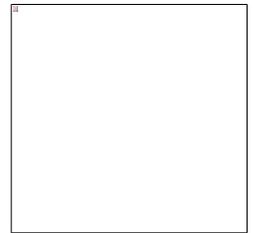
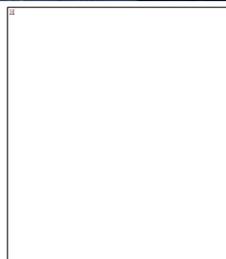
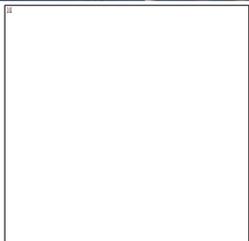
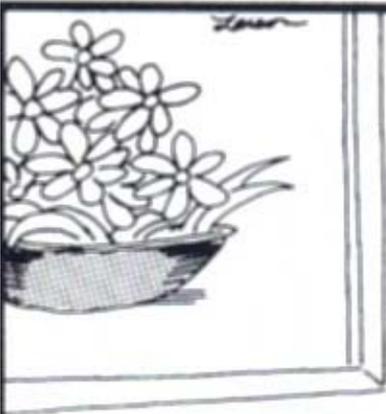


Do You Feel My Pain:
Obstacles, challenges and solutions in Pain Management

Alex Cahana MD, DAAPM, FIPP
Professor & Chief, Division of Pain Medicine
acahana@uw.edu





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Just plain
nuts!



Disclosures

- I am not opio-phobic
- I am not opio-philic
- I am not needle-phobic
- I am not needle-philic
- I am not CAM-phobic
- I am not CAM-philic
- 'I just wanna know how my folks are doin'
- Because I **don't** measure outcome I believe my practice is **not** medically, financially or ethically sustainable

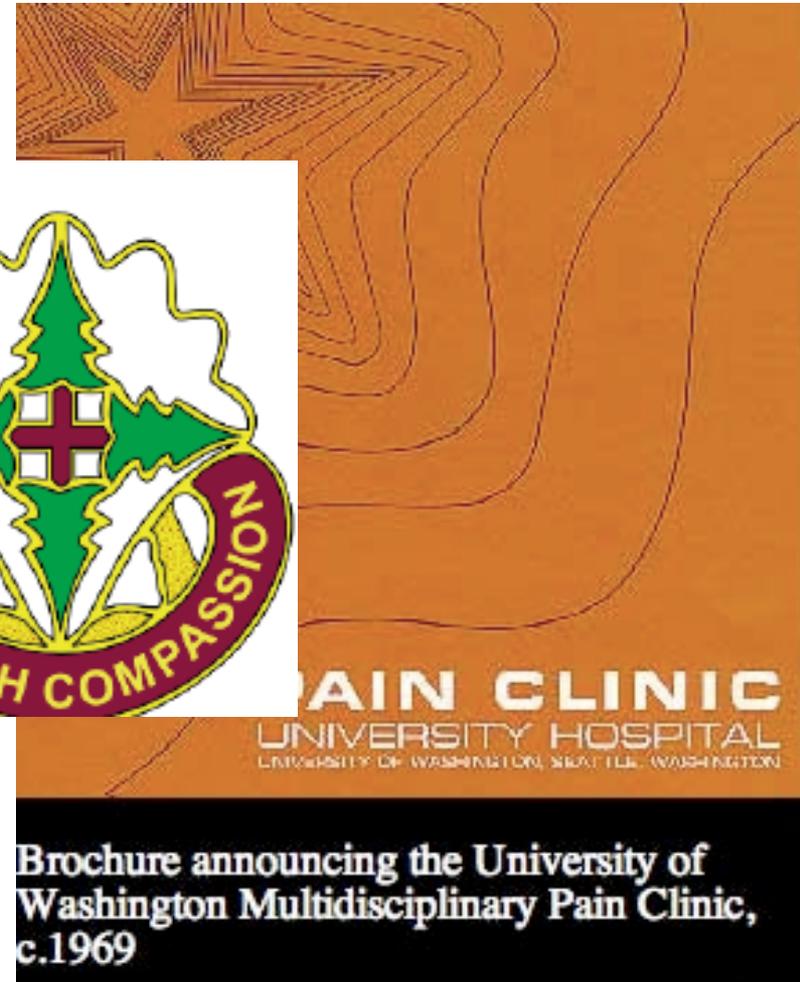
Today:

- **Introduction (5 minutes)**
- **Pain and the Brain (15 minutes)**
- **How to measure Pain (15 min)**
- **How will that change my practice (10 min)**

John J. Bonica



UNIVERSITY OF WASHINGTON
MEDICAL CENTER
UW Medicine



John D. Loeser



UWMC

Inpatient

Outpatient

HMC

Inpatient

Outpatient

SCH

Inpatient

Outpatient

VAPSHCS

Inpatient

Outpatient

SCCA

Outpatient

**The last 50 years have seen an
explosion in medical advances**

Antibiotics



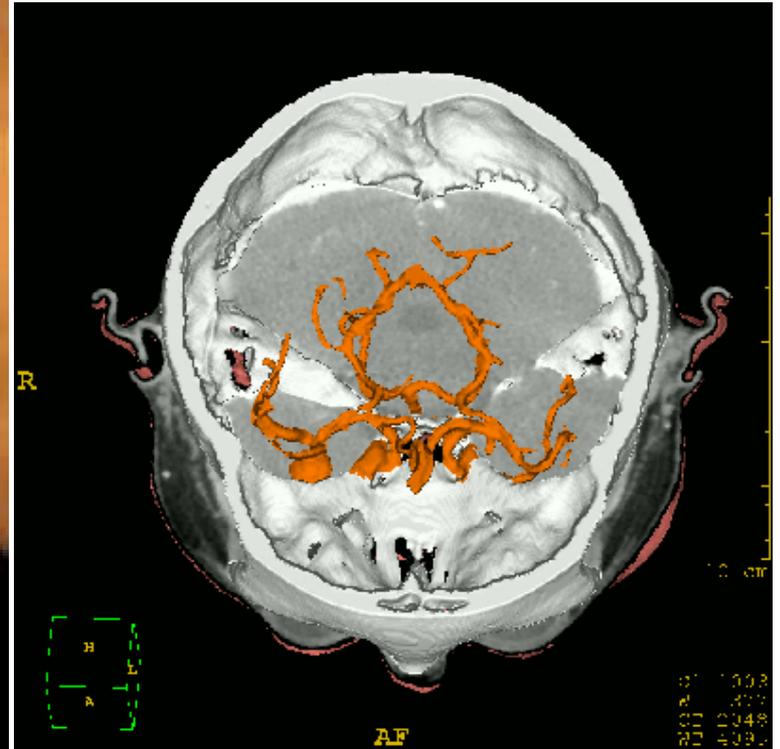
Organ Transplants



PERCIVAL
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Imaging



But we have made very little progress treating Pain

- 1 out of 5 suffer from chronic pain
- As the population ages, this number is expected to increase

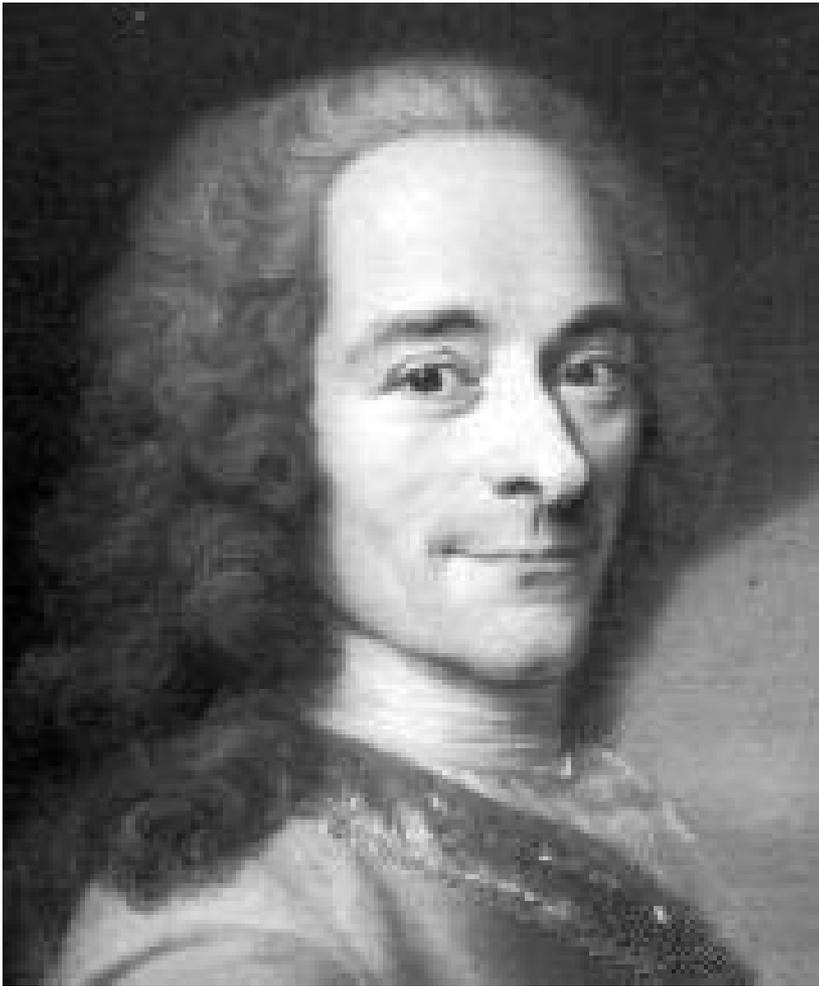


Pain is hard for the us



- We are not taught to treat pain in school or residency
- There are no tests for pain
- Doctors are being arrested for prescribing too many pain medicines
- Some patients are selling their pain medicines, so doctors are afraid of being scammed



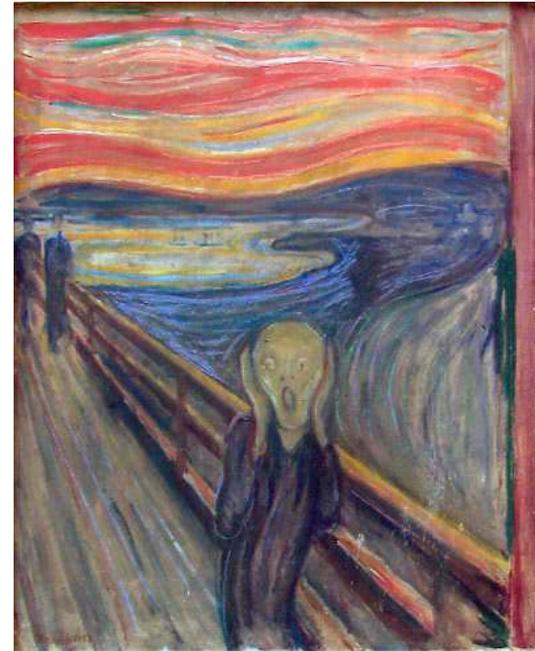


**Doctors pour drugs,
of which they know
little, for diseases of
which they know less,
into patients - of which
they know nothing.**

Voltaire (1694-1778)

Pain is hard for the patient

- There are no tests for pain
- Surgery often makes patients worse
- Pain causes depression, anxiety, and frustration, which alienates family and friends
- Because tests may be negative, doctors, employers, and even family may doubt that the pain is real



Pain is hard for society

- Increased disability cost and lost productivity
- Increased pain cost in “absenteeism” as well as “presenteeism”
- Increased suffering tears apart the family fabric



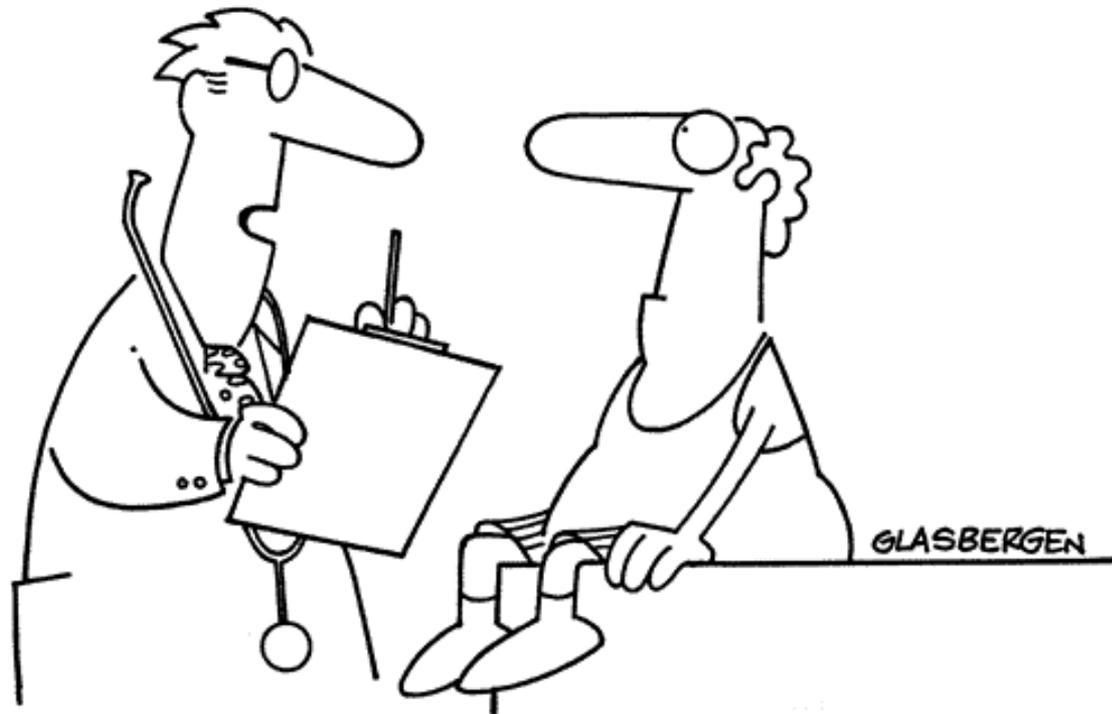
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“Good news! According to the Government you’re not dead and you can go back to work!”

Treatment is not Always Mechanism Based

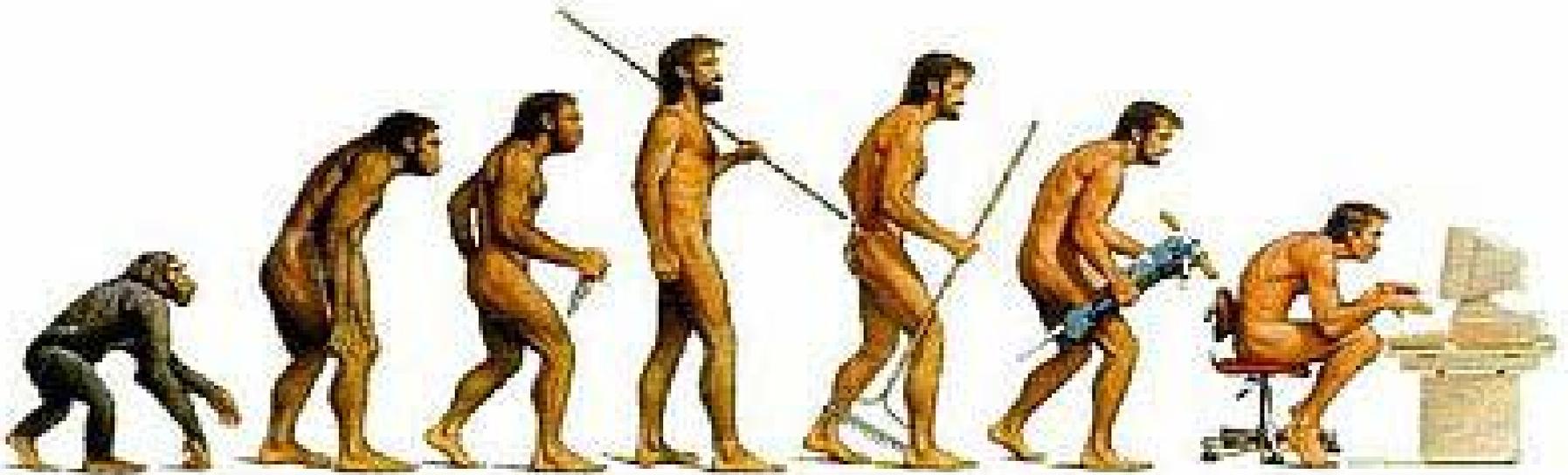
Copyright 2002 by Randy Glasbergen.
www.glasbergen.com



“We can’t find anything wrong with you, so we’re going to treat you for Symptom Deficit Disorder.”

What so special about Pain?

