Disorders Screening Tools > GAD-7
Mood Disorder Questionnaire (MDQ)	Integration.SAMHSA.gov > Clinical Practice > Screening Tools > Bipolar Disorder Screening Tools > The Mood Disorder Questionnaire
CAGE-AID questionnaire	Integration.SAMHSA.gov > Clinical Practice > Screening Tools > Drug & Alcohol Use Screening Tools > CAGE AID
Opioid Risk Tool (ORT)	National Institute on Drug Abuse website (DrugAbuse.gov) > Medical & Health Professionals > Screening Tools and Prevention > Screening and Assessment Tools Chart > Opioid Risk Tool

Pathways for engagement

The optimal method for engaging your patient in managing pain and addressing behavioral needs will vary, depending on his or her readiness level. Use the guide below to help make this determination.

Patient readiness level	Intervention or action	
<p>Level 1: Patient understands his or her clinical condition and the risk of opioids, and welcomes the specialist referral (i.e., behavioral, pain management referral, or other).</p>	<p>The provider will: Refer the patient to a specialist.</p>	
<p>Level 2: Patient is ambivalent or resistant to the referral.</p> <p>References to support managing difficult conversations (OregonPainGuidance.org > Tools > Patient-Provider Communication)</p> <ul style="list-style-type: none"> • VEMA Tool for Managing Difficult Conversations • Difficult-Conversations-Real-Life-Examples-and-Helpful-Hint 	<p>The provider will:</p> <ul style="list-style-type: none"> • Educate the patient about the: <ul style="list-style-type: none"> ○ Need for specialized management by additional health care providers or specialists. ○ Side effects, limited long-term ineffectiveness, and risks of long-term opioid use. • Consider a behavioral health referral, and continue to work with the patient. <p>After education or behavioral health referral, the provider will:</p> <ul style="list-style-type: none"> • Refer the patient to a health care provider or specialist. 	<p>If the patient refuses a referral, the provider may:</p> <ul style="list-style-type: none"> • Consider developing a collaborative tapering plan, providing a list of specialist providers within the Cigna network, redirecting care, or terminating treatment and rendering emergency coverage for 60 days (or per practice policy). • Schedule an interdisciplinary phone call with a specialist (i.e., pain, behavioral, or both), with the patient in attendance, if the patient agrees to the consultation. <p>OR</p> <p>Continue to work with the patient, and attempt engagement at a later date (at the provider’s discretion).</p>
<p>Level 3: The patient refuses to:</p> <ul style="list-style-type: none"> • Entertain any changes in opioid use. • Consult with or be referred to a specialist. • Accept education about opioids. • Engage in any type or behavioral health or substance abuse interventions, and wants opioids only. 	<p>The provider may:</p> <ul style="list-style-type: none"> • Consider tapering and terminating the patient from the practice, providing a list of pain management providers within the Cigna network, and rendering emergency coverage for 60 days only. • Continue to work with the patient, and attempt engagement at a later date (at the provider’s discretion). 	

Provider resources

Resource	Link
CDC Guideline for Prescribing Opioids for Chronic Pain	CDC.gov > More > Injury, Violence & Safety > Opioid Overdose Prevention > Information for Providers > Guideline Overview > Guideline for Prescribing Opioids for Chronic Pain
Nonopioid Treatments for Chronic Pain	CDC.gov > More > Injury, Violence & Safety > Opioid Overdose Prevention > Information for Providers > Guideline Resources > Clinical Tools > Nonopioid Treatments for Chronic Pain
Treating pain: What you should know	See Exhibit J .
Prescribing Opioids for Chronic Pain <i>Surgeon General's pocket card offering guidance on safe prescribing according to CDC guidelines</i>	TurntheTideRx.org > Treatment Options > TurnTheTideRX pocket card > Prescribing Opioids for Chronic Pain
Medication Use Agreement <i>American Academy of Family Physicians</i>	CignaforHCP.com > Resources > Pharmacy Resources > Pharmacy Clinical Programs > Opioid Resources > Enhanced Narcotic Therapy Management – Pain Medication Use Agreement from American Academy of Physicians
Calculating Total Daily Dose of Opioids for Safer Dosage	CDC.gov > More > Injury, Violence & Safety > Opioid Overdose Prevention > Information for Providers > Guideline Resources > Clinical Tools > Calculating Total Daily Dose of Opioids for Safer Dosage
Opioid Dose Calculator State of Washington <i>Agency Medical Director's Group, State of Washington</i>	AgencyMedDirectors.wa.gov > Opioid Dose Calculator > Web-based Opioid Dose Calculator
Cigna's Opioid Prescriber Pledge <i>Cigna for Health Care Professionals website (CignaforHCP.com)</i>	CignaforHCP.com > Resources > Pharmacy Resources > Pharmacy Clinical Programs > Opioid Resources > Opioid Quality Improvement – Opioid Quality Improvement Pledge
Decisions in Recovery: Treatment for OUD <i>SAMHSA</i>	Web page: http://archive.SAMHSA.gov/MAT-Decisions-in-Recovery/ Supportive handbook (free): http://store.samhsa.gov/shin/content/SMA16-4993/SMA16-4993.pdf
Enhanced Narcotic Therapy Management <i>CignaforHCP.com</i>	CignaforHCP.com > Resources > Pharmacy Resources > Pharmacy Clinical Programs > Opioid Resources > Enhanced Narcotic Therapy Management
Acute Pain Flow Sheet <i>For the evaluation and treatment of acute pain</i>	Go to Oregonpainguidance.org > Tools > Flow Sheets > Acute and Chronic Pain Flow Sheets
The Art of Difficult Conversations <i>Oregon Pain Guidance</i>	OregonPainGuidance.org > Resources > Difficult Conversations > Handouts: The Art of Difficult Conversations
Pain: Considering Complementary Approaches (eBook) <i>National Center for Complementary and Integrative Health (NCCIH)</i>	NCCIH.NIH.gov > All Health Topics from A-Z > Pain > Consumer Information on Pain > Pain eBook

