SAFE MANAGEMENT OF NON-PALLIATIVE PAIN
FOR PRIMARY CARE PROVIDERS

1. All patients need a comprehensive **initial assessment** comprised of a complete history, including both medical and social history; evaluation of functional level; a review of past medical records including any studies done and any treatments received; and a determination of whether or not there is a diagnosis for which opioid treatment is indicated.
2. Perform **risk assessments** to evaluate risk factors for opioid-related harms including co-morbidities, sleep apnea, mental health issues, and potential for medication misuse (past substance abuse, history of trauma or PTSD).
3. **Non-pharmacologic therapy** and **non-opioid pharmacologic therapy** should be tried first. Consider starting a **non-opioid regimen** such as NSAIDs or acetaminophen, and consider utilizing non-pharmacologic options such as self-care, exercise, physical therapy, behavioral health, peer or other support groups, mindfulness, acupuncture, yoga, and chiropractic or osteopathic care.
4. Establish **functional goals and a treatment plan**. Provide detailed patient education that includes the risks associated with opioid use. Plan for reassessment and discontinuation, and explain this to patients at the initiation of opioid treatment.
5. When starting patients on opioids, write a prescription for only a **short duration** (e.g., several days or weekly supply), start with **short or intermediate acting medications**, and use the lowest dose necessary. Conduct a clinical re-evaluation **within days to 2 weeks** time of the initiation of treatment.
6. **Proceed with extreme caution when prescribing opioids for more than 60 days** and conduct an evaluation to determine if long-term use is appropriate. The efficacy of long-term opioid use for chronic non-palliative pain has not been established and there is a high rate of patients treated with chronic opioid medications who develop opioid use disorders.
7. **Monitor the patient** throughout treatment including performing a Urine Drug Screen at least annually, reviewing the California Prescription Drug Monitoring Program (CURES) at least twice a year, and having the patient sign a treatment use agreement (a.k.a. medication use agreement) and reviewing it annually.
8. At regular intervals, at least once every three months, **conduct a clinical re-evaluation** that reviews the functional goals and re-assesses the risks versus benefits of opioid treatment. If pain is not resolving as expected, try alternate treatments, consider specialty referrals, and consider discontinuation of opioids.
9. Considerations for Special Populations: 1) **Women of reproductive age** — when pregnancy is possible or if currently breast feeding, it is recommended that providers review the added potential risks of opioid use to the pregnancy and the fetus. **Co-prescribing contraceptives** is strongly recommended. 2) **Geriatric population** — consider the **additional level of risk** that opioid medications may create. Health care providers also need to do a complete medication reconciliation and evaluate potential drug interactions.
10. **Taper and/or discontinue opioids** if there is no clinically meaningful improvement in function and pain, **if patient is >80 MEDs**, if treatment resulted in a severe adverse outcome (e.g. overdose, bowel obstruction, sleep apnea), or if there is a current/history of substance use disorder (excluding tobacco).
11. **Do not co-prescribe opioids with** benzodiazepines, sedative-hypnotics or barbiturates.
12. Set up an **agency practice infrastructure** to support safe and effective pain management.
13. Provide education on overdose prevention and co-prescribe naloxone for any patient at risk for overdose or prescribed benzodiazepines.

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