The desire to relieve pain is probably as old as our species



Relief of Pain is the primary reason for health care



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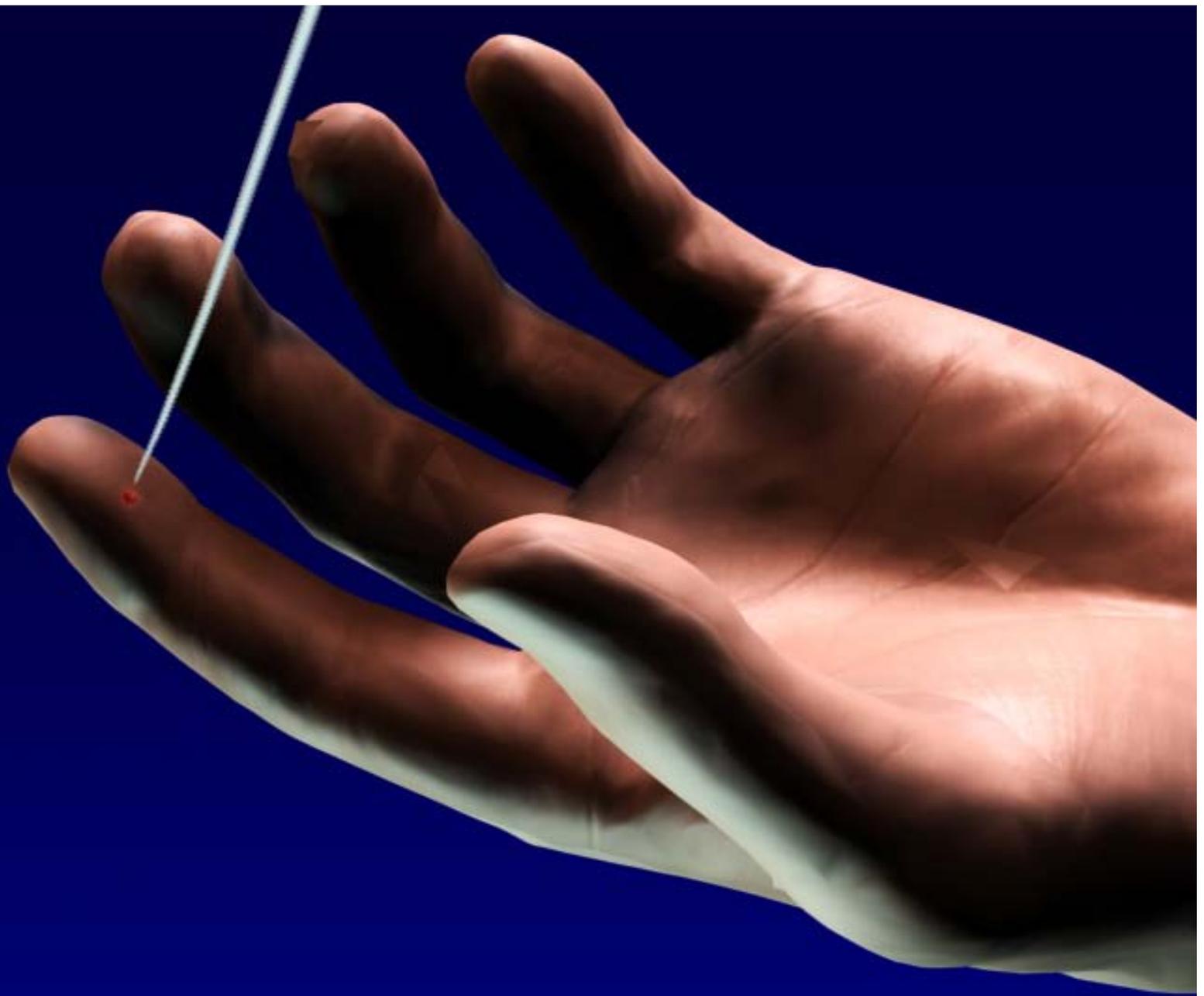
"I'M THE ONE WITH THE MEDICAL DEGREE, I'LL DETERMINE
IF YOUR BACK IS BOTHERING YOU, OR NOT..."

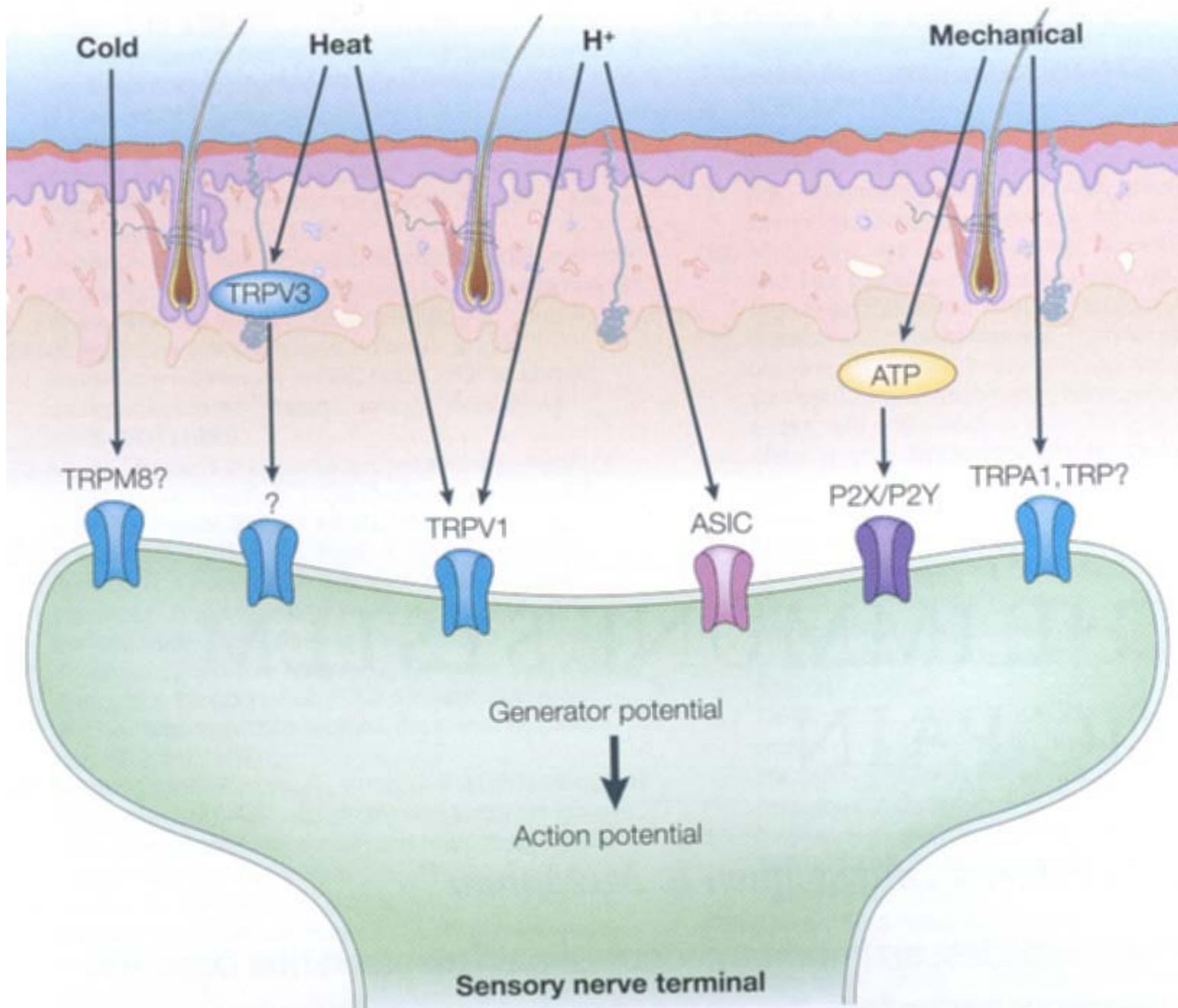
Today:

- Introduction (5 minutes)
- Pain and the Brain (15 minutes)
- How to measure Pain (15 min)
- How will that change my practice (10 min)