Customer resources

Resource	Link
Low Back Pain	See Exhibit K.
Low Back Pain: Exercises	See Exhibit L.
Treating pain: What you should know	See Exhibit J.
Your Health: How to Talk to your Doctor about Pain	See Exhibit M.
Your Health: How to Safely Store and Get Rid of Opiate Pills and Patches	See Exhibit N.
Pain Management: Keeping a Pain Diary	See Exhibit O.
Nonopioid Treatments for Chronic Pain <i>CDC</i>	CDC.gov > More > Injury, Violence & Safety > Opioid Overdose Prevention > Information for Providers > Guideline Resources > Clinical Tools > Nonopioid Treatments for Chronic Pain
Mediterranean Eating Plan <i>VA</i>	VA.gov/PatientCenteredCare > Resources > Whole Health Education for Veterans > Whole Health Veteran Education Handouts > Food and Drink > How to Eat a Mediterranean Diet
An Introduction to Food and Drink for Whole Health <i>VA</i>	VA.gov/PatientCenteredCare > Helpful Resources > Whole Health Education for Veterans > Whole Health Veteran Handouts > Food and Drink > An Introduction to Food and Drink for Whole Health

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14. Examples of validated assessment tools include the Oswestry questionnaire, the VAS for pain, PHQ-4 or PHQ-9, the GAD-7 questionnaire, the CAGE-AID questionnaire, and the Opioid Risk Tool (ORT).

Exhibits

Exhibit A: Clinical Opiate Withdrawal Scale (COWS)

Clinical Opiate Withdrawal Scale (COWS)

Flow-sheet for measuring symptoms for opiate withdrawals over a period of time.

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

Patient's Name: _____ Date: _____ Enter scores at time zero, 30min after first dose, 2 h after first dose, etc. Times: _____				
Resting Pulse Rate: (record beats per minute) <i>Measured after patient is sitting or lying for one minute</i> 0 pulse rate 80 or below 1 pulse rate 81-100 2 pulse rate 101-120 4 pulse rate greater than 120				
Sweating: <i>over past ½ hour not accounted for by room temperature or patient activity.</i> 0 no report of chills or flushing 1 subjective report of chills or flushing 2 flushed or observable moistness on face 3 beads of sweat on brow or face 4 sweat streaming off face				
Restlessness <i>Observation during assessment</i> 0 able to sit still 1 reports difficulty sitting still, but is able to do so 3 frequent shifting or extraneous movements of legs/arms 5 Unable to sit still for more than a few seconds				
Pupil size 0 pupils pinned or normal size for room light 1 pupils possibly larger than normal for room light 2 pupils moderately dilated 5 pupils so dilated that only the rim of the iris is visible				
Bone or Joint aches <i>If patient was having pain previously, only the additional component attributed to opiates withdrawal is scored</i> 0 not present 1 mild diffuse discomfort 2 patient reports severe diffuse aching of joints/ muscles 4 patient is rubbing joints or muscles and is unable to sit still because of discomfort				
Runny nose or tearing <i>Not accounted for by cold symptoms or allergies</i> 0 not present 1 nasal stuffiness or unusually moist eyes 2 nose running or tearing 4 nose constantly running or tears streaming down cheeks				

COWS / Flow-sheet format for measuring symptoms over a period of time

GI Upset: over last ½ hour 0 no GI symptoms 1 stomach cramps 2 nausea or loose stool 3 vomiting or diarrhea 5 Multiple episodes of diarrhea or vomiting				
Tremor observation of outstretched hands 0 No tremor 1 tremor can be felt, but not observed 2 slight tremor observable 4 gross tremor or muscle twitching				
Yawning Observation during assessment 0 no yawning 1 yawning once or twice during assessment 2 yawning three or more times during assessment 4 yawning several times/minute				
Anxiety or Irritability 0 none 1 patient reports increasing irritability or anxiousness 2 patient obviously irritable anxious 4 patient so irritable or anxious that participation in the assessment is difficult				
Gooseflesh skin 0 skin is smooth 3 piloerection of skin can be felt or hairs standing up on arms 5 prominent piloerection				
Total scores with observer's initials				

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

Exhibit B: Functional Status and Pain Screening Tools for Low Back Pain

FUNCTIONAL STATUS AND PAIN SCREENING TOOLS FOR LOW BACK PAIN

For Health Care Providers

Clinical status and scenario	Screening tool	Scoring and intervention	
Functional status	ODI	The Oswestry Disability Index (ODI), also known as the Oswestry Low Back Pain Disability Questionnaire, is an extremely important tool that researchers and disability evaluators use to measure a patient's permanent functional disability. The test is considered to be the "gold standard" of low back functional outcome tools.* The ODI is used to assess the patient's subjective rating of perceived disability related to his or her functional limitations, such as work status or difficulty caring for oneself. The higher the score, the higher the perceived disability. Using this test at the initial visit helps the examiner understand the patient's perception of how his or her back pain is affecting his or her life.	
		ODI scoring	
		0 to 20%: Minimal disability	The patient can cope with most living activities. Usually no treatment is indicated apart from advice on lifting, sitting, and exercise.
		21 to 40%: Moderate disability	The patient experiences more pain and difficulty with sitting, lifting, and standing. Travel and social life are more difficult, and they may be disabled from work. Personal care, sexual activity, and sleeping are not grossly affected, and the patient can usually be managed by conservative means.
		41 to 60%: Severe disability	Pain remains the main problem in this group, but activities of daily living are affected. These patients require a detailed investigation.
		61 to 80%: Crippled	Back pain impinges on all aspects of the patient's life. Positive intervention is required.
		81 to 100%: Bed bound These patients are either bed-bound or exaggerating their symptoms. Manage with urgency and aggressively. Avoid the negative effect of pain and disability.	
Pain screening	VAS, VRS, and NRS	The pain scale scoring will vary based on the tool used. Pain rating scales such as the Visual Analog Scale (VAS), Verbal Rating Scale (VRS), and Numeric Rating Scale (NRS) should be used in addition to the functional assessment and appropriate behavioral screening assessments. The pain rating tool should be used initially, and on follow-up visits, to assess the patient's perception of pain, and to assess if improvement has occurred.	

