Body System: Pain		
Session Topic: Chronic Pain		
Educational Format		**Faculty Expertise Required**
REQUIRED	Interactive Lecture	Expertise in the field of study. Experience teaching in the field of study is desired. Preferred experience with audience response systems (ARS). Utilizing polling questions and engaging the learners in Q&A during the final 15 minutes of the session are required.
OPTIONAL	Problem-Based Learning (PBL)	Expertise teaching highly interactive, small group learning environments. Case-based, with experience developing and teaching case scenarios for simulation labs preferred. Other workshop-oriented designs may be accommodated. A typical PBL room is set for 50-100 participants, with 7-8 each per round table. Please describe your interest and plan for teaching a PBL on your proposal form.

Professional Practice Gap	**Learning Objective(s) that will close the gap and meet the need**	**Outcome Being Measured**
• Knowledge gaps regarding specific strategies to effectively train staff in their practices on roles and responsibilities related to patient-centered management of patients with chronic pain. • Knowledge gaps regarding the ability to design an on-going management plan for their patients with chronic pain that incorporates strategies related to titration for safety and efficacy, risk assessment screening tools, and prescribing agreements to minimize misuse and addiction of opioids. • Knowledge gaps in providing adequate legal documentation to satisfy local/state law enforcement requirements related to prescribing opioids for pain management. • Elderly patients and patients with terminal illnesses are often untreated	1. Formulate strategies to better train care team staff to perform specific tasks and responsibilities as outlined in their role to provide patient-centered care of patients with chronic pain. 2. Assess patients with chronic pain to determine the mechanisms of pain through documentation of pain location, intensity, quality and onset/duration; functional ability and goals; and psychological/social factors such as depression or substance abuse utilizing patient-based and physician-based data collection and documentation tools/instruments. 3. Utilize appropriate/evidence-based clinical/specialty/regulatory guidelines and tools including State-based controlled medication utilization databases or prescription monitoring programs (PMP's). 4. Develop collaborative treatment plans emphasizing physical and psychological modalities, prescription of non-opioid analgesics, treatment of comorbid mood	Learners will submit written commitment to change statements on the session evaluation, indicating how they plan to implement presented practice recommendations.

or undertreated for pain, despite advances in understanding pain physiology and available pharmacotherapies. • Patients are often non-adherent to prescribed treatment therapies for managing chronic pain.	disorders, and restoration of sleep utilizing patient-based and physician-based data collection and documentation tools/instruments. 5. Identify and utilize evidence-based guidelines for the use of non-pharmacologic, non-opioids, and opioids in chronic pain management including special populations like the elderly, terminally ill, and pregnant patients. 6. Establish plans to coordinate referral to a multidisciplinary team or pain specialist where first-line therapies are ineffective, complex patient management, and there is poor patient adherence to treatment plans.	

ACGME Core Competencies Addressed (select all that apply)

X	Medical Knowledge		Patient Care
X	Interpersonal and Communication Skills		Practice-Based Learning and Improvement
	Professionalism	X	Systems-Based Practice

Faculty Instructional Goals

Faculty play a vital role in assisting the AAFP to achieve its mission by providing high-quality, innovative education for physicians, residents and medical students that will encompass the art, science, evidence and socio-economics of family medicine and to support the pursuit of lifelong learning. By achieving the instructional goals provided, faculty will facilitate the application of new knowledge and skills gained by learners to practice, so that they may optimize care provided to their patients.

- Provide up to 3 evidence-based recommended practice changes that can be immediately implemented, at the conclusion of the session; including SORT taxonomy & reference citations
- Facilitate learner engagement during the session
- Address related practice barriers to foster optimal patient management
- Provide recommended journal resources and tools, during the session, from the American Family Physician (AFP), Family Practice Management (FPM), and Familydoctor.org patient resources; those listed in the References section below are a good place to start
    - Visit http://www.aafp.org/journals for additional resources
    - Visit http://familydoctor.org for patient education and resources
- Provide recommendations for formulating strategies to better train care team staff to perform specific tasks and responsibilities as outlined in their role to provide patient-centered care of patients with chronic pain.
- Provide recommendations to assess patients with chronic pain to determine the mechanisms of pain through documentation of pain location, intensity, quality and onset/duration; functional ability and goals; and psychological/social factors such as

depression or substance abuse utilizing patient-based and physician-based data collection and documentation tools/instruments.
- Provide recommendations for utilizing appropriate/evidence-based clinical/specialty/regulatory guidelines and tools including State-based controlled medication utilization databases or prescription monitoring programs (PMP's)
- Provide recommendations for developing collaborative treatment plans emphasizing physical and psychological modalities, prescription of non-opioid analgesics, treatment of comorbid mood disorders, and restoration of sleep utilizing patient-based and physician-based data collection and documentation tools/instruments
- Provide recommendations for evidence-based guidelines for the use of non-pharmacologic, non-opioids, and opioids in chronic pain management including special populations like the elderly, terminally ill, and pregnant patients
- Provide strategies for establishing plans to coordinate referral to a multidisciplinary team or pain specialist where first-line therapies are ineffective, complex patient management, and there is poor patient adherence to treatment plans.
- Provide recommendations regarding guidelines for Medicare reimbursement.
- Provide recommendations to maximize office efficiency and guideline adherence to management of chronic pain.
- Provide an overview of newly available treatments, including efficacy, safety, contraindications, and cost/benefit relative to existing treatments.