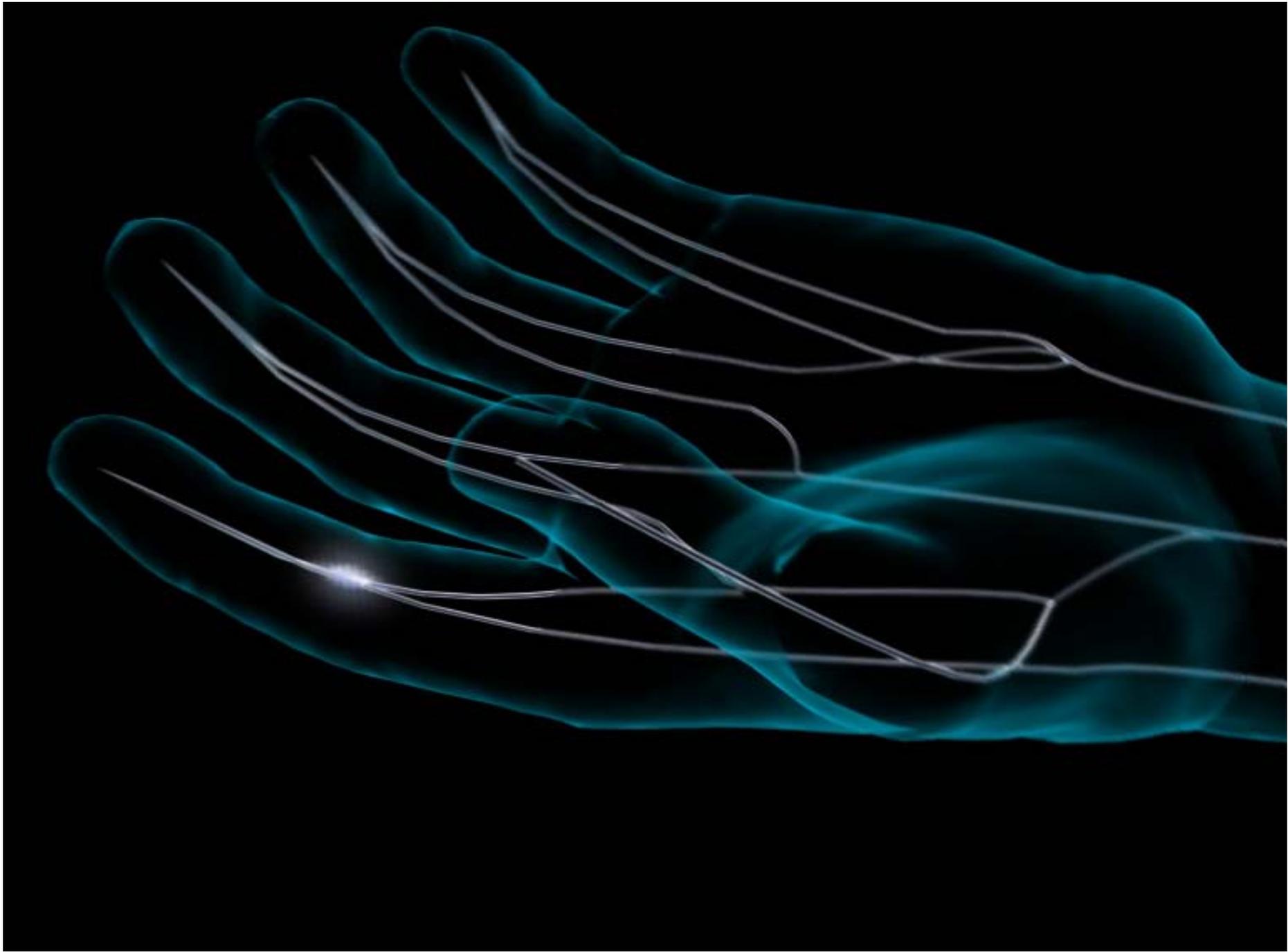


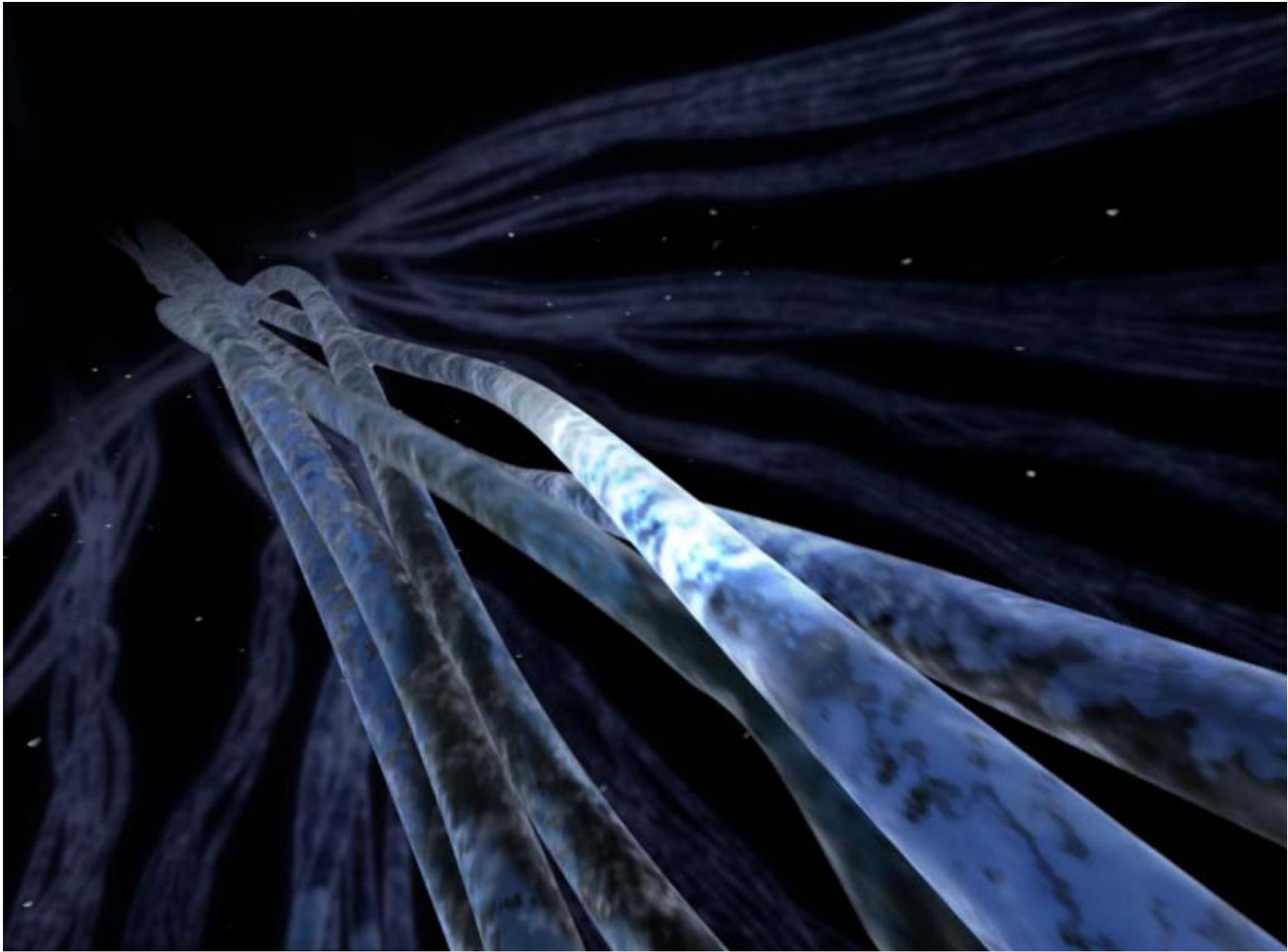
HARD-WIRED NERVOUS SYSTEM

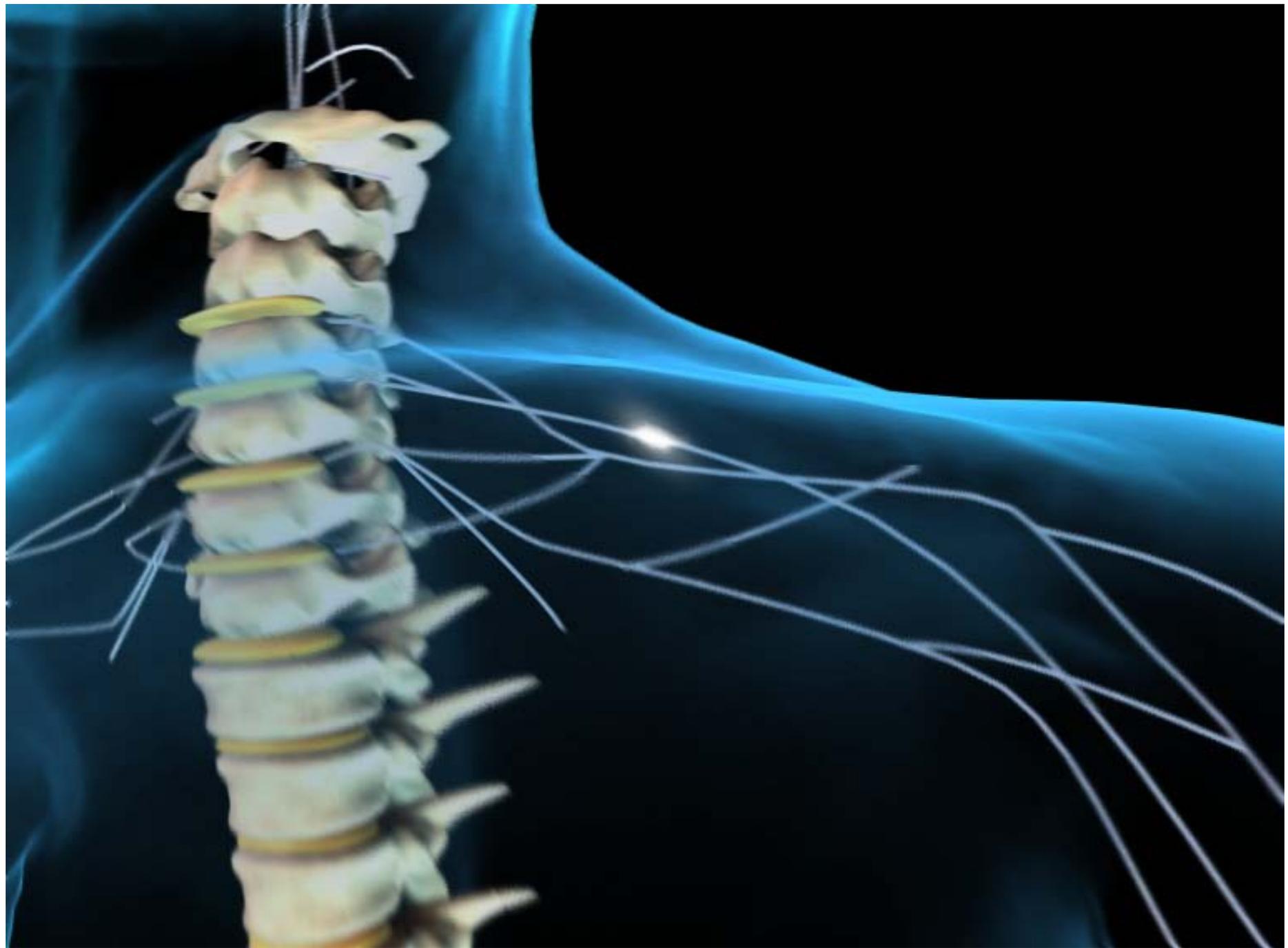


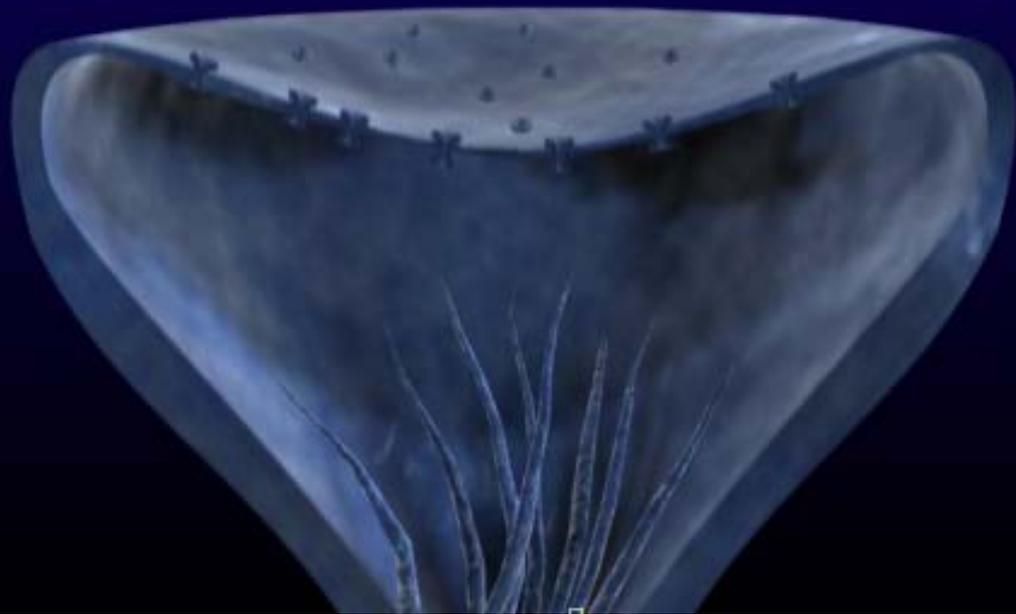
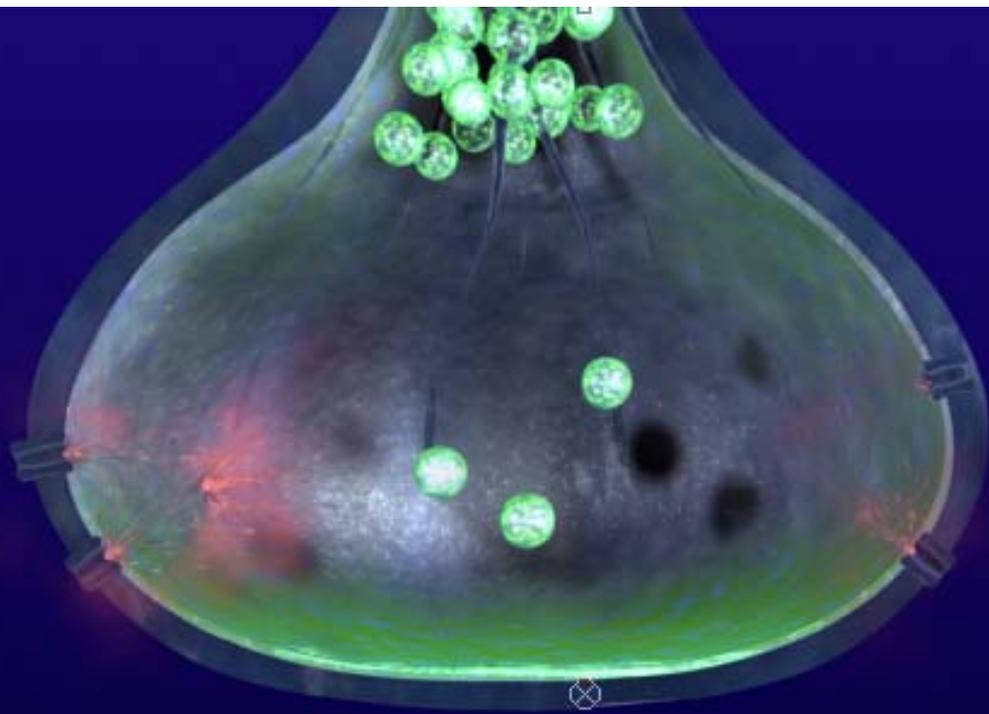






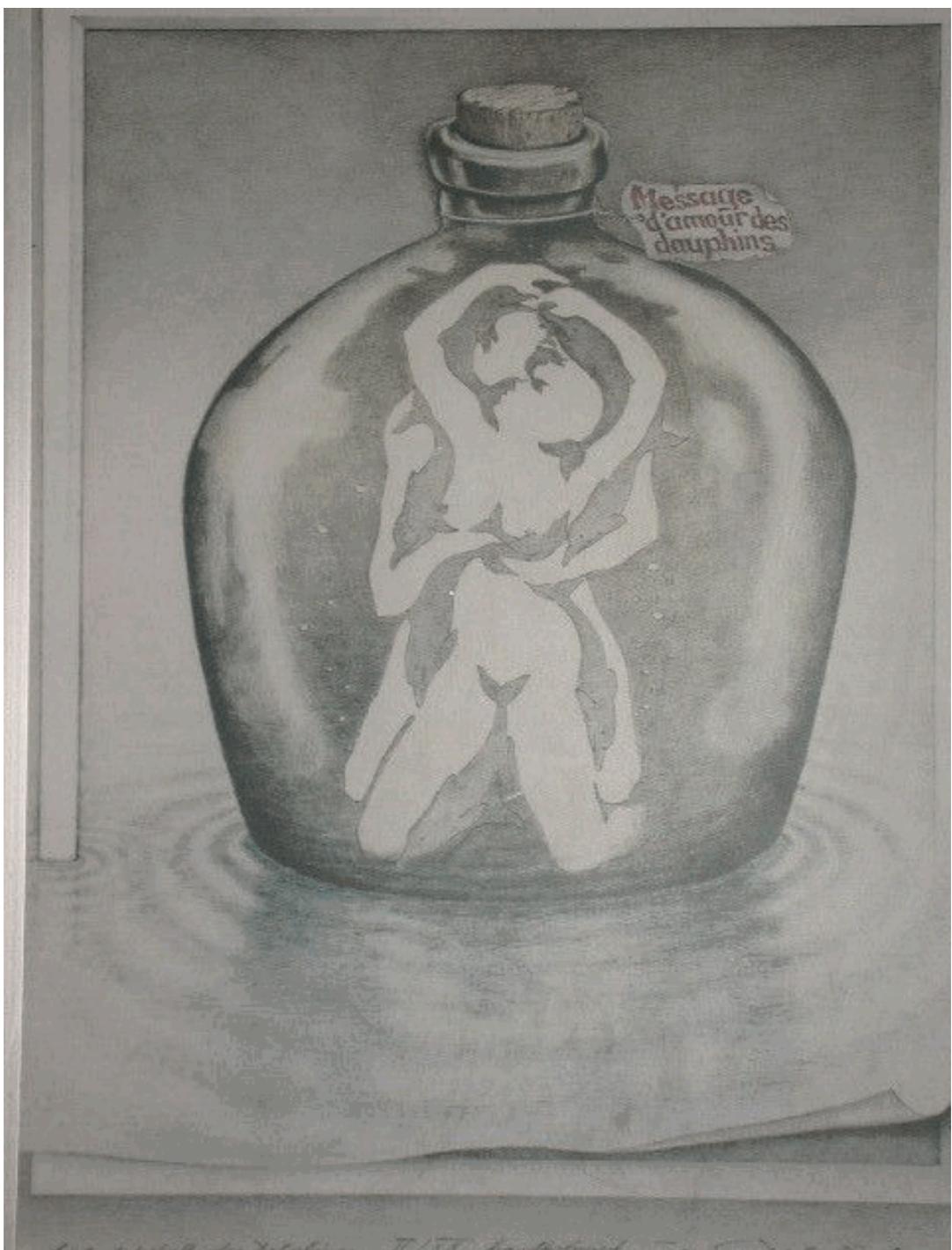








With what do we see?



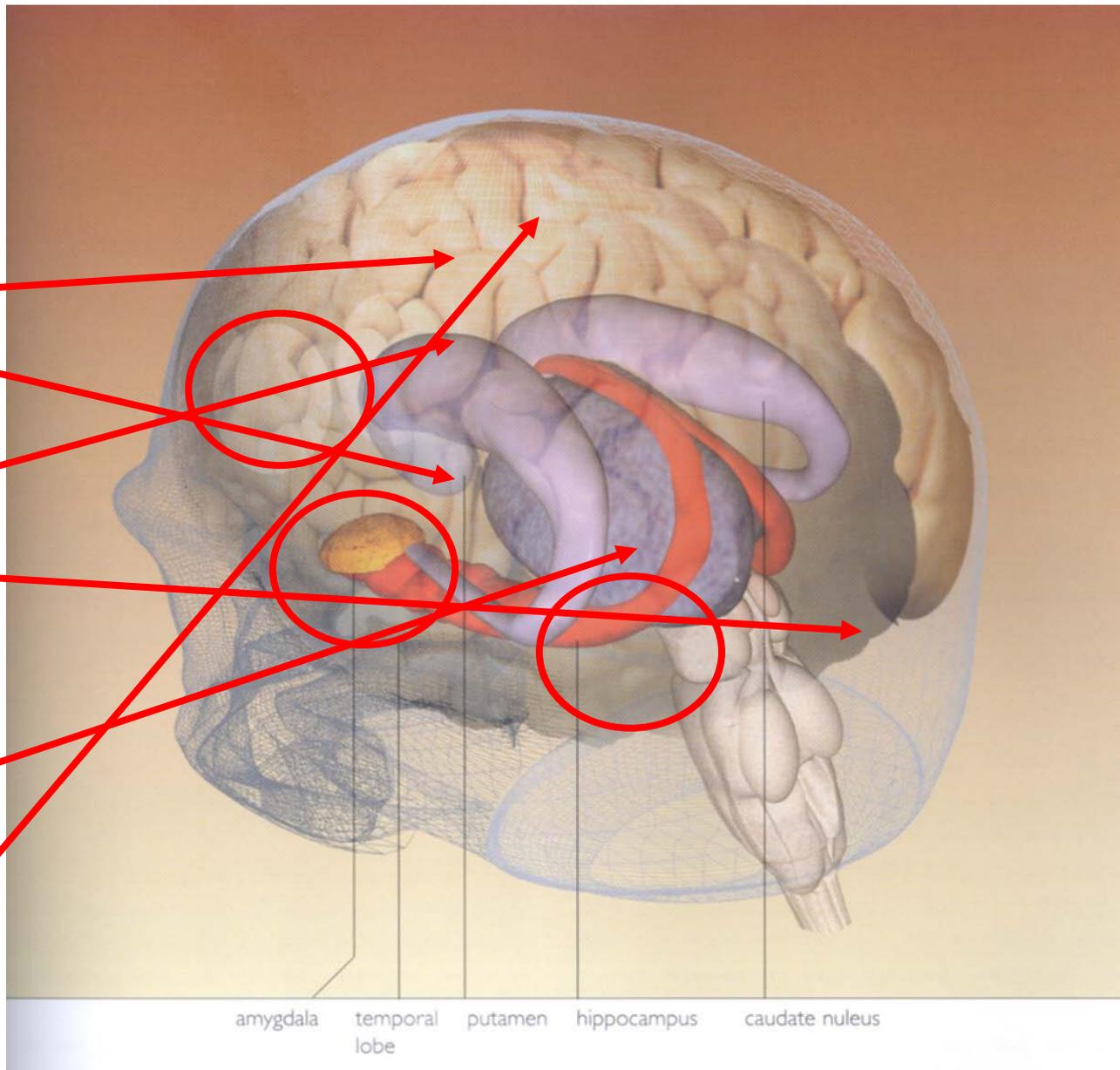
Message
d'amour des
dauphins

With what do we 'feel' pain?





- SII
- Insular Cortex (emotions)
- ACC (self, awareness)
- Amygdala (rage, fear)
- Thalamus
- SI



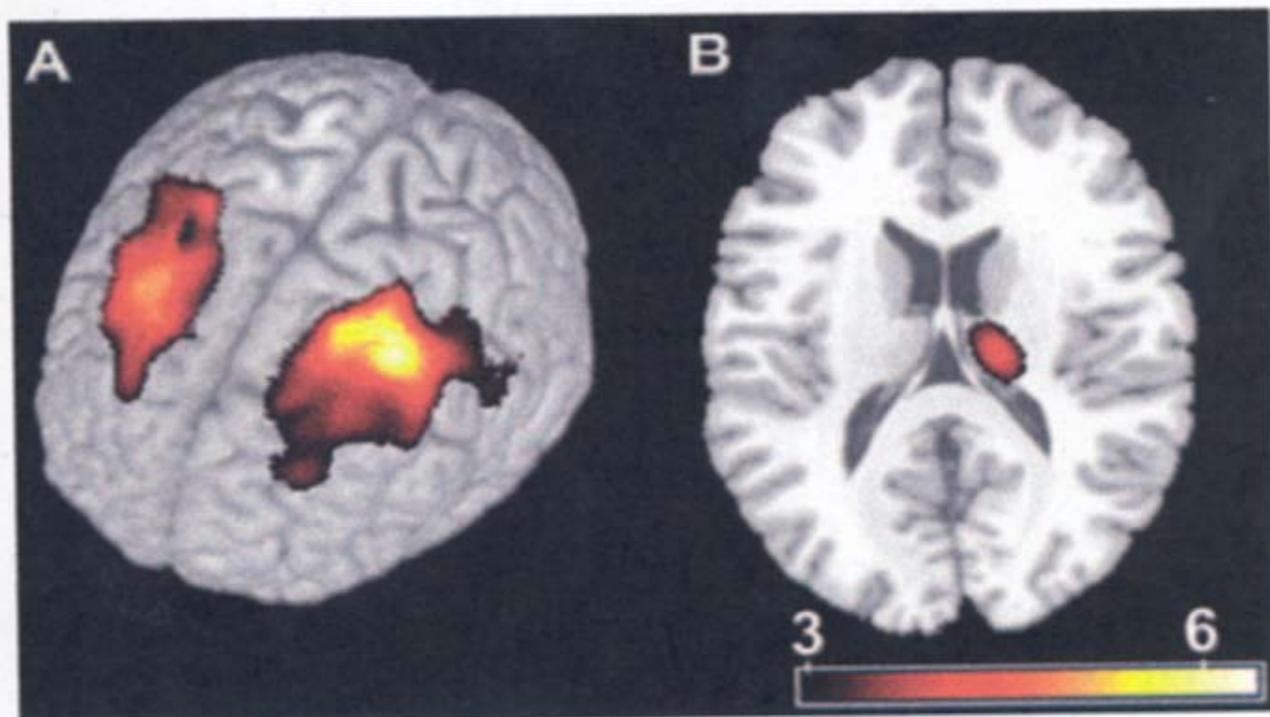
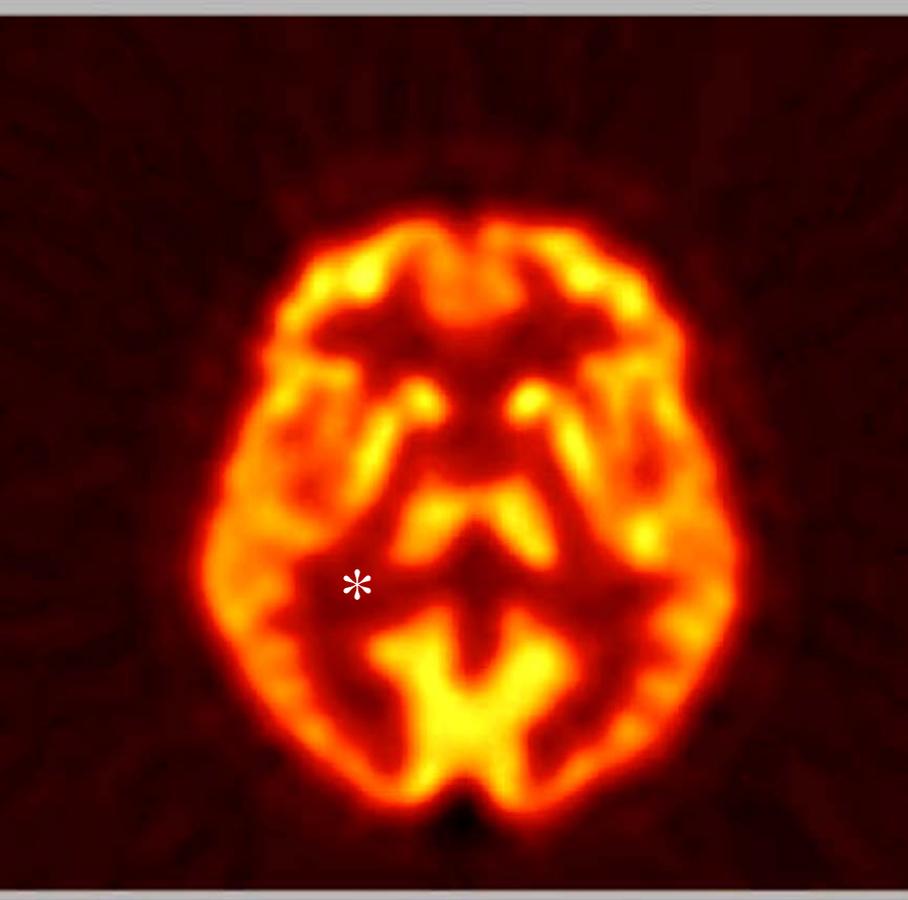
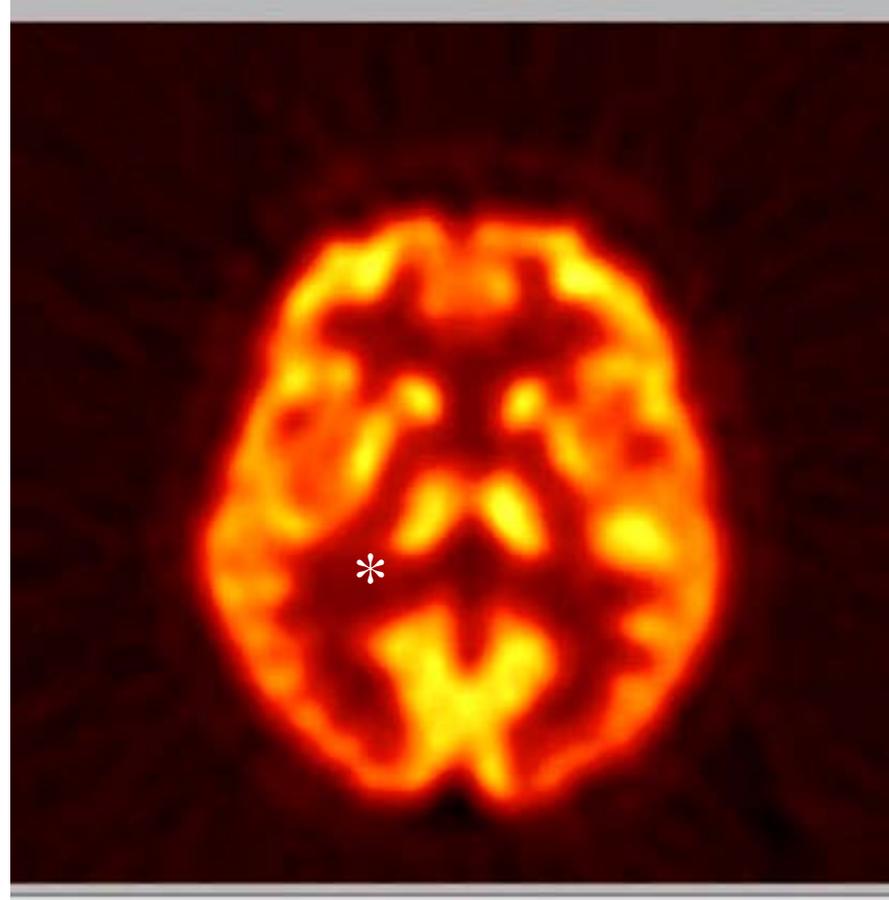