* Fairbank JC, Pynsent PB. The Oswestry Disability Index. Spine 2000 Nov 15;25(22):2940-52; discussion 52.

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Exhibit C: Oswestry Low Back Pain Disability Questionnaire

Oswestry Low Back Pain Disability Questionnaire

Sources: Fairbank JCT & Pynsent, PB (2000) The Oswestry Disability Index. *Spine*, 25(22):2940-2953.

Davidson M & Keating J (2001) A comparison of five low back disability questionnaires: reliability and responsiveness. *Physical Therapy* 2002;82:8-24.

The Oswestry Disability Index (also known as the Oswestry Low Back Pain Disability Questionnaire) is an extremely important tool that researchers and disability evaluators use to measure a patient's permanent functional disability. The test is considered the 'gold standard' of low back functional outcome tools ^[1].

Scoring instructions

For each section the total possible score is 5: if the first statement is marked the section score = 0; if the last statement is marked, it = 5. If all 10 sections are completed the score is calculated as follows:

Example: 16 (total scored)
 50 (total possible score) x 100 = 32%

If one section is missed or not applicable the score is calculated:

 16 (total scored)
 45 (total possible score) x 100 = 35.5%

Minimum detectable change (90% confidence): 10% points (change of less than this may be attributable to error in the measurement)

Interpretation of scores

0% to 20%: minimal disability:	The patient can cope with most living activities. Usually no treatment is indicated apart from advice on lifting sitting and exercise.
21%-40%: moderate disability:	The patient experiences more pain and difficulty with sitting, lifting and standing. Travel and social life are more difficult and they may be disabled from work. Personal care, sexual activity and sleeping are not grossly affected and the patient can usually be managed by conservative means.
41%-60%: severe disability:	Pain remains the main problem in this group but activities of daily living are affected. These patients require a detailed investigation.
61%-80%: crippled:	Back pain impinges on all aspects of the patient's life. Positive intervention is required.
81%-100%:	These patients are either bed-bound or exaggerating their symptoms.

Oswestry Low Back Disability Questionnaire

Oswestry Low Back Pain Disability Questionnaire

Instructions

This questionnaire has been designed to give us information as to how your back or leg pain is affecting your ability to manage in everyday life. Please answer by checking ONE box in each section for the statement which best applies to you. We realise you may consider that two or more statements in any one section apply but please just shade out the spot that indicates the statement which most clearly describes your problem.

Section 1 – Pain intensity

- I have no pain at the moment
- The pain is very mild at the moment
- The pain is moderate at the moment
- The pain is fairly severe at the moment
- The pain is very severe at the moment
- The pain is the worst imaginable at the moment

Section 2 – Personal care (washing, dressing etc)

- I can look after myself normally without causing extra pain
- I can look after myself normally but it causes extra pain
- It is painful to look after myself and I am slow and careful
- I need some help but manage most of my personal care
- I need help every day in most aspects of self-care
- I do not get dressed, I wash with difficulty and stay in bed

Section 3 – Lifting

- I can lift heavy weights without extra pain
- I can lift heavy weights but it gives extra pain
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently placed eg. on a table
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned
- I can lift very light weights
- I cannot lift or carry anything at all

Section 4 – Walking*

- Pain does not prevent me walking any distance
- Pain prevents me from walking more than 1 mile
- Pain prevents me from walking more than 1/2 mile
- Pain prevents me from walking more than 100 yards
- I can only walk using a stick or crutches
- I am in bed most of the time

Oswestry Low Back Disability Questionnaire

Section 5 – Sitting

- I can sit in any chair as long as I like
- I can only sit in my favourite chair as long as I like
- Pain prevents me sitting more than one hour
- Pain prevents me from sitting more than 30 minutes
- Pain prevents me from sitting more than 10 minutes
- Pain prevents me from sitting at all

Section 6 – Standing

- I can stand as long as I want without extra pain
- I can stand as long as I want but it gives me extra pain
- Pain prevents me from standing for more than 1 hour
- Pain prevents me from standing for more than 30 minutes
- Pain prevents me from standing for more than 10 minutes
- Pain prevents me from standing at all

Section 7 – Sleeping

- My sleep is never disturbed by pain
- My sleep is occasionally disturbed by pain
- Because of pain I have less than 6 hours sleep
- Because of pain I have less than 4 hours sleep
- Because of pain I have less than 2 hours sleep
- Pain prevents me from sleeping at all

Section 8 – Sex life (if applicable)

- My sex life is normal and causes no extra pain
- My sex life is normal but causes some extra pain
- My sex life is nearly normal but is very painful
- My sex life is severely restricted by pain
- My sex life is nearly absent because of pain
- Pain prevents any sex life at all

Section 9 – Social life

- My social life is normal and gives me no extra pain
- My social life is normal but increases the degree of pain
- Pain has no significant effect on my social life apart from limiting my more energetic interests eg, sport
- Pain has restricted my social life and I do not go out as often
- Pain has restricted my social life to my home
- I have no social life because of pain

Section 10 – Travelling

- I can travel anywhere without pain
- I can travel anywhere but it gives me extra pain
- Pain is bad but I manage journeys over two hours
- Pain restricts me to journeys of less than one hour
- Pain restricts me to short necessary journeys under 30 minutes
- Pain prevents me from travelling except to receive treatment

References

1. Fairbank JC, Pynsent PB. The Oswestry Disability Index. Spine 2000 Nov 15;25(22):2940-52; discussion 52.

Exhibit D: The Keele STarT Back Screening Tool

The Keele STarT Back Screening Tool

Patient name: _____ Date: _____

Thinking about the last 2 weeks tick your response to the following questions:

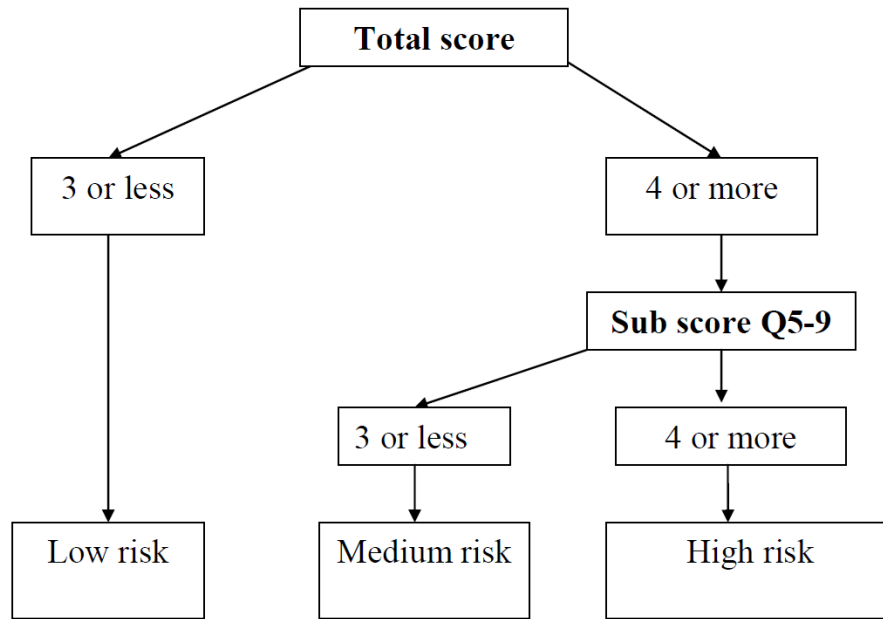
	Disagree 0	Agree 1
1 My back pain has spread down my leg(s) at some time in the last 2 weeks	<input type="checkbox"/>	<input type="checkbox"/>
2 I have had pain in the shoulder or neck at some time in the last 2 weeks	<input type="checkbox"/>	<input type="checkbox"/>
3 I have only walked short distances because of my back pain	<input type="checkbox"/>	<input type="checkbox"/>
4 In the last 2 weeks, I have dressed more slowly than usual because of back pain	<input type="checkbox"/>	<input type="checkbox"/>
5 It's not really safe for a person with a condition like mine to be physically active	<input type="checkbox"/>	<input type="checkbox"/>
6 Worrying thoughts have been going through my mind a lot of the time	<input type="checkbox"/>	<input type="checkbox"/>
7 I feel that my back pain is terrible and it's never going to get any better	<input type="checkbox"/>	<input type="checkbox"/>
8 In general I have not enjoyed all the things I used to enjoy	<input type="checkbox"/>	<input type="checkbox"/>

9. Overall, how bothersome has your back pain been in the last 2 weeks?

Not at all	Slightly	Moderately	Very much	Extremely
<input type="checkbox"/> 0	<input type="checkbox"/> 0	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 1

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Funded by Arthritis Research UK

The STarT Tool Scoring System



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Funded by Arthritis Research UK

Exhibit F: Visual Rating Scale for pain

Pain intensity	Score
No pain	0
Mild pain	1
Moderate pain	2
Severe pain	3
Excruciating pain	4

Exhibit G: Numeric Rating Scale for pain

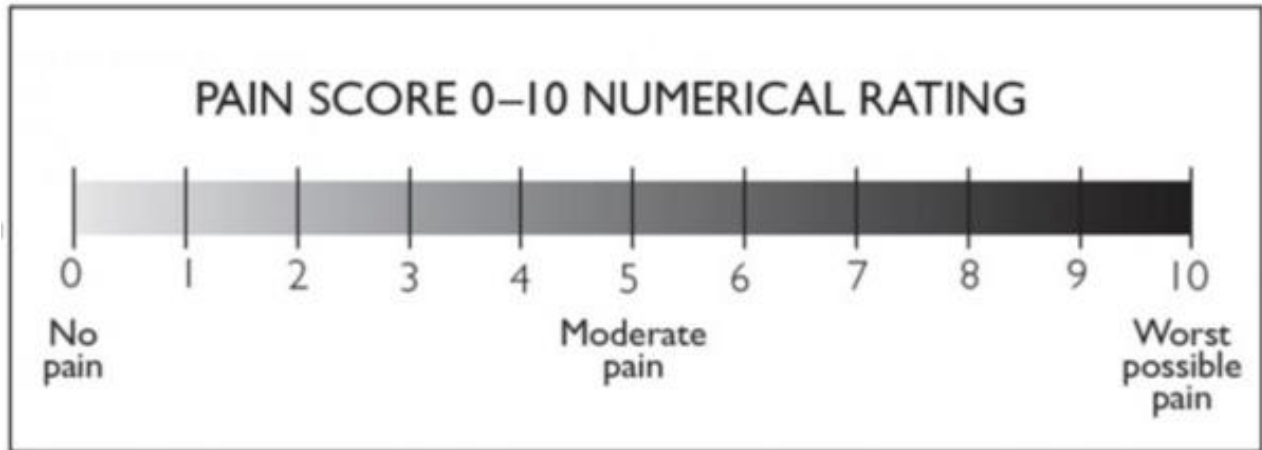


Exhibit H: The Veterans Rand 12-Item Health Survey

Self-Administered

OMB ###-####

Administrative use only:

Local Identifier

Study ID: _____

Navigator: _____

Date: _____

THE VETERANS RAND 12-ITEM HEALTH SURVEY (VR-12)

The following questions ask for your views about your health—how you feel and how well you are able to do your usual activities. All kinds of people across the country are being asked these same questions. Their answers and yours will help to improve health care for everyone. There are no right or wrong answers; please choose the answer that best fits your life right now.

Answer each question by marking an 'X' next to the best response. For example:

What is your gender?

- Male
- Female

Q1. In general, would you say your health is:

- Excellent
- Very good
- Good
- Fair
- Poor

Q2. The following questions are about activities you might do during a typical day. Does **your health now limit you** in these activities? If so, how much?

a. **Moderate activities**, such as moving a table, pushing a vacuum cleaner, bowling or playing golf?