Needs Assessment:
*Note: In terms of scope, specific types of pain (e.g. low back pain, headache, abdominal) is already addressed by another topic; also, opioid prescribing, and opioid addiction are covered by other topics.

Chronic pain affects approximately one-third of U.S. adults, is more prevalent in women than men, becomes more prevalent with age, and 5 percent receive opioid treatment.[1,2] The Institute of Medicine Report: *Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education, and Research*, pain is a significant public health problem that costs society at least $560-$635 billion annually, an amount equal to about $2,000.00 for everyone living in the U.S.[3,4]

Chronic pain may be associated with musculoskeletal disorders, such as degenerative spine conditions, lower back problems, and arthritis as well as diabetes, cardiovascular disease, and neurologic disease. Despite its prevalence, chronic pain is under-recognized and inappropriately treated.[5]

The American Academy of Family Physicians (AAFP) CME Needs Assessment Survey data indicate that family physicians have statistically significant and meaningful gaps in the medical skill necessary to provide optimal pain management, manage drug abuse and addiction, and utilize risk evaluation mitigation strategies (REMS).[6] More specifically, CME outcomes data from 2012-2016 AAFP FMX (formerly Assembly) *Chronic Pain Management* sessions, suggest physicians have knowledge and practice gaps with regard to managing risk associated with evidence-based screening and evaluation of pain; providing adequate health coaching for non-

pharmacologic treatment options; effective use of cognitive behavioral therapy; utilizing pain contracts/informed consent and random drug testing; increasing awareness of state drug monitoring programs; assessing for depression; effective monitoring strategies; having an awareness of new treatments and guidelines; having an understanding of ER/LA opioid REMS; and using a stepwise approach to pain management.[7-11] A literature review confirms this data, suggesting frequent non-adherence to guidelines for the management of chronic pain, including substantial variability in the use of pain contracts.[12-14]

The lack of education and awareness of the risks associated with prescription extended-release (ER) and long-acting (LA) opioid medications has, along with other factors, contributed to a severe increase in opioid abuse, misuse, and diversion over the last 20 years, leading to a concomitant increase in the number of unintended deaths associated with this class of medication. The statistics on non-medical use of opioids are particularly revealing. Between 1997 and 2002, sales of oxycodone and methadone nearly quadrupled.[15] The National Survey on Drug Use and Human Health found that in 2009, there were 2.6 million new users of prescription pain medications, 2.2 million of whom were non-medical users. In 2008, more than 13% of all Americans aged 12 and older had used a prescription pain medication non-medically at least once in their lifetime.[16]

Data from the Centers for Disease Control and Prevention (CDC) reveals that deaths from unintentional drug overdoses in the United States have been rising steeply since the early 1990s and are the second-leading cause of accidental death, with 27,658 such deaths recorded in 2007.[17] That increase has been propelled by a rising number of overdoses of opioids, which caused 11,499 of the deaths in 2007—more than heroin and cocaine combined, and second only to motor vehicle crash deaths among leading causes of unintentional injury death.[15,16] Visits to emergency departments for opioid abuse more than doubled between 2004 and 2008, and admissions to substance-abuse treatment programs increased by 400% between 1998 and 2008, with prescription painkillers being the second most prevalent type of abused drug after marijuana.[17] Although both per capita opioid sales and death rates from the drugs vary widely among the 50 states, studies have found a strong correlation between states with the highest drug-poisoning mortality and those with the highest opioid consumption; per capita sales are most strongly linked with methadone- and oxycodone-related mortality.[15] In contrast, although rates of suicide caused by drug overdoses have also increased somewhat and chronic pain remains a risk factor for depression-linked suicide, the majority of opioid-overdose deaths are accidental. More often than not, laboratory tests reveal the presence of one or more substances in addition to the opioid, suggesting that the depressant effects of alcohol or other drugs on the central nervous system were additive with those of the pain reliever in causing death.[18]