Figure 2. Regional gray matter density decreases in CBP subjects. A nonparametric comparison of voxel-based morphometry between CBP and control subjects is shown. *A*, Gray matter density is bilaterally reduced in the DLPFC. The result is from a VBM permutation-based pseudo-*t* test and voxel-level contrasts when all brain gray matter voxels were compared between controls and CBP subjects. Pseudocolor highly positive values indicate regions where gray matter density was reduced in CBP subjects (controls — CBP). *B*, A nonparametric comparison spatially limited to the thalami revealed a significant decrease in gray matter density in the right anterior thalamus. A slice at the peak of decreased thalamic gray matter is shown. Pseudo-*t* values are color coded; range is 3–6.



before lidocaine



after lidocaine





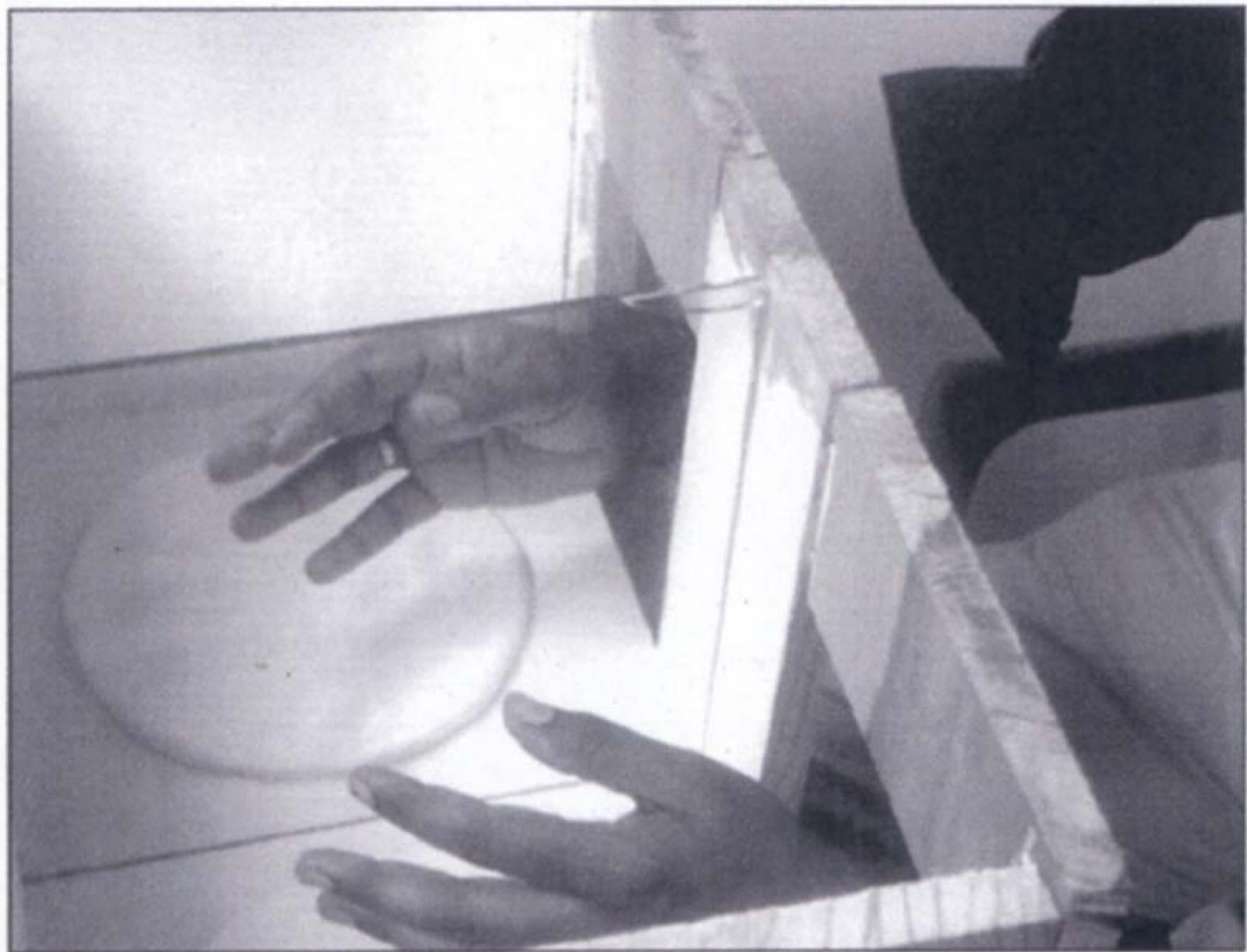
Pain Related Brain Activity is reduced during VR



No VR



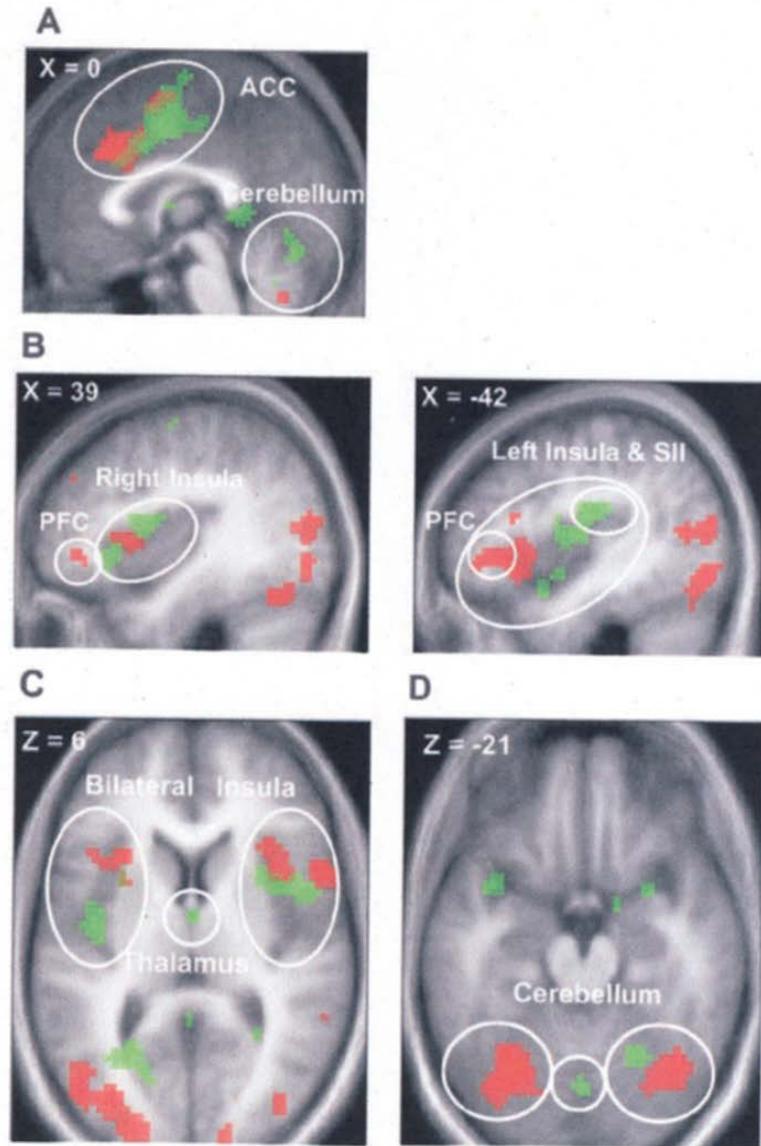
VR



The affective but not the discriminative sensorial components of pain are activated during empathy

Singer T, 2004, 2005, 2007, 2009

Fig. 1. Pain-related activation associated with either experiencing pain in oneself or observing one's partner feeling pain. Areas in green represent significant activation ($P < 0.001$) for the contrast pain–no pain in the "self" condition and areas in red for the contrast pain–no pain in the "other" condition. The results are superimposed on a mean structural scan of the 16 subjects. Activations are shown on sagittal (A and B) and axial (C and D) slices. (A) Activation in ACC and cerebellum. (B) Bilateral insula cortex extending into lateral prefrontal cortex, left posterior insula extending into secondary somatosensory cortex (SII), bilateral occipital cortex, and fusiform cortex. (C) Bilateral insula and mediodorsal thalamus. (D) Middle and lateral cerebellum/fusiform gyrus. For coordinates of peak activations from "self" and "other" conditions, see tables S1 and S2.



Empathy

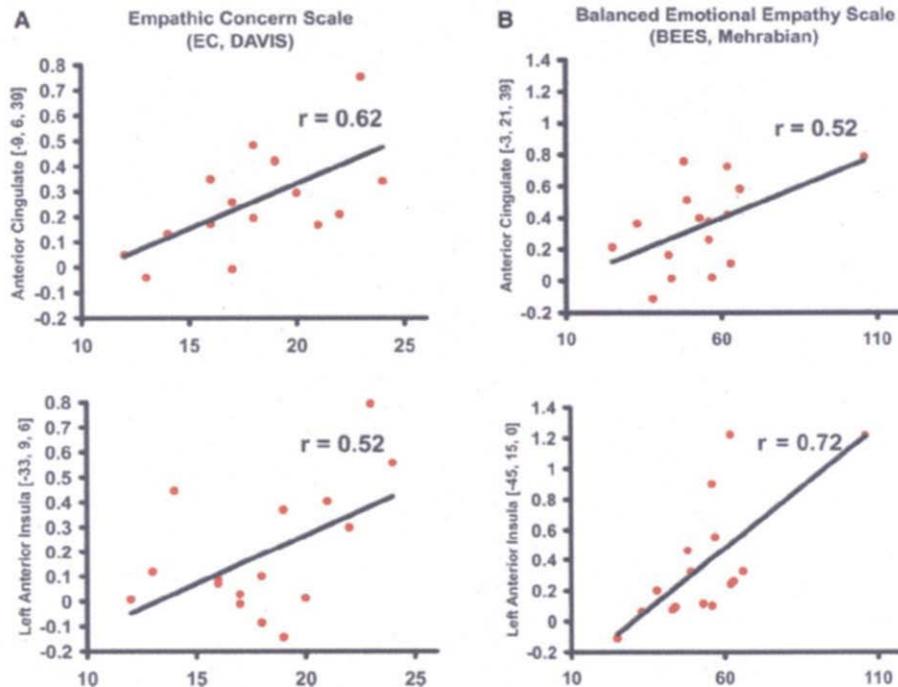


Fig. 4. Activation level (parameter estimates) observed within peaks of the ACC and the left insula during empathy-related conditions (pain–no pain in other) are significantly correlated with individual differences in empathy as measured by (A) the Empathic Concern Scale of Davis (20) and (B) the Balanced Emotional Empathy Scale of Mehrabian (18, 19). The lines represent the linear best fit; r refers to the correlation coefficient. All correlations are significant on the $P < 0.05$ level. Peak activations lie within regions of ACC and left insula that were activated in the simple contrast pain–no pain in others. Coordinates refer to peak activations and are in mm.

**Brain activity increases with subject intimacy
(emotional contagion)**

CONTEXT

Pain beliefs
Expectation
Placebo

MOOD

Depression
Catastrophizing
Anxiety

Pain Experience

COGNITIVE SET

Hypervigilance
Attention
Distraction
Catastrophizing

CHEMICAL & STRUCTURE

Neurodegeneration
Metabolic (e.g. opioidergic, dopaminergic)
Maladaptive plasticity

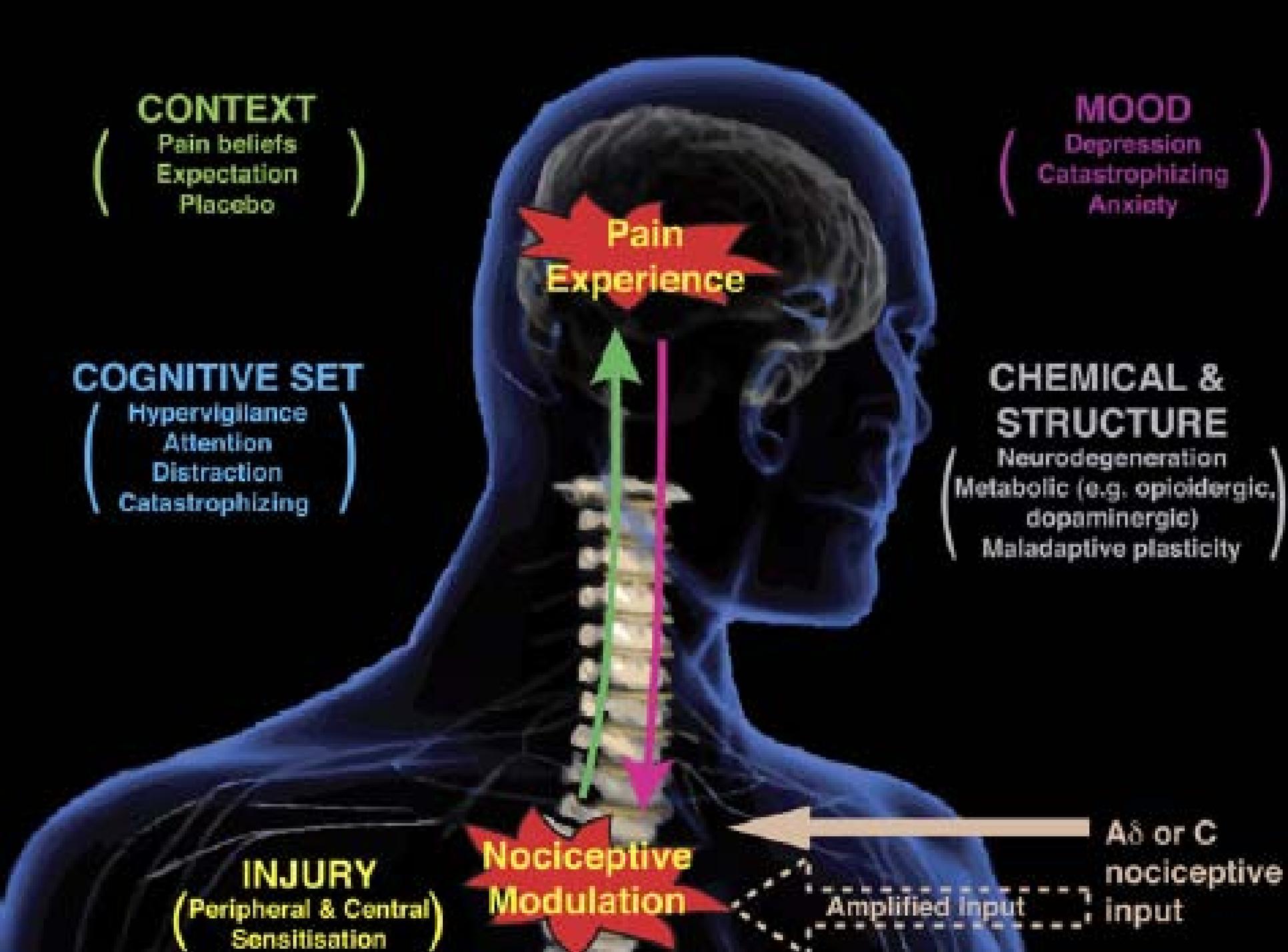
INJURY

(Peripheral & Central)
Sensitisation

Nociceptive Modulation

A δ or C nociceptive input

Amplified Input



- **Until the mid 20th century, pain was always described as a byproduct of some disease state.**



- **Proper treatment of the disease should bring pain relief**

**Today we know that
acute pain is a symptom
Chronic pain is a disease**

(and a very expensive one...)