- Yes, limited a lot
- Yes, limited a little
- No, not limited at all

b. Climbing **several** flights of stairs?

- Yes, limited a lot
- Yes, limited a little
- No, not limited at all

Public reporting burden for this collection of information is estimated to average 7 minutes per response. This time includes the length of time allotted for the survey questions. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: Address, ATTN: PRA (XXX-XXXX). Do not return the completed form to this address.

Rev 19-Sep-2011

Entered: ___ / ___ / ___ By: _____

Self-Administered

Q3. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities **as a result of your physical health**?

a. Accomplished **less** than you would like.

- No, none of the time
- Yes, a little of the time
- Yes, some of the time
- Yes, most of the time
- Yes, all of the time

b. Were limited in the **kind** of work or other activities.

- No, none of the time
- Yes, a little of the time
- Yes, some of the time
- Yes, most of the time
- Yes, all of the time

Q4. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities **as a result of any emotional problems** (such as feeling depressed or anxious)?

a. **Accomplished less** than you would like.

- No, none of the time
- Yes, a little of the time
- Yes, some of the time
- Yes, most of the time
- Yes, all of the time

b. Didn't do work or other activities as **carefully** as usual.

- No, none of the time
- Yes, a little of the time
- Yes, some of the time
- Yes, most of the time
- Yes, all of the time

↪ Continue to next page

Self-Administered

Q5. During the past 4 weeks, how much did **pain** interfere with your normal work (including both work outside the home and housework)?

- Not at all
- A little bit
- Moderately
- Quite a bit
- Extremely

These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling.

Q6a. How much of the time during the past 4 weeks:

Have you felt calm and peaceful?

- All of the time
- Most of the time
- A good bit of the time
- Some of the time
- A little of the time
- None of the time

Q6b. How much of the time during the past 4 weeks:

Did you have a lot of energy?

- All of the time
- Most of the time
- A good bit of the time
- Some of the time
- A little of the time
- None of the time

Q6c. How much of the time during the past 4 weeks:

Have you felt downhearted and blue?

- All of the time
- Most of the time
- A good bit of the time
- Some of the time
- A little of the time
- None of the time

[↪ Continue to next page](#)

Self-Administered

Q7. During the past 4 weeks, how much of the time has your **physical health or emotional problems** interfered with your social activities (like visiting with friends, relatives, etc.)?

- All of the time
- Most of the time
- Some of the time
- A little of the time
- None of the time

Now, we'd like to ask you some questions about how your health may have changed.

Q8. Compared to one year ago, how would you rate your **physical health** in general now?

- Much better
- Slightly better
- About the same
- Slightly worse
- Much worse

Q9. Compared to one year ago, how would you rate your **emotional problems** (such as feeling anxious, depressed or irritable) **now**?

- Much better
- Slightly better
- About the same
- Slightly worse
- Much worse

Your answers are important!

Thank you for completing this questionnaire!

The items in this questionnaire were obtained from the Medicare Health Outcomes Survey (HOS) with the express permission of NCQA and the Centers for Medicare & Medicaid Services (CMS). However, this survey is not being used as part of the Medicare HOS program and is not recognized as such by NCQA or CMS.

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Items 1-9: The VR-12 Health Survey item content was developed and modified from a 36-item health survey.

This survey was developed at RAND as part of the Medical Outcomes Study.

It was developed with support from the US Department of Veterans Affairs.

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Exhibit I: Behavioral Screening Tools for Depression, Anxiety, and Substance Abuse

BEHAVIORAL SCREENING TOOLS FOR DEPRESSION, ANXIETY, AND SUBSTANCE ABUSE

For Health Care Providers

Clinical status and scenario	Screening tool	Scoring and intervention	
Depression and anxiety screening: Initial and primary	PHQ-4	The Patient Health Questionnaire-4 (PHQ-4) is a four-item inventory rated on a four-point Likert-type scale. Its items are drawn from the first two items of the Generalized Anxiety Disorder-7 (GAD-7) scale, and the Patient Health Questionnaire-9 (PHQ-9). Its purpose is to allow for very brief and accurate measurement of depression and anxiety.	
		PHQ-4 scoring	
		None: 0-2	No immediate action, unless clinical judgment dictates.
		Mild: 3-5	<input checked="" type="checkbox"/> For suicidal ideation <input checked="" type="checkbox"/> Subscale score <input type="checkbox"/> 3 or greater with anxiety → GAD-7 <input type="checkbox"/> 3 or greater for depression → PHQ-9 <input checked="" type="checkbox"/> Provide education and resource information, and rescreen at a later visit, as appropriate AND / OR <input checked="" type="checkbox"/> Access behavioral resource and refer <i>if warranted or requested</i> .
		Moderate: 6-8	<input checked="" type="checkbox"/> For suicidal ideation <input checked="" type="checkbox"/> Subscale score <input type="checkbox"/> 3 or greater with anxiety → GAD-7 <input type="checkbox"/> 3 or greater for depression → PHQ-9 <input checked="" type="checkbox"/> Provide education and resource information, and rescreen at a later visit, as appropriate AND / OR <input checked="" type="checkbox"/> Access behavioral resource and refer.
Severe: 9-12	Immediate referral is recommended – Providers can access Cigna Behavioral Health or preferred local market behavioral partners. <i>Use clinical judgment if additional screening beyond PHQ-4 is warranted prior to referral or intervention. Additional Information may be helpful to the resource team in managing the request.</i> <input checked="" type="checkbox"/> For suicidal ideation <input checked="" type="checkbox"/> Subscale score <input type="checkbox"/> 3 or greater with anxiety → GAD-7 <input type="checkbox"/> 3 or greater for depression → PHQ-9 <input checked="" type="checkbox"/> Provide education and resource information, and work to schedule the patient for an appointment with a behavioral provider for further evaluation ASAP.		