In almost every age group, men have higher death rates from drug overdoses than women. The highest mortality for both sexes occurs among people 45 to 54 years of age, although young adults abuse opioids and other drugs more frequently and are more likely to be seen with drug-related symptoms in emergency rooms.[18] Whites and Native Americans have higher death rates from drug overdoses than blacks, while education level and income level are additional indices of risk for overdose.[19] National prescription-tracking data show that more than 40% of opioid prescriptions are written by primary care—principally family physicians, or internists, most commonly for diseases of the musculoskeletal system and connective tissue. More than 3% of

U.S. adults currently receive long-term opioid therapy for chronic non-cancer pain, and patients taking high daily doses appear to be at increased risk for overdose.[20] Additionally, elderly patients and patients with terminal illnesses are often untreated or undertreated for pain, despite advances in understanding pain physiology and available pharmacotherapies; therefore, physicians may need continuing medical education to help them feel comfortable administering a repeat dose after the time to peak analgesic effect if the patient is still in pain.[21,22]

Reducing deaths from opioid overdoses is challenging because such deaths stem from factors that reside both with the patient and the treating physician.[15] Patient factors often relate to the addictive nature of opioids and thus include misuse or abuse of drugs, "doctor shopping" to obtain multiple prescriptions, and diversion of opioids leading to illicit sales and abuse. In addition, patient sharing of their pain pills with relatives or friends, with little regard for the consequences is common.[15,23] Much of the risk associated with opioid use also comes through patients making mistakes that put them at grave risk. Patients may be driven to misuse opioids by their desire for greater pain relief or to self-medicate comorbid mental health problems or other issues.[13,23-26] However, family physicians have the potential to be at the forefront of combating this problem. Based on the growing implementation of the patient centered medical home (PCMH) model for patient care,[27] many of these physicians have at their disposal the multiple patient touch points needed to facilitate appropriate drug selection, follow-up, and monitoring that will tailor therapy for an individual as well as identifying and eliminating sources for opioid abuse/misuse.

Contributing physician factors include inappropriate prescribing along with inadequate counseling and monitoring, reflecting knowledge, competence, and performance deficits.[25] Physicians need to ensure that opioids are being given to the right patients under the appropriate circumstances and within the confines of set parameters to truly benefit patients.[28] To improve care, physicians must play a central role by being specific and write pain drug prescriptions with explicit directions. There is also a need to consider alternative agents in patients who don't require opioids.[15,25] These steps are critical to decreasing the potential for abuse and associated mortality risk in the future. Furthermore, methadone is implicated far more often than any other as a drug that is the subject of abuse and overdose potential. Yet its sales for chronic pain have increased partly in response to pressure from insurers and Medicaid programs, because the medication has been viewed as a cheaper and potentially less abusable alternative to other long-acting pain relievers. However, use of the drug presents problems to the treating physician as its very long half-life makes it difficult to manage and especially dangerous when combined with other drugs.[28]

Family physicians should be presented with continuing education, based on evidence-based recommendations and guidelines for the management of chronic nonterminal pain.[1,29] In order to minimize misuse or abuse, physicians should understand appropriate patient selection for opioid therapy using opioid risk tools, utilize visit checklists, urine testing, prescription monitoring, written agreements, selecting an initial opioid, understand when short-acting versus long-acting opioids are appropriate, know when to refer to a pain subspecialist, and understand how to taper or discontinue therapy.[1]

Physicians may improve their care of patients with chronic pain by engaging in continuing medical education that provides practical integration of current evidence-based guidelines and recommendations into their standards of care, including, but not limited to the following:[1,22,30-32]

- Chronic pain assessment should include determining the mechanisms of pain through documentation of pain location, intensity, quality and onset/duration; functional ability and goals; and psychological/social factors such as depression or substance abuse.
- The goal of treatment is an emphasis on improving function through the development of long-term self-management skills including fitness and a healthy lifestyle in the face of pain that may persist.
- A patient-centered, multifactorial, comprehensive care plan is necessary, one that includes addressing biopsychosocial factors. Addressing spiritual and cultural issues is also important. It is important to have an interdisciplinary team approach coordinated with the primary care physician to lead a team including specialty areas of psychology and physical rehabilitation.
- Patients with chronic nonterminal pain should receive a comprehensive evaluation, including assessment for potential opioid responsiveness and opioid risk.
- Chronic nonterminal pain requires treatment of physical and psychological modalities, prescription of nonopioid analgesics, treatment of comorbid mood disorders, and restoration of sleep.
- Tricyclic antidepressants or selective serotonin-norepinephrine reuptake inhibitors should be included in patients with chronic nonterminal pain with a neuropathic component.
- Opioid therapy should be avoided in patients with chronic central or visceral pain syndromes such as fibromyalgia, headaches, or abdominal pain.
- Opioids should be initiated as a trial, to be continued if progress is documented toward functional goals, and if there is no evidence of complications, including misuse or diversion.
- Opioid dosages exceeding 100 mg of morphine or its equivalent may increase the risk of