**Not all Doctors or administrators of Health plans
understand this.....**

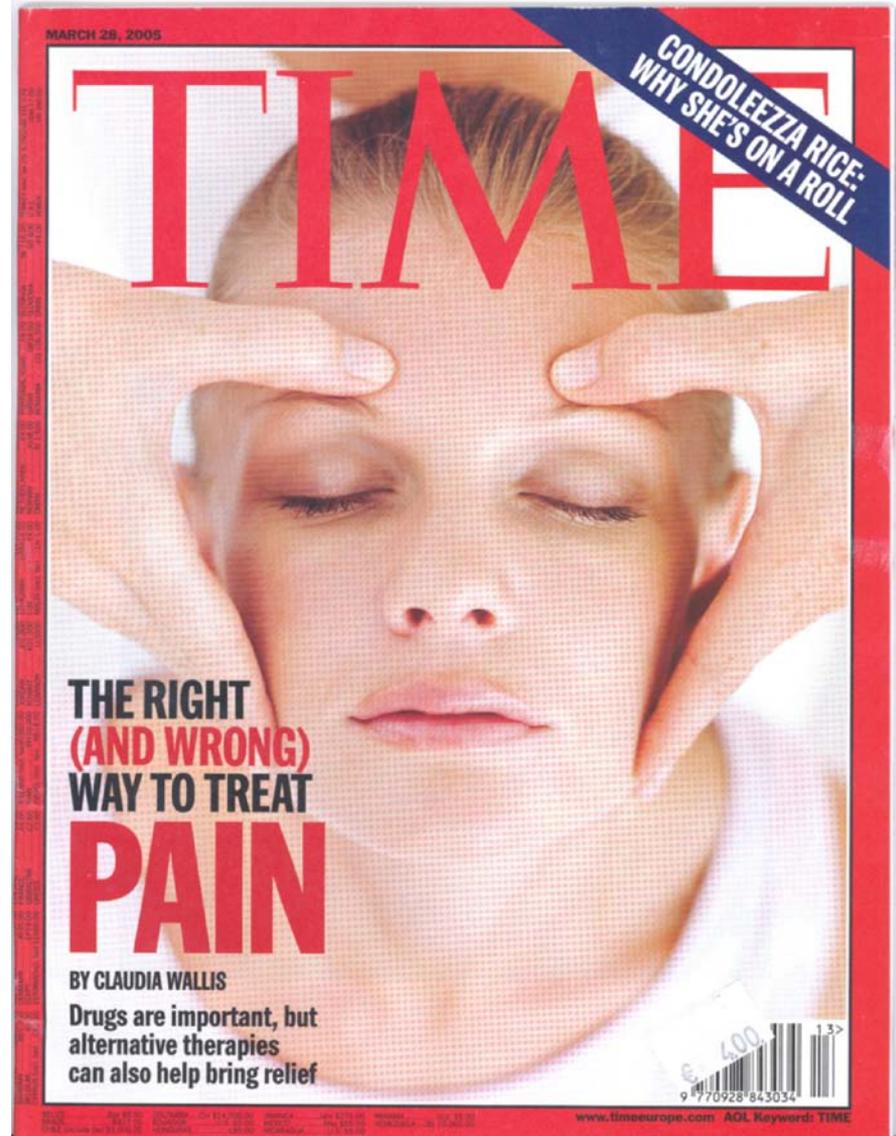
**The public is misinformed about Pain
and its treatment:**

by providers

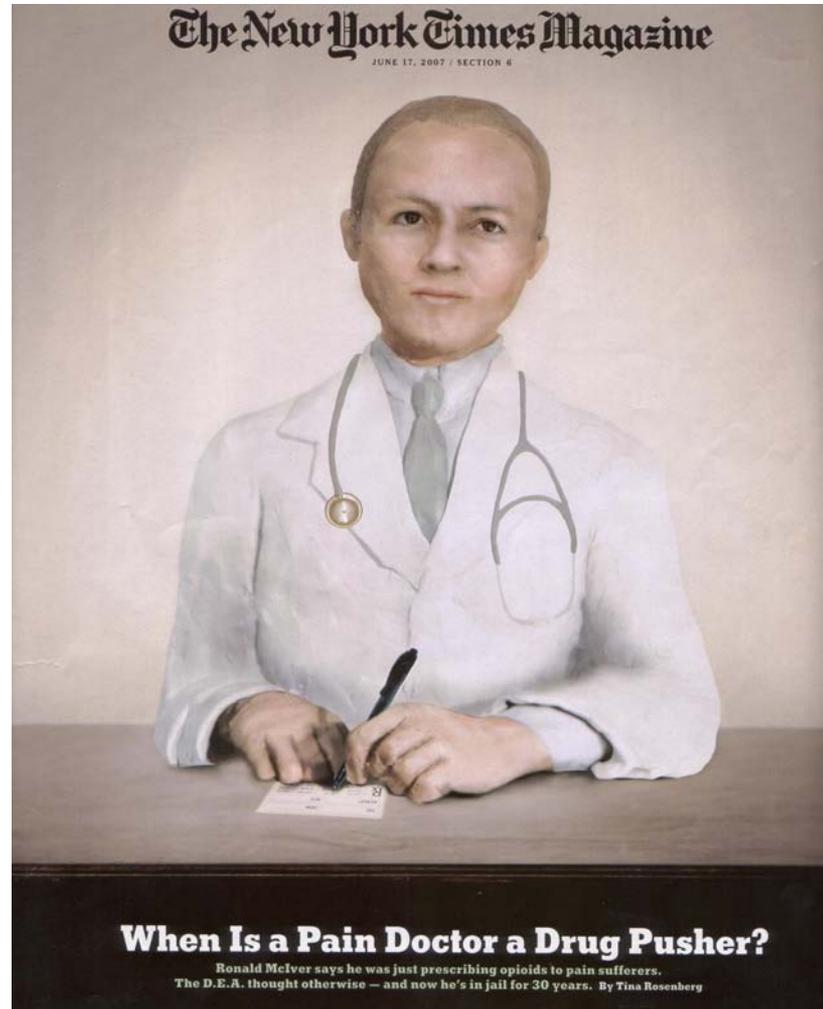
by drug companies

by device manufacturers

by the press

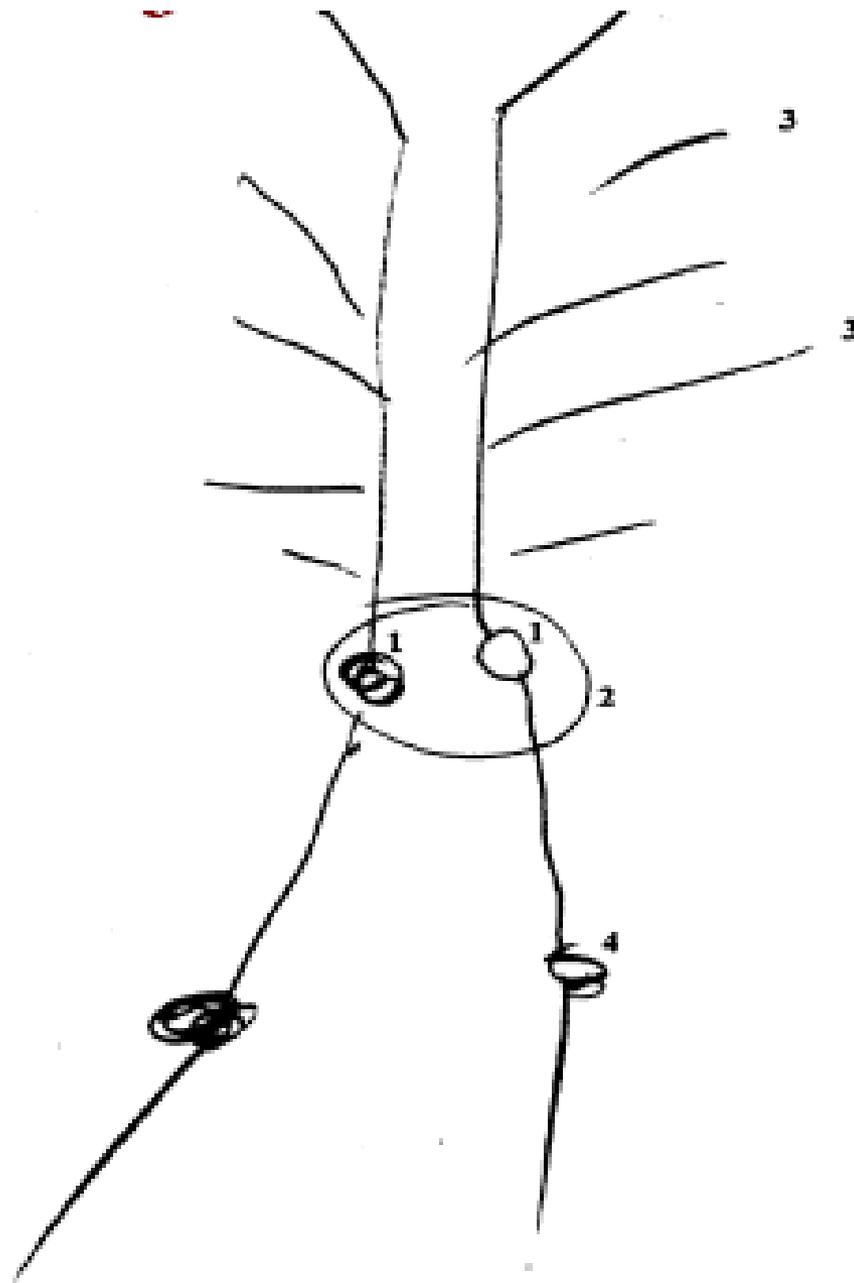


pain is not Pain



Today:

- Introduction (5 minutes)
- Pain and the Brain (15 minutes)
- **How to measure Pain (15 min)**
- How will that change my practice (10 min)



- 1. disques
- 2. rotule
- 3. côtes
- 4. genoux

Outcome Measures Approach*

1. Pain
2. Physical functioning
3. Emotional functioning
4. Participant ratings of improvement and satisfaction with treatment
5. Symptoms and adverse events
6. Participant disposition

*IMMPACT's 6 core domains Turk et al. Pain 2003;106:337-45



Background

- Background
- Beliefs
- Current Medications
- Substance Use and Psychosocial History
- Current Mental Health
- Global Functioning
- End of MPAT

Pain Assessment

Please tell us about your pain

Where is your worst pain?

What kind of pain are you experiencing? (Select all that apply)

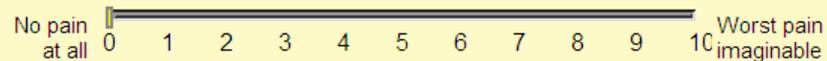
- | | |
|------------------------------------|---|
| <input type="checkbox"/> Burning | <input type="checkbox"/> Stabbing |
| <input type="checkbox"/> Searing | <input type="checkbox"/> Pins & needles |
| <input type="checkbox"/> Dull | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Throbbing | <input type="checkbox"/> Shooting |
| <input type="checkbox"/> Deep | <input type="checkbox"/> Tight |
| <input type="checkbox"/> Aching | <input type="checkbox"/> Other <input type="text"/> |

For the next questions, please click and slide the marker to indicate your level of pain.

What was your **highest** level of pain last week?



What was your **lowest** level of pain last week?



What was your **average** level of pain last week?

[back](#)[next](#)

M-PAT

Multidimensional Pain Assessment Tool

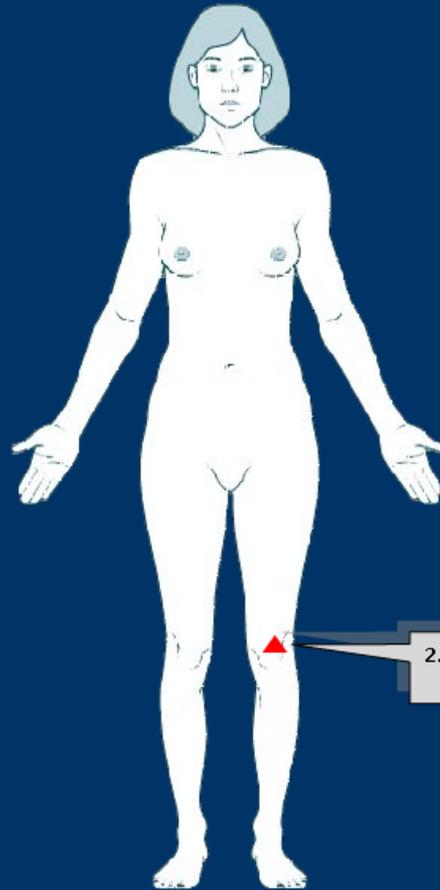


Background

- Background
- Beliefs
- Current Medications
- Substance Use and Psychosocial History
- Current Mental Health
- Global Functioning
- End of MPAT

Use the diagram below to indicate the types of pain you experience on the front of your body. When you're finished, please click the submit button. You will have an opportunity to indicate pain on the back of your body on the next page. If you have no pain on the front of your body, simply do nothing but click submit. If you make a mistake, you may click the reset button to start over.

PAIN DIAGRAM (choose a pain type and indicate where it occurs on your body)



Pain Type

- ▲ throbbing
- numbness
- deep
- aching
- ▼ stabbing
- ★ burning
- ⚡ pins and needles
- ⚡ shooting
- ♥ throbbing

1. Choose pain type

2. Click on location

RESET

SUBMIT

back

M-PAT

Multidimensional
Pain Assessment Tool



Background

- Background
- Beliefs
- Current Medications
- Substance Use and Psychosocial History
- Current Mental Health
- Global Functioning
- End of MPAT

Use the diagram below to indicate the types of pain you experience on the back of your body. When you're finished or if you have no pain on the back of your body, please click the submit button. If you make a mistake, you may click the reset button to start over.

PAIN DIAGRAM (choose a pain type and indicate where it occurs on your body)

Pain Type	
▲	tightness
⊘	numbness
■	deep
●	aching
▼	stabbing
✱	burning
⋈	pins and needles
⚡	shooting
♥	throbbing

RESET SUBMIT

back

Current Mental Health Status		Name: Case Study3 ID: CaseStudy3	
Generalized Anxiety:	17, Possible Anxiety Disorder	GAD-7 (0-9 = Negative, 10-21 = Possible anxiety disorder)	
Somatization:	5, Possible Somatization	Whiteley-7 (0-4 = Negative, 5-7 = Possible somatization)	
Depression:	21, Possible Depressive Disorder	CES-D 10 (0-9 = Negative, 10-30 = Possible depressive disorder)	
Tobacco Use		Past and current use of tobacco products	
Past use:	Yes	Has ever used any form of tobacco	
Current use:	No	Currently uses any form of tobacco	
Time since quit:	4 Year(s)	If applicable, length of time since quit using tobacco	
Cigarettes/day:	Pipe bowls/day:	Qty. cigarettes, pipes	
Cigars/day:	Snuff/chew cans or pouches/week:	Qty. cigars, smokeless tobacco	
Alcohol Use Disorders Identification Test (AUDIT)		Alcohol use during the past year	
Alcohol use:	7-9 drinks, 2-3 x/wk	Qty. Frequency (Nondrinkers or light drinkers skip subsequent questions)	
Binge drinking:	Weekly	Frequency 5+ drinks on one occasion	
Blackouts:	Less than monthly	Frequency unable to remember previous night	
Signs of alcohol dependence:	5	Range = 0-12 (sum of 3 items)	
Presence of alcohol-related harms:	6	Range = 0-16 (sum of 4 items)	
Recommendation:	20, Refer to specialist for treatment	Total score (8-15 = advice, 16-19 = brief counseling, 20-40 = refer to specialist)	
Alcohol risk level:	20, Very high	Total score (0-7 = low, 8-15 = moderate, 16-19 = high, 20-40 = very high)	

Drug Use Disorders Identification Test (DUDIT)		Illicit drug use and Rx abuse during the past year	
Drug use:	N/A, Non-drug user	Intensity, Frequency (Non-drug users skip subsequent questions)	
Polydrug use:	Never	Frequency >1drug on one occasion	
Heavily influenced by drugs:	Never	Frequency	
Signs of drug dependence:	0	Range = 0-12 (sum of 3 items)	
Presence of drug-related harms:	0	Range = 0-16 (sum of 4 items)	
Recommendation:	0, No intervention needed	Total score (0-females: 1 = brief counseling, 2-44 = refer to brief counseling, 6-44 = refer to specialist)	
Opioid Risk Tool (ORT)		Probability of patient displaying aberrant behaviors when	
Family Hx	Alcohol abuse: Yes	Point value 1	Point value 3 (Webster)
	Illegal drug abuse: No	for females: 2	for males: 3
	Rx drug abuse: No	4	4
Personal Hx	Alcohol abuse: Yes	3	3
	Illegal drug abuse: No	4	4
	Rx drug abuse: No	5	5
	Hx preadolescent sexual abuse: No	3	0
	Ever Dx ADD, OCD, BIPO, SCHZ: No	2	2
	Ever Dx Depression: Yes	1	1
	Age 16-45: Yes	1	1
Opioid risk level:	8, High	Total score (0-3 = low, 4-7 = moderate, 8-26 = hi	

SCORE SUMMARY

Identifying Information

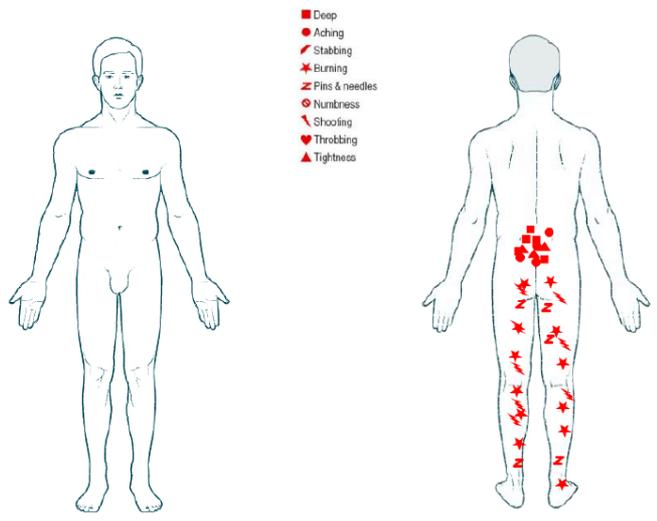
Name: Case Study3
 ID: CaseStudy3
 Date completed: 1/31/2010
 Patient age: 45
 DOB: 11/15/1965

Latino/a? Select

- American Indian/Alaska Native
- Asian/Asian American
- Black/African American
- Hawaiian/Pacific Islander
- White
- Other:

Personal Characteristics

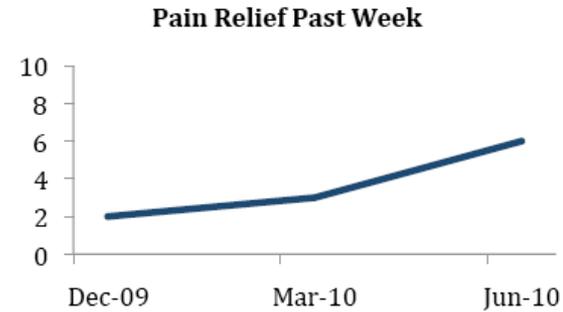
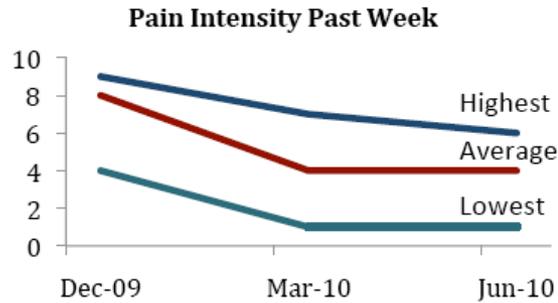
Handedness: Left
 Marital status: Married
 Education level: BA/BS
 Learning difficulties: No
 Explanation:
 Living in a safe environment: Yes
 Explanation:



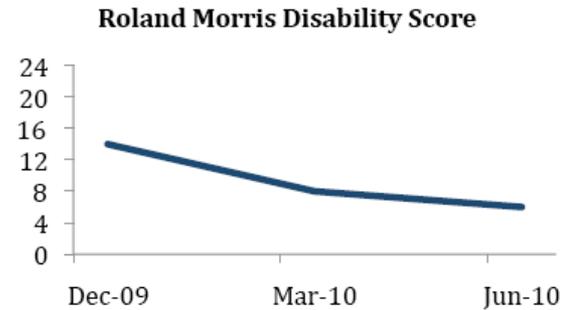
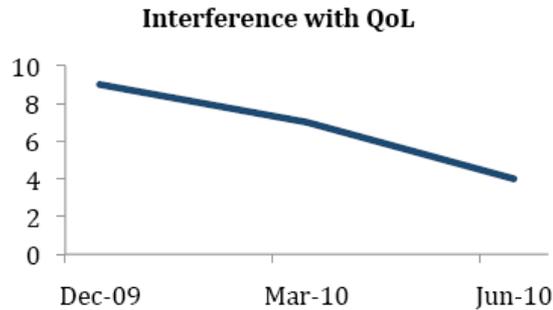
CPAIN Patient Profile Report - Update