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Clinical status and scenario	Screening tool	Scoring and intervention	
+PHQ-4 with depression: Post PHQ-4 results	PHQ-9	Depression screening can be administered repeatedly to reflect improvement or worsening of depression in response to treatment.	
		PHQ-9 scoring:	
		Below 5	No immediate action unless clinical judgment dictates.
		Mild: 5-9	<input checked="" type="checkbox"/> For suicidal ideation
		Moderate: 10-14 Moderately severe: 15-19	For scores of 5 or more, refer to the Cigna Behavioral Health resource line for providers who participate in Accountable Care programs: 1.855.873.6189.
Severe: 20-27	Immediate referral is recommended. Refer to the Cigna Behavioral Health resource line for providers who participate in Accountable Care programs: 1.855.873.6189.		
+PHQ-4 with anxiety: Post PHQ-4 results	GAD-7	GAD-7 is a self-reported questionnaire for screening and measuring the severity of GAD. It has seven items, which measure the severity of various signs of GAD according to reported response categories with assigned points.	
		GAD-7 scoring	
		Below 5	No immediate action unless clinical judgment dictates.
		Mild: 5-7	<input checked="" type="checkbox"/> For suicidal ideation
		Moderate: 10-14 Severe: 15 or higher	For scores of 5 or more, refer to the Cigna Behavioral Health resource line for providers who participate in Accountable Care programs: 1.855.873.6189.
Alcohol and substance abuse screening: Initial screening	CAGE-AID	The CAGE questionnaire is used to test for alcohol abuse and dependence in adults. The CAGE-AID version of the tool has been adapted to include drug use. Item responses on the CAGE and CAGE-AID are scored 0 or 1, with a higher score indicating alcohol or drug use problems. A total score of 2 or higher is considered clinically significant, which should then lead the physician to ask more specific questions about frequency and quantity.	
		CAGE-AID scoring	
		1 or higher	<ul style="list-style-type: none"> A score of 1 or more is positive, and requires additional screening for current use, and abuse history to determine appropriate intervention. Need to determine if alcohol or drugs and other substances are of concern.
Opioid and substance abuse risk: Initial screening	ORT	The Opioid Risk Tool (ORT) is a brief, self-report screening tool designed for use with adult patients in primary care settings to assess the risk for opioid abuse among individuals who are prescribed opioids for treatment of chronic pain. Patients categorized as high risk are at increased likelihood of future abusive drug-related behavior. The ORT can be administered and scored in less than one minute, and has been validated in both male and female patients, but not in non-pain populations.	
		<i>This tool should be administered to patients upon an initial visit prior to beginning opioid therapy for pain management.</i>	
		ORT scoring	
		Low: 0-3	No immediate action unless clinical judgment dictates.
		Moderate: 4-7	<ul style="list-style-type: none"> Monitor patient closely for at-risk behaviors and comorbid risks. Refer to the Cigna Behavioral Health resource line for providers who participate in Accountable Care programs: 1.855.873.6189.
High: 8 or higher	Refer to the Cigna Behavioral Health resource line for providers who participate in Accountable Care programs: 1.855.873.6189.		

Cigna Behavioral Health resource line for providers who participate in Accountable Care programs: 1.855.873.6189

Other markets: Refer to preferred local network-participating providers for outpatient services.

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Exhibit J: Treating Pain



TREATING PAIN

What you should know

Living with severe or constant pain is hard. It can impact all areas of your life, and all you want is relief. We understand that. We can't promise to make the pain go away completely, but we will do our best to manage your pain so that you can live your life.

Key considerations

In some cases, prescription pain relievers, or opioids (oxycontin, oxycodone, codeine and hydrocodone, for example) can be an important part of treatment. Doctors often give them to treat severe pain from surgery or a serious injury, or pain that results from health conditions like chronic back pain. But while these drugs may help relieve pain, they also have serious risks, including dependence, addiction, accidental overdose, and even death.

To help protect you from these risks, we will work together with you to determine if an opioid prescription is the right fit for you. It's important that we talk about:

- › Pain treatment options, such as physical, occupational, and behavioral therapies that don't include prescription drugs
- › Other prescribed medications that you may be taking
- › Your past or current drug and alcohol use
- › Possible risks and benefits of taking prescription opioids
- › Setting realistic goals for managing your pain

We're here to help.

Opioid addiction can impact anyone. If you think you are becoming dependent or may be addicted, tell us immediately. We can help connect you to the resources you need.



Why talking is important

For most people, when opioids are taken as directed for a short time, they reduce pain and are safe. But some people may start to depend on them or become addicted. That's why we want to get to know you. We will ask questions and we will listen to you. Then we will share all of your options, how they work, and possible side effects. We want to provide the safest and most effective care. But we can only do that by working together to decide on the best treatment. And by continuing to talk about any side effects, symptoms, or concerns you may have.

Other important information

Store your medications in a child-resistant bottle and in one safe location where it cannot be easily accessed by a child, pet, or others. Share details about your prescription(s) only with a caregiver or others that need to know.

Dispose of any unused medicines to avoid unnecessary health risks in your home, especially if there are children present. To do so:

- › Ask your pharmacist if they know of disposal programs in your area
- › Visit the Drug Enforcement Administration (DEA) website (www.dea.gov) and search for a drug disposal area
- › Call the DEA at **800.882.9539** and ask for the location of an authorized collector in your community

For more information about opioid use, check out the CDC fact sheet at <http://www.cdc.gov/drugoverdose/pdf/aha-patient-opioid-factsheet-a.pdf>, or visit <http://www.cdc.gov/drugoverdose/prescribing/patients.html>

Alternative therapies

Your health plan may have programs available to help you address chronic pain or substance use disorders and help you reach your health goals.

Therapies that may be covered or offered at a discount through your medical insurance include:

- › Occupational therapy
- › Physical therapy
- › Acupuncture
- › Chiropractic care
- › Behavioral health treatment, such as stress management or treatment for depression

Refer to your policy for details.

You may want to consider other options

These may include over-the-counter remedies such as pain relievers, ice and heat therapy, supplements, herbs, an exercise regimen, or massage.