John Public ID: 102345643

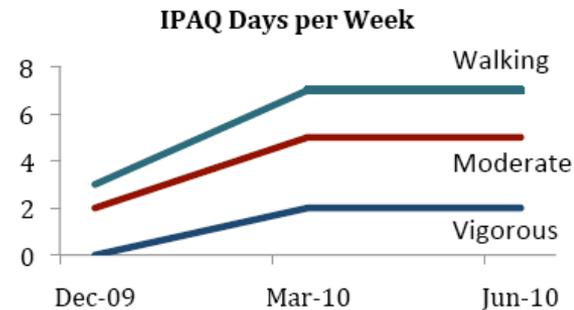
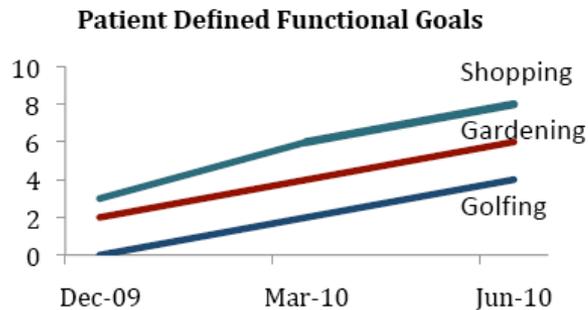
Pain Level and Relief



Interference with QoL and Disability



Functional Goals, IPAQ





Assessment

- Choose an Activity to Monitor
- Assessment

Pain Location

Below is a list of possible pain locations. In the first column, please indicate one or more areas where you usually hurt. In the second column, please indicate the ONE location of your most severe pain:

Location	Any pain?	Worst pain?
Head	<input type="checkbox"/>	<input type="radio"/>
Neck	<input type="checkbox"/>	<input type="radio"/>
Chest	<input type="checkbox"/>	<input type="radio"/>
Stomach	<input type="checkbox"/>	<input type="radio"/>
Back	<input type="checkbox"/>	<input type="radio"/>
Arm	<input type="checkbox"/>	<input type="radio"/>
Hand	<input type="checkbox"/>	<input type="radio"/>
Buttocks	<input type="checkbox"/>	<input type="radio"/>
Genital/Urinary	<input type="checkbox"/>	<input type="radio"/>
Leg	<input type="checkbox"/>	<input type="radio"/>
Knee	<input type="checkbox"/>	<input type="radio"/>
Foot	<input type="checkbox"/>	<input type="radio"/>

How INTENSE has your pain been recently?

No pain 0 1 2 3 4 5 6 7 8 9 10 Extreme pain

How much has pain INTERFERED with your activities recently?

Not at all 0 1 2 3 4 5 6 7 8 9 10 Extremely

The activity you have chosen to monitor is: brushing

To change your activity [click here](#).

How difficult is it for you to do your activity now?

Not at all difficult 0 1 2 3 4 5 6 7 8 9 10 Extremely Difficult

Over the last 2 weeks, how often have you...

Pain Tracker

	Not at all 0	Several days 1	More than half the days 2	Nearly every day 3
...had little interest or pleasure in doing things?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
...felt down, depressed, or hopeless?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
...felt nervous, anxious, or on edge?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Medications [? Tips for completing this section](#)

< TD >

What medications are you now taking for pain? Please list the name and dose of the medication.

OPIOIDS (Check here if no opioids for pain relief in the past month)

Name of medication	Dose (mg/day)
1. <input type="text"/>	<input type="text"/>
2. <input type="text"/>	<input type="text"/>
3. <input type="text"/>	<input type="text"/>

NON-OPIOIDS (Check here if no non-opioid pain relievers in the past month)

Name of medication	Dose (mg/day)
1. <input type="text"/>	<input type="text"/>
2. <input type="text"/>	<input type="text"/>
3. <input type="text"/>	<input type="text"/>

Are you having any side effects from the medications you take for pain? If so, what are they?

In the past month, how many "bad days" have you had where you needed to take more pain medication than your doctor is currently prescribing?

- None
- 1-2
- 3-5
- More than 5

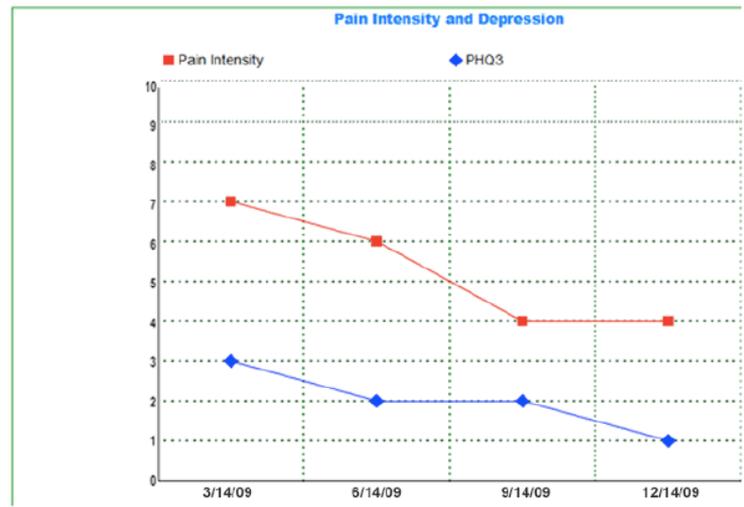
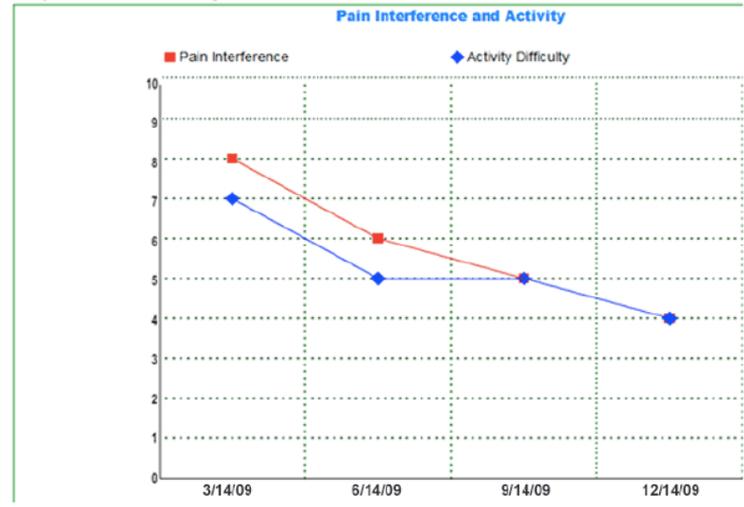


Summary Report

- Choose an Activity to Monitor
- Assessment

Sample report showing patient responses over time:

Patient ID: 550123
Activity Chosen to Monitor: Swimming



3/14/09	6/14/09	9/14/09	12/14/09
---------	---------	---------	----------

Measurement based care

Integrates with CPAIN®

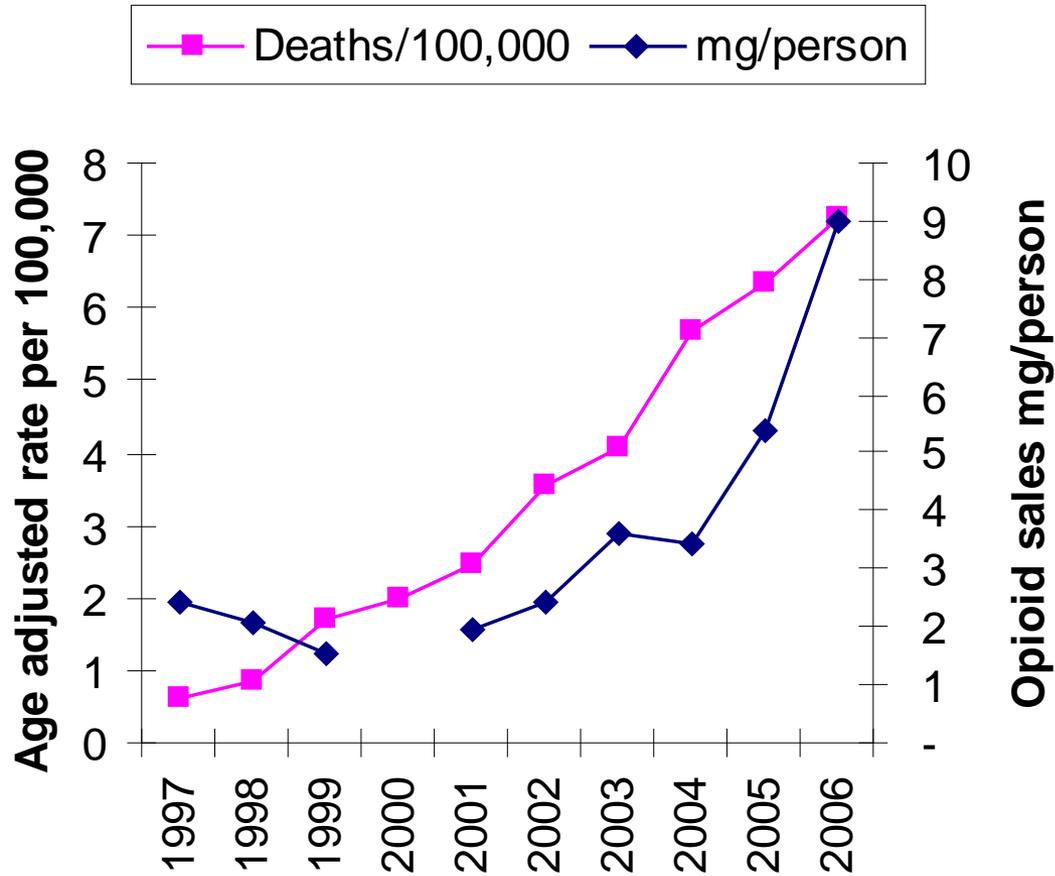
Today:

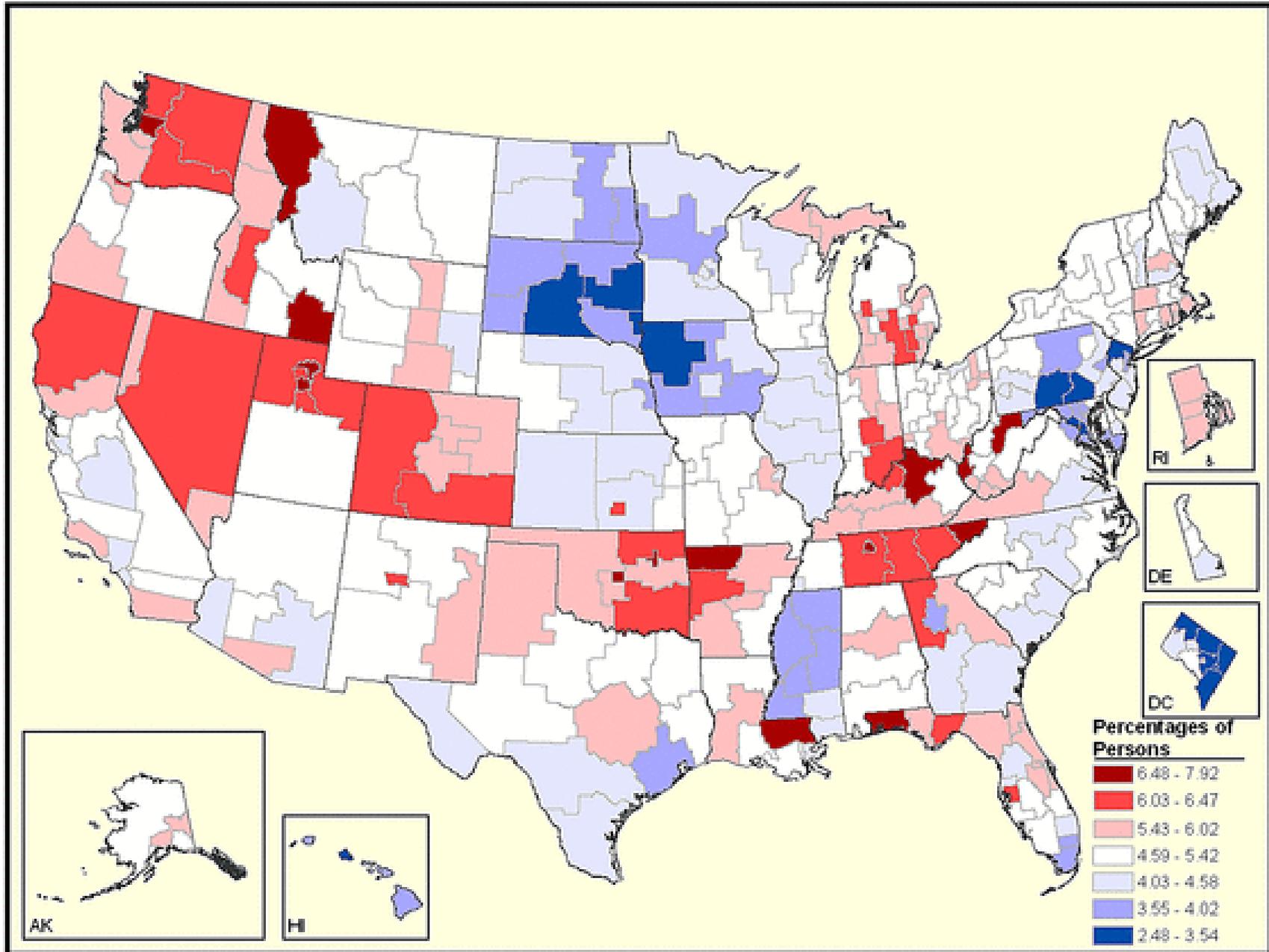
- **Introduction (5 minutes)**
- **Pain and the Brain (15 minutes)**
- **How to measure Pain (15 min)**
- **How will that change my practice (10 min)**

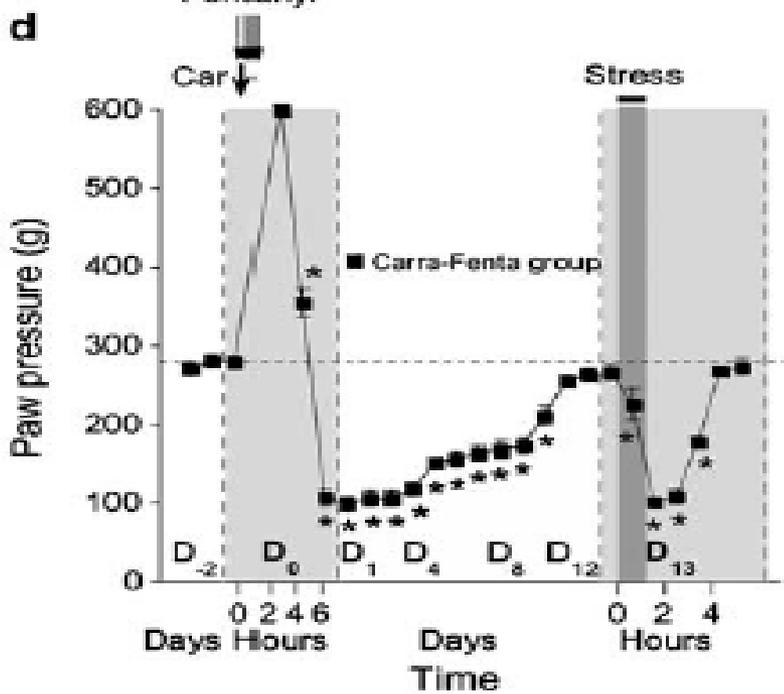
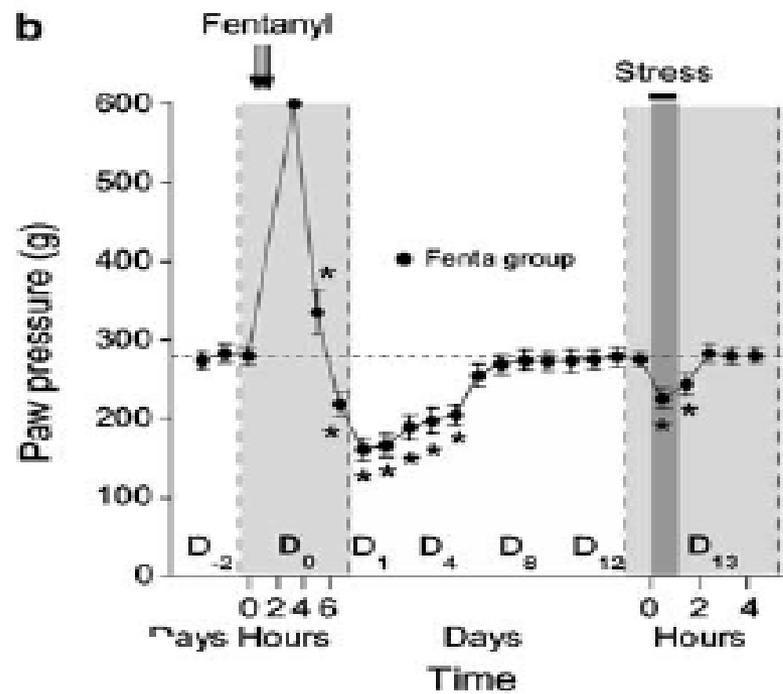
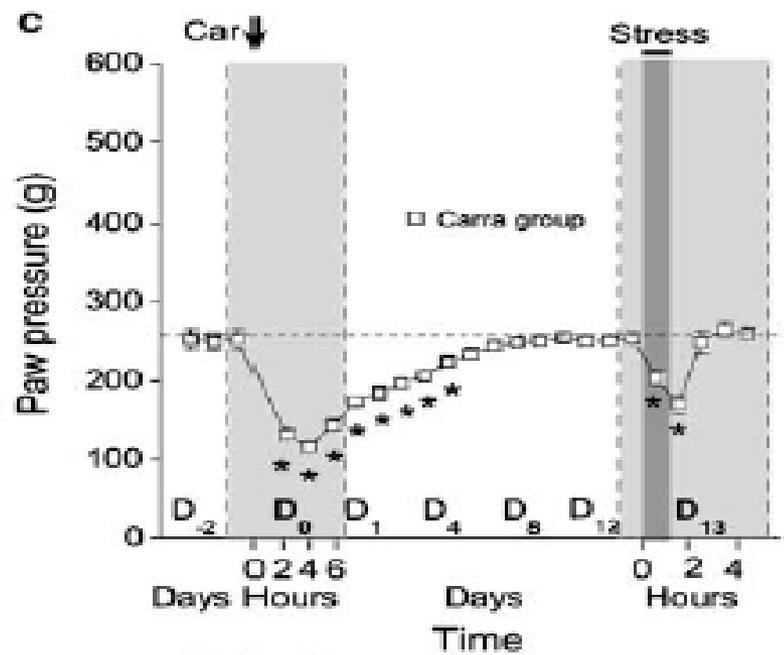
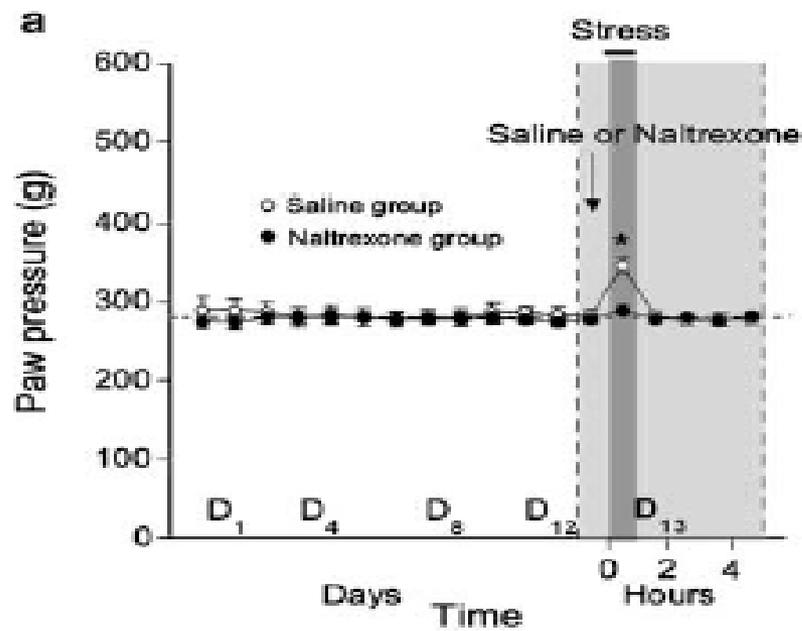


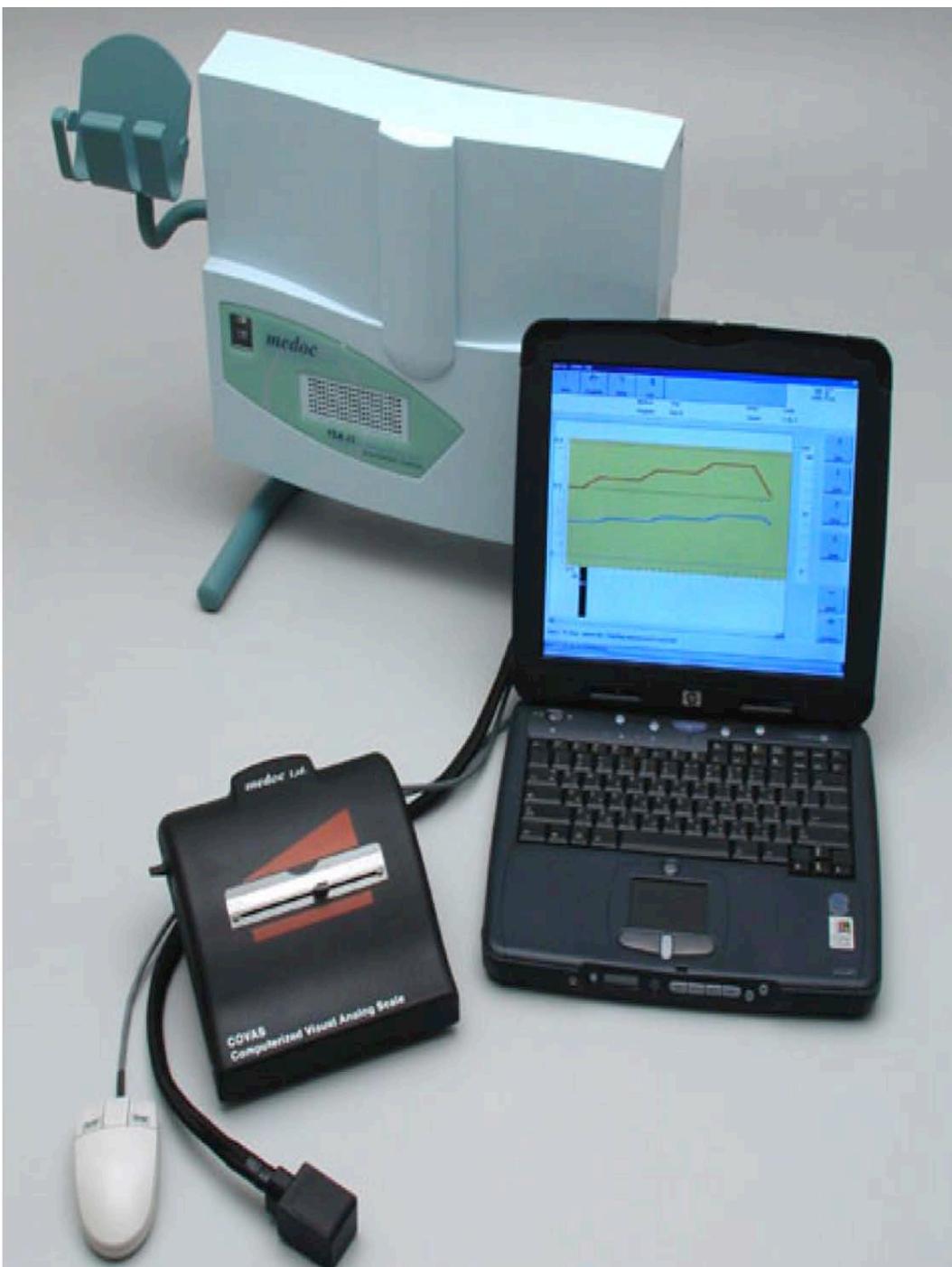
"Enough acupunctur — get me a couple of aspirin."

Unintentional Opioid Overdose Related Deaths & Sales of Rx Opioid Painkillers in WA









Prediction of risk for CPTP by pre-op DNIC scores

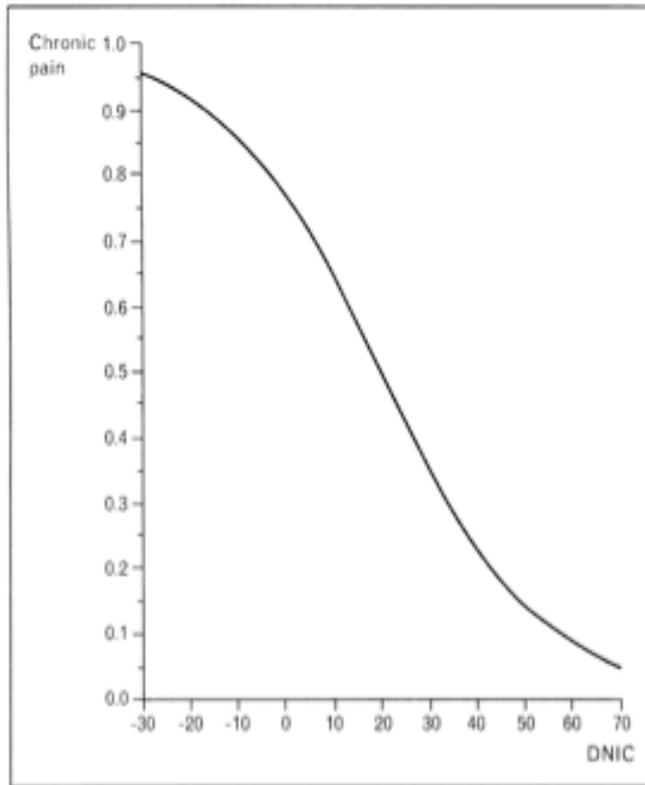
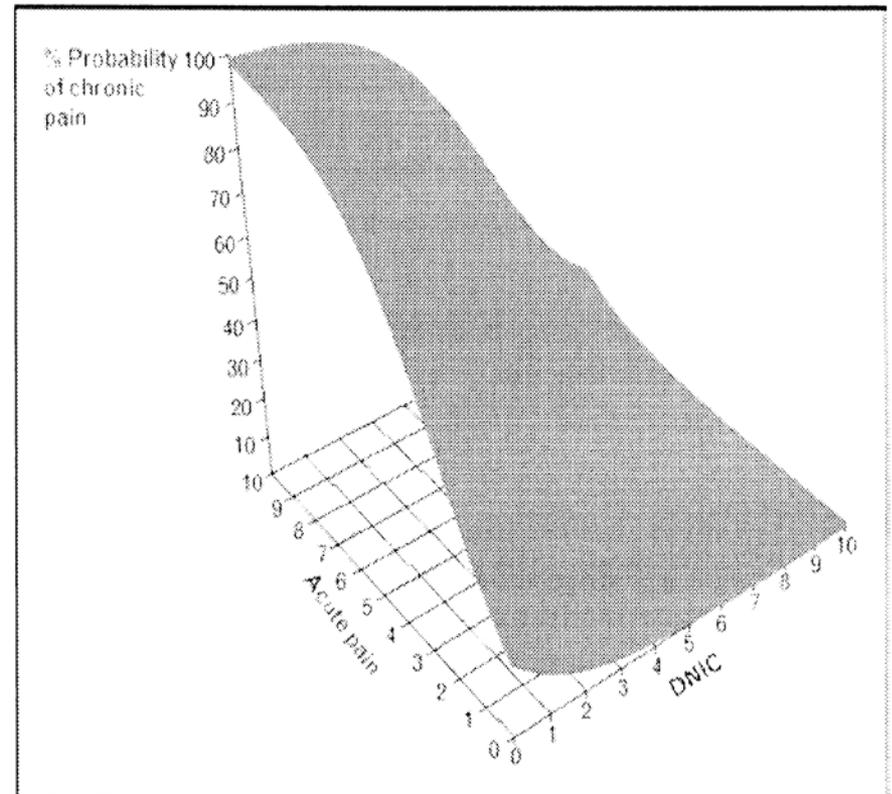
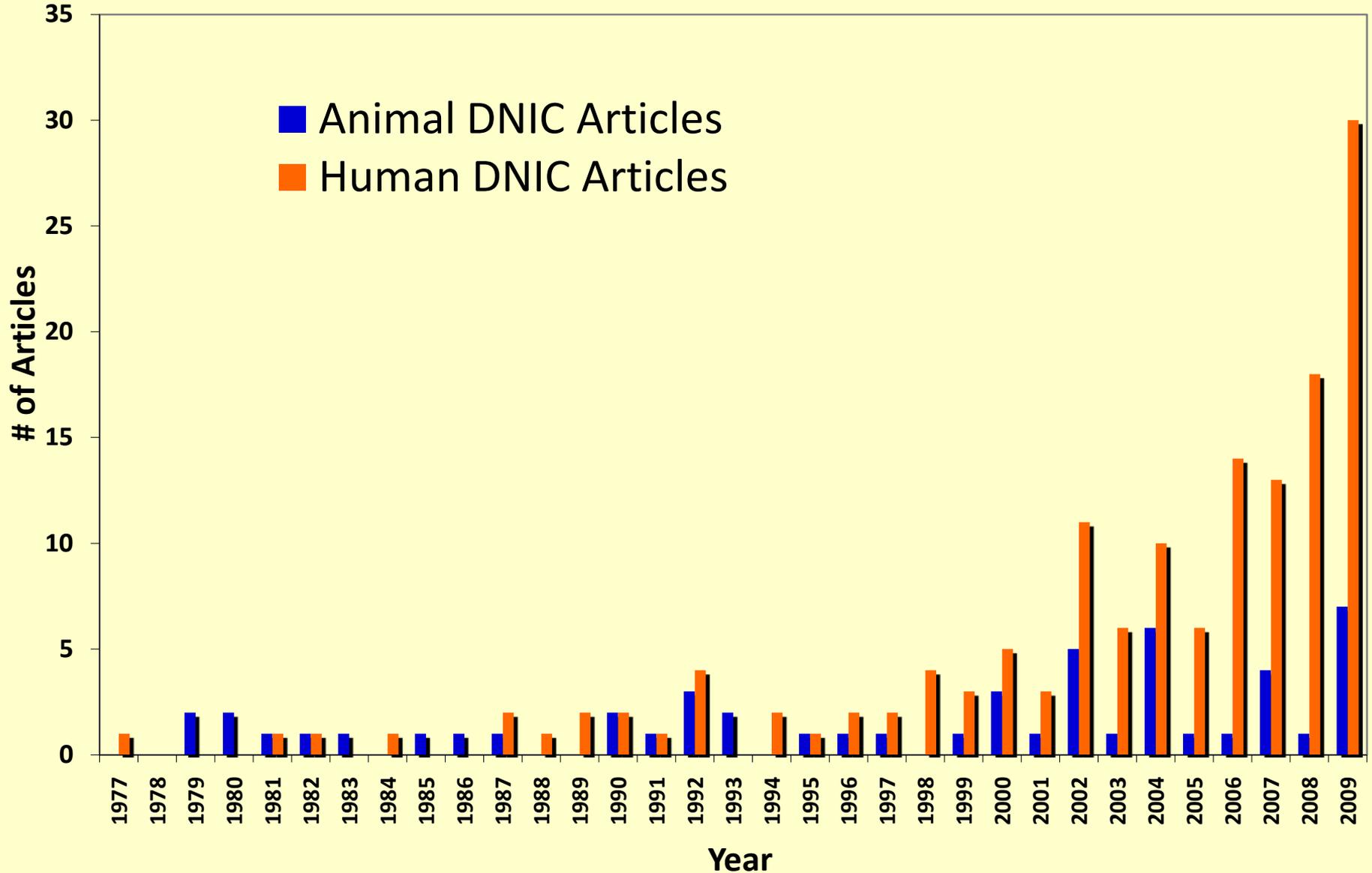


Figure 1 The percentage probability of chronic pain based on acute pain and DNIC scores



Less efficient DNIC and higher acute pain scores predicted enhanced persistent pain intensity and occurrence

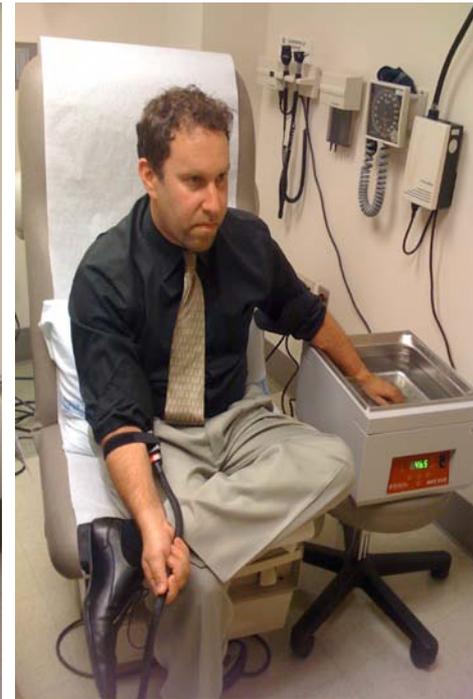
DNIC Publications (1977-2009)



Conditions (2007-2009)	Studies (C/cases)	Modality	Findings
Chronic opioids	(37/73)	Heat thermode, CPT	Opioids (♂) decrease DNIC
IBS	(28/14) (20/40)	Heat thermode, WB Rectal distension, CPT	IBS -> deficient DNIC
Fibromyalgia	(10/52) (36/37) (16/16)	Spatial summation Heat thermode, CPT Pressure pain/fMRI	FM -> deficient DNIC (worse if depression) (COMT/DOP SNP)
CRPS	(27/27)	Electrical summation	CRPS -> deficient DNIC
Chronic fatigue	(31/31)	Spatial summation	CFS -> deficient DNIC
Headache	(23/28/31)	NWR, CPT	Headache->deficient DNIC (worse medication overuse)
TMD	(53) (28/14)	PPT, CPT Heat thermode, WB	TMD-> deficient DNIC (worse if sleep deprived)
Thoracotomy	(62)	Heat thermode, WB	Pre-op DNIC predicts CPTP

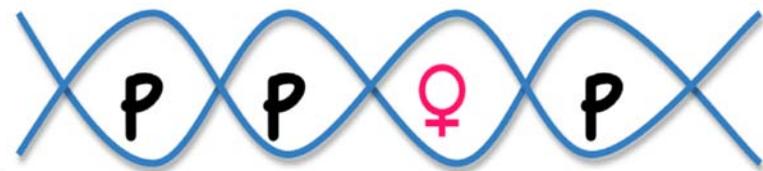
- ✓ Ongoing chronic pain ‘exhausts’ DNIC, making it less effective (or causes increased facilitation through descending pathway)
- ✓ Less efficient DNIC predisposes to chronic pain

Simple to do...



Jeff Mogil, UWMC June 17th 2009

Simple to repeat...



1 TSA Familiarization

(1-2 minutes)

- Attach TSA thermode on volar forearm of dominant hand.
- Apply 43°C for 7 sec.
- At t = 6sec, ask women to rate the noxious sensation on a 0-100 verbal numerical pain scale (VNPS).
- Do the same again at 44°C.

2 TSA Pain-60 Detection

(5-10 minutes)

- Attach TSA thermode on volar forearm of dominant hand.
- Apply a series of 3-6 randomly selected temperatures (43-48°C) for 7 sec each.
- At t = 6sec, ask women to rate the noxious sensation on VNPS.

The aim is to find the temperature that induces -60/100 ⇒ T60.

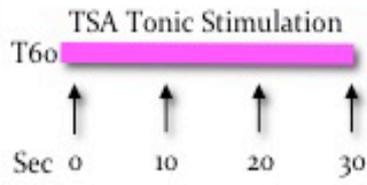
(NOTE: subject is blinded to this)

- Confirm the T60 rating at that temperature.

3 TSA Tonic Stimulation

(30 seconds)

- Attach TSA thermode on volar forearm of dominant hand.
- Apply T60 for 30sec during which you ask the subject to rate the noxious sensation (VNPS) once it reached the destination and every 10sec thereafter.



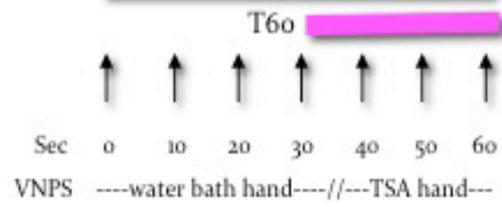
4 DNIC Paradigm

(2-3 minutes)

- Attach TSA thermode on volar forearm of dominant hand.
- Explain first that subject will have to rate VNPS of the immersed hand 4 times and then switch the rating to the VNPS on the TSA arm.
- Have subject immerse their non-dominant hand in a 46.5°C water bath (total time of 60sec) during which the subject will rate the VNPS for the immersed hand at t = 0, 10, 20, 30 sec.
- At 30sec, ensure the TSA reaches T60 on volar forearm and record VNPS at t = 40, 50, 60 sec (while the other hand is still in the bath).

DNIC Paradigm

Conditioning Stimulus (Water Bath)



5 Mechanical Temporal Summation (mTS)

(1-2 minutes)

- Apply a single prick (Von Frey filament) on volar forearm of dominant hand and ask women to give a VNPS (0-10 scale)
- Apply 10 random pricks 1sec apart to the same area and ask women to give VNPS of the 10th prick.



Simple to document...

1) Familiarization

43°C → 5
44°C → 5

2) Pain-60 Determination

1st Test 2nd Test 3rd Test
 46°C → 6 46°C → 5 45°C → 2
 44°C → 4 44°C → 3 47°C → 6
 45°C → 5 45°C → 3 46°C → 3

3) Pain-60 Confirmation

47°C → 6 (or see #2)



mTS

Pain Score pt. 1	0.5
Pain Score pt. 11	0.5
$\Delta \text{Pain} = (\text{pt. 11} - \text{pt. 1}) =$	0

4) Pain-60 Temperature: 47 °C

5) Pain-60 TSA Tonic Stimulation for 30 sec:

Pain Score 1 (t = 0 sec)	4
Pain Score 2 (t = 10 sec), A ₁	6
Pain Score 3 (t = 20 sec), A ₂	6
Pain Score 4 (t = 30 sec), A ₃	5

6) DNIC:

a. Bath, non-dominant hand:

Pain Score 1 (t = 0 sec)	4
Pain Score 2 (t = 10 sec)	4
Pain Score 3 (t = 20 sec)	3
Pain Score 4 (t = 30 sec)	3

b) TSA, dominant hand:

Pain Score 1 (t = 40 sec)	5
Pain Score 2 (t = 50 sec), B ₂	4
Pain Score 3 (t = 60 sec)	3

"No mTS" = ($\Delta \text{Pain} < 0$)

"Evoked mTS" = ($\Delta \text{Pain} > 0$)



'DNIC score 0-10 points'

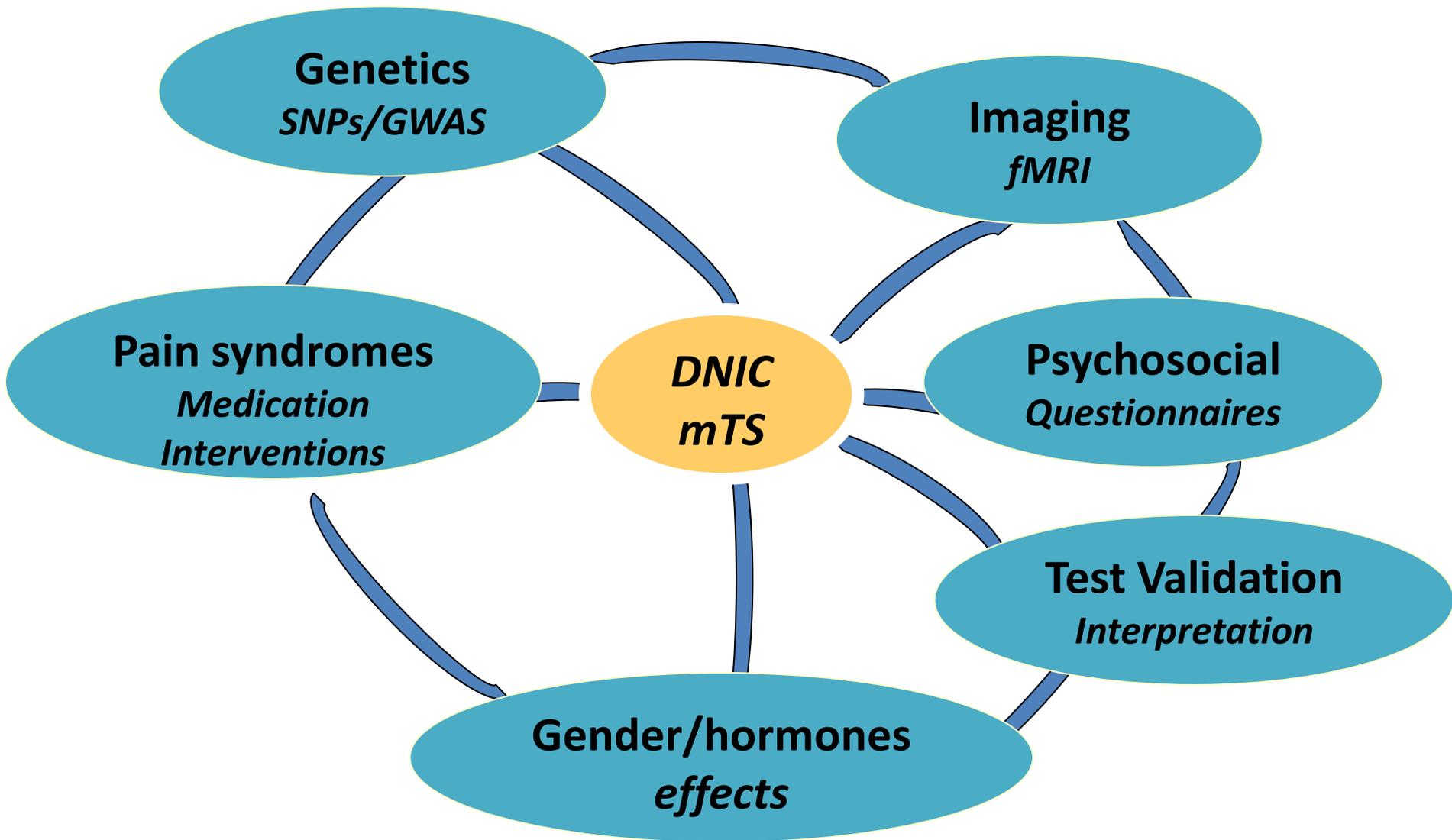
$$DNIC = \left(\left(\frac{A_1 + A_2 + A_3}{3} \right) - \left(\frac{B_1 + B_2 + B_3}{3} \right) \right)$$

DNIC = 1.67

Phenotyping/Genotyping/Psychotyping

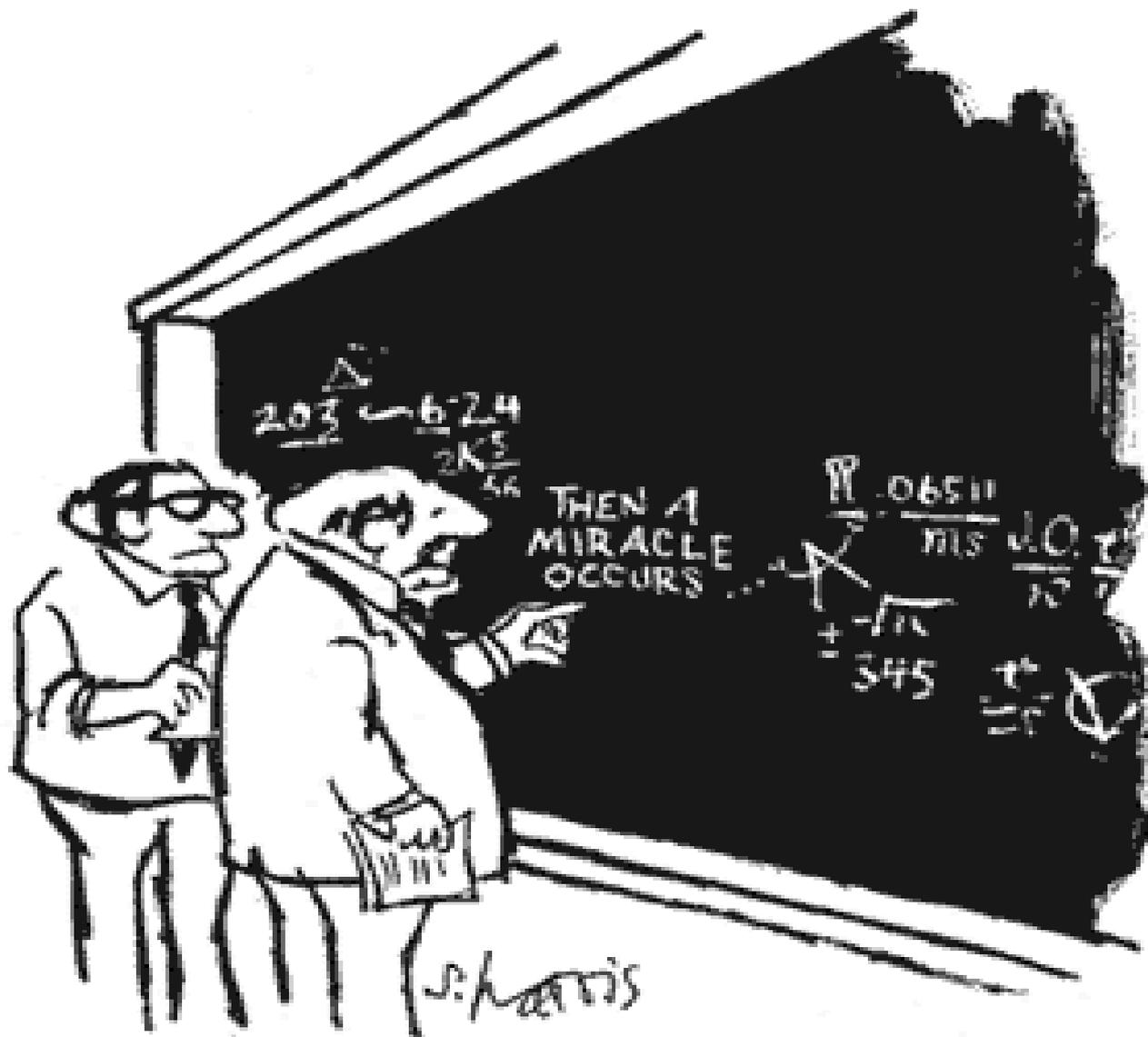
- **HSJ (Brazil) n= 500**
- **UWMC (Seattle) n= 200**
- **UCL (Belgium) n= 100**
- **KKH (Singapore) n= 800**

- **Pre-op DNIC + mTS, questionnaires**
- **Peri-operative data (pain, analgesics, hyperalgesia)**
- **8 weeks, 6 months, 12 months follow-up**



Today:

- **Introduction (5 minutes)**
- **Pain and the Brain (15 minutes)**
- **How to measure Pain (15 min)**
- **How will that change my practice (10 min)**
- **Summary**



"I THINK YOU SHOULD BE MORE EXPLICIT HERE IN STEP TWO."



Interagency Guideline on Opioid Dosing for Chronic Non-cancer Pain:

*An educational aid to improve
care and safety with opioid therapy*

2010 Update

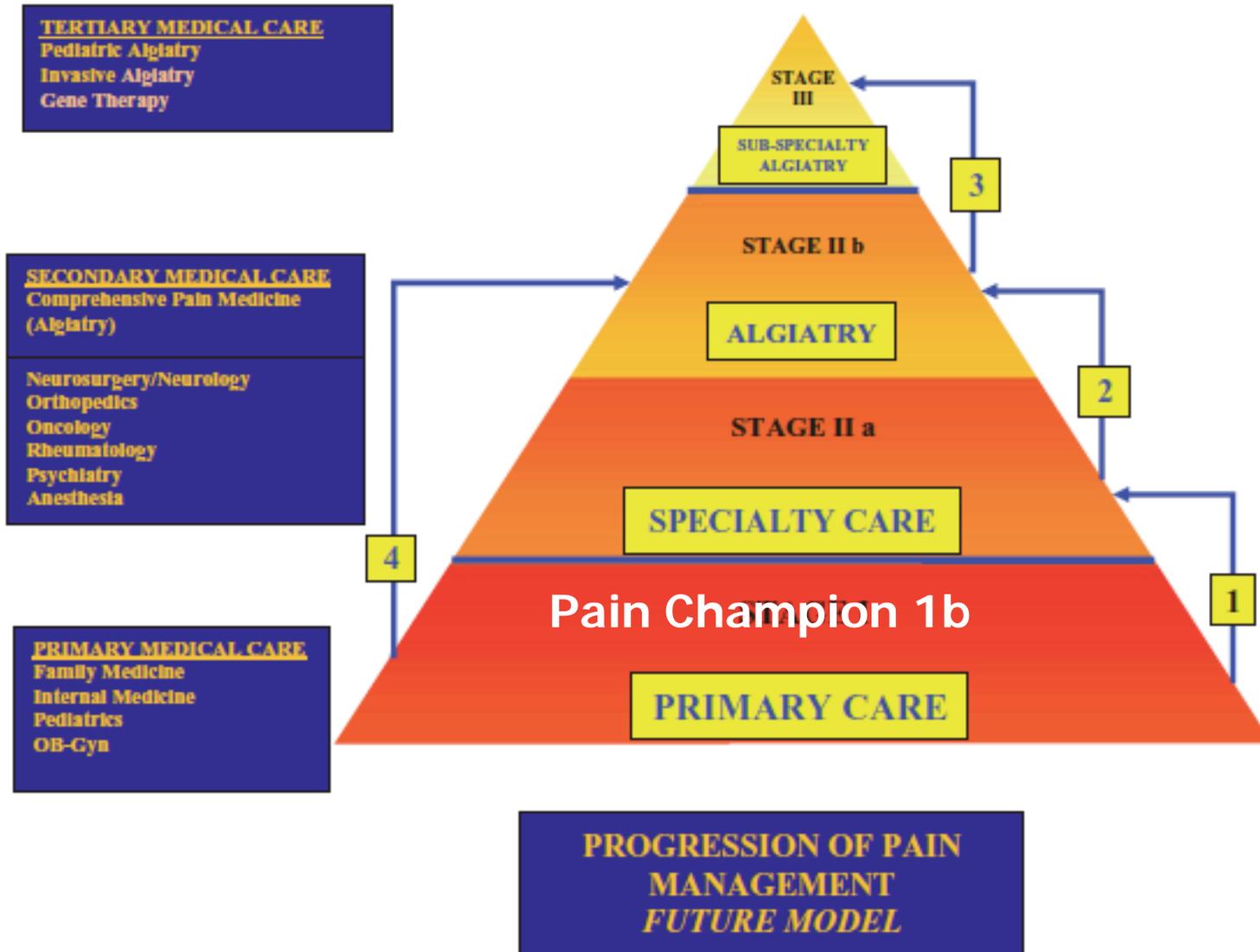
Get to know the guidelines

What is New in this Revised Guideline

- New data, including scientific evidence to support the 120mg MED dosing threshold
- Tools for calculating dosages of opioids during treatment and when tapering
- Validated screening tools for assessing substance abuse, mental health, and addiction
- Validated two-item scale for tracking function and pain
- Urine drug testing guidance and algorithm
- Information on access to mentoring and consultations (including reimbursement options)
- New patient education materials and resources
- Guidance on coordinating with emergency departments to reduce opioid abuse
- New clinical tools and resources to help streamline clinical care

You can find this guideline and related tools at the Washington State Agency Medical Directors' site at www.agencymeddirectors.wa.gov

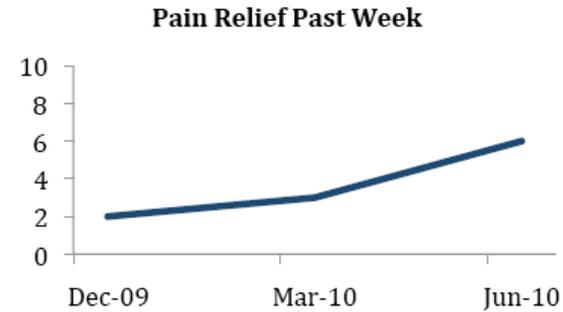
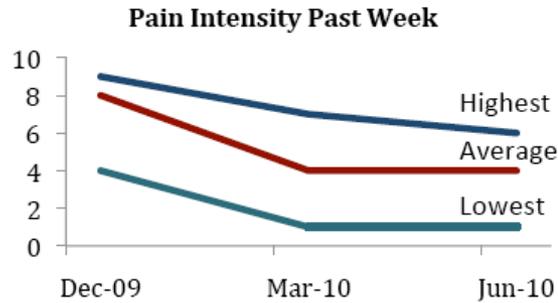
We are here to help in training



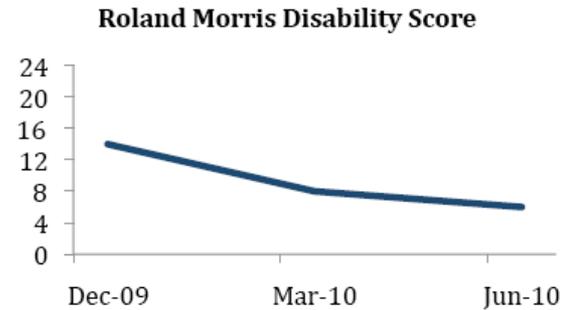
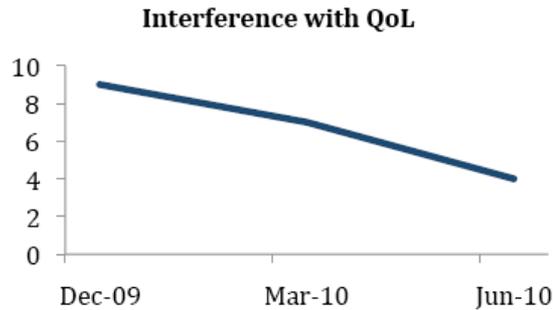
CPAIN Patient Profile Report - Update

John Public ID: 102345643

Pain Level and Relief



Interference with QoL and Disability



Functional Goals, IPAQ