Talk to us. We want to be sure the care you receive meets your needs.

This information is for educational purposes only. It is not meant to provide medical advice tailored to you in any way. It does not constitute medical advice and is not intended to be a substitute for proper medical care provided by a physician. Always consult with your doctor for appropriate examinations, treatment, testing and care recommendations. Do not rely on this information as a tool for self-diagnosis. If you have a medical emergency, go to the nearest hospital or call 911.

Exhibit K: Low Back Pain

Low Back Pain



What is low back pain?

Low back pain is pain that can occur anywhere below the ribs and above the legs. It is very common. Almost everyone has it at one time or another.

Low back pain can be:

- **Acute.** This is new pain that can last a few days to a few weeks—at the most a few months.
- **Chronic.** This pain can last for more than a few months. Sometimes it can last for years.

What are some myths about low back pain?

Here are some common myths about low back pain—and the facts:

- **Myth:** I need to rest my back when I have back pain. **Fact:** Staying active won't hurt you. It may help you get better faster.
- **Myth:** I need prescription pain medicine. **Fact:** It's best to try to let time and being active heal your back. Opioid pain medicines—such as hydrocodone or oxycodone—usually don't work any better

than over-the-counter medicines like ibuprofen or naproxen. And opioids can cause serious problems like addiction or overdose.

- **Myth:** I need a test like an X-ray or an MRI to diagnose my low back pain. **Fact:** Getting a test right away won't help you get better faster. And it could lead you down a treatment path you may not need, since most people get better on their own.

What causes low back pain?

In most cases, there isn't a clear cause. This can be frustrating because your back hurts and there is no obvious reason. Your back pain can be caused by:

- **Overuse or muscle strain.** This can happen from doing sports, lifting heavy things, or not being physically fit.
- **A herniated disc.** This is a problem with the cushion between the bones in your back.
- **Arthritis.** With age, you may have changes in your bones that can narrow the space around your nerves.
- **Other causes.** Rarely, the cause is a serious illness like an infection or cancer. But there are usually other symptoms as well.

What are the symptoms?

Your symptoms depend on your body and the cause of your back pain. You may feel:

- **Pain that's sharp or dull.** It may be in one small area or over a broad area. But even bad pain doesn't mean that it's caused by something serious.
- **Leg pain, numbness, or tingling.** When a nerve gets squeezed—such as from a disc problem or arthritis—you may have symptoms in your leg or foot. You can even have leg symptoms from a back problem without having any pain in your back.

Exhibit L: Low Back Pain Exercises

Low Back Pain: Exercises

Here are some examples of typical rehabilitation exercises for your condition. Start each exercise slowly. Ease off the exercise if you start to have pain.

Your doctor or physical therapist will tell you when you can start these exercises and which ones will work best for you.

How to do the exercises

Press-up



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1. Lie on your stomach, supporting your body with your forearms.
2. Press your elbows down into the floor to raise your upper back. As you do this, relax your stomach muscles and allow your back to arch without using your back muscles. As your press up, do not let your hips or pelvis come off the floor.
3. Hold for 15 to 30 seconds, then relax.
4. Repeat 2 to 4 times.

Alternate arm and leg (bird dog) exercise



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Note: Do this exercise slowly. Try to keep your body straight at all times, and do not let one hip drop lower than the other.

1. Start on the floor, on your hands and knees.
2. Tighten your belly muscles.
3. Raise one leg off the floor, and hold it straight out behind you. Be careful not to let your hip drop down, because that will twist your trunk.
4. Hold for about 6 seconds, then lower your leg and switch to the other leg.
5. Repeat 8 to 12 times on each leg.
6. Over time, work up to holding for 10 to 30 seconds each time.
7. If you feel stable and secure with your leg raised, try raising the opposite arm straight out in front of you at the same time.

Exhibit M: How to Talk to Your Doctor About Pain

Your Health: How to Talk to Your Doctor About Pain



An important part of managing your pain is keeping a pain diary. A pain diary is a place to record how you feel, what you are doing, and what helps you feel better.

Take your pain diary with you to the doctor. It will help you remember things, answer questions, and describe your pain.

Describe your pain

By describing your pain, you will help your doctor know how best to treat it. In your pain diary, keep track of the following:

- Where do you feel pain?
- What does it feel like? Sharp? Dull? Throbbing? Burning? Steady?
- How bad is your pain? Use a pain scale from 0 to 10. Zero means no pain. Ten means the pain is as bad as it can be. Give yourself a score between 0 and 10 to chart your pain.
- How long does the pain last? Does the pain have a pattern of when it comes and goes?

- What eases the pain? What makes it worse?
- Does the pain start suddenly or build up over time?
- Can you think of anything that starts or causes the pain?
- Do you have any other symptoms with the pain?
- What medicine do you take, and how much does it help?
- What pain medicine has worked for you in the past? What has not helped?

Get support

When you are in pain, you may have a hard time remembering what your doctor tells you. Bring a friend or family member to the doctor with you to help you understand and remember or write down what your doctor said.

Ask your doctor to give you written or printed information. Take notes or record the conversation. Ask your doctor to slow down or repeat information when you need more time to write it down. Later, you can review the information whenever you need to.

Be open and honest

It is important to be open and honest with your doctor about your pain.

If you do not feel like you can talk with your doctor, there may be things you can do to improve communication. Think through your concerns. State them as honestly and openly as you can. You may want to use one of these opening statements:

- "I am concerned that we are not communicating well, and here's why . . ."
- "I need to be able to talk with you about _____, and I am having trouble getting started. Can we talk about this?"

- "I realize that you are very busy, but I really need to talk about _____ at more length. Can we schedule a time to do that?"
- "I want to be a partner with you and tell you everything that is bothering me so you can understand and help me."
- "I am having trouble understanding _____. Can you help me?"

When to call your doctor

Call your doctor immediately if you cannot control your pain with medicine or one of the following happens:

- You have a headache with vomiting.
- You have a fever with chills.
- You have sudden pain in your arm, leg, or back.
- You faint.
- You have hives, severe itching, or shortness of breath.
- You cannot move a limb.
- You can't pass stool or urine.
- You are confused.



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Exhibit N: How to Safely Store and Get Rid of Opioid Pills and Patches

Your Health: How to Safely Store and Get Rid of Opioid Pills and Patches



Why are opioid pills and patches dangerous?

When your doctor prescribes an opioid for pain relief, you're getting strong medicine. You're also taking on a big job to protect others from its risks. Opioid medicine can cause serious problems, even death, if it's misused.

Children and pets are at high risk when an opioid isn't kept out of their reach. Opioid skin patches, such as fentanyl, pose the most danger. Even after you're done using it, a patch still has a high dose of medicine in it. Small children have been killed by used opioid patches they've found in the trash at home.

Opioids can also be abused or stolen. Be sure to store your medicine in a safe and secure place. When you're done with an opioid medicine, get rid of it right away, in the safest way you can.

How do you safely store opioid pills and patches?

It's important to store opioids safely so that they aren't used by the wrong person.

Your pain medicine is only for you to take. If someone else takes your medicine, it can harm them.

You can safely store your medicine. Follow these tips:

- Store pills and patches up high and out of sight, away from children and pets. Remember to return the container to the same place each time you take your medicine.
- Try locking your opioid medicine in a cabinet. Keep track of how many pills or patches you have left. (You may want to keep track in a notebook.)
- Make sure the bottles are closed tightly. If they have a safety cap, make sure that it's locked. Tighten the cap until you hear a click or can't twist it anymore.
- Let people who live with you know about your medicine and that it is only for you to take. If guests have opioid medicine with them, ask them to keep it safe.

How can you safely get rid of opioid pills and patches?

Unused opioid pills or patches

If you have opioid pills or patches that you're not going to use, get rid of them right away. The U.S. Food and Drug Administration (FDA) recommends that you take your opioid pills or patches to a medicine drop-off box or take-back program that is authorized by the U.S. Drug Enforcement Administration (DEA).

If you can't get to a DEA-authorized site right away and your medicine doesn't have specific disposal information (such as flushing), you can dispose of them in your household trash using these steps.

- Take the medicine out of its container.

- Mix it with something that tastes bad, such as cat litter or coffee grounds.
- Place the mixture in a sealed plastic bag, and put the bag in your household trash.

Only flush your medicine down the toilet if you can't get to a DEA-approved site or if your medicine instructions state clearly to flush them. Go to www.fda.gov/Drugs/ResourcesForYou/Consumers/BuyingUsingMedicineSafely/EnsuringSafeUseofMedicine/SafeDisposalofMedicines/ucm186187.htm to see a list of medicines that should be flushed.

Opioid patches after use

Take special care with opioid skin patches. As soon as you've peeled a patch off of your skin, fold it in half with the sticky sides together.

Immediately take it to a DEA-authorized site or flush it down the toilet if a DEA-authorized site isn't available in your area. **Do not throw medicine patches in the trash.**

Where can you go to learn more?

You can look online at the DEA's Diversion Control Division website (deadiversion.usdoj.gov) to find a disposal site near you. You can also visit fda.gov and search for "unused medicine disposal."



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Exhibit O: Pain Management: Keeping a Pain Diary

Pain Management: Keeping a Pain Diary



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Everyone experiences pain differently. You may be able to do things even when you hurt. Someone else may not feel like they can get out of bed.

Pain can feel sharp or dull. It may throb or burn. You may feel it one place in your body, such as with a headache or stomach ulcer. Or you may feel it all over your body, like when your muscles ache from the flu. And some people feel pain deep in their organs from an injury or a health problem such as cancer.

Pain may come and go or it may be constant. It may hurt for a little while or a long time.

How tracking your pain helps

It's your pain and it's your body. Your doctor can't tell by looking at you how you're feeling. But when you can describe your pain and how bad it is, your doctor can help.

Pain may be something you have to live with for a long time. But you and your doctor can work together to come up with a plan to help ease your pain enough so that you're more comfortable, happier, and able to focus on what's important to you.

Understanding your pain—when it happens, what causes it, and what makes it better—can help you discover ways and things you can do to manage your pain.

Without tracking, it can be hard to remember how you felt last week compared to how you feel right now.

A pain diary also helps uncover:

- **Pain triggers.** For example, does it hurt before or after you eat?
- **Patterns.** For example, does it hurt more during the day and less at night?
- **Emotions.** For example, does stress seem to be making your pain worse?
- **Challenges.** For example, how does pain affect your life each day?

How to keep a pain diary

While tracking takes your time, you may find that it can show you and your doctor when your pain is not getting better or is worse. You may discover that your pain is actually decreasing a little bit each day.

Along with how much or how little you're hurting, your doctor may want to know other things such as:

- Do you take any medicine for the pain? If so, what is the dose? Do you have any side effects?
- Does the pain move from one part of your body to another?
- Does it hurt to move? For example, do you have pain when you stand up after sitting? Or does it hurt when you do certain chores or bend down to tie your shoes?

Your pain diary

The faces in the image show how much something can hurt. You can use these faces to help choose a number that shows how much you or your child hurts right now. The face on the left shows no pain. The other faces in turn show more and more pain. The face on the right shows the worst pain you have ever known. For example, if you have a "2" on the scale, your pain may be minor with stronger twinges now and then, but it doesn't impact your ability to do things. If you have an "8" on the scale, you may have very strong pain that makes it hard to do anything.

Using a pain scale and a pain diary can help you describe how much pain you're having. These tools also can help you tell your doctor what your pain feels like so that he or she can help you.

You can use this diary or make one of your own. The following form is just one way to track how you feel. Any method for tracking can work if it's something you like and can keep using. If you want, use the pictures of the faces to help you track your pain.

Date	Time	Pain-scale rating	Medicine and dose	Medicine side effects	What made the pain better today?	What made the pain worse today?

Keeping a pain diary can help you and your doctor find out what works best to manage your pain. You can use it as long as you both find it helpful.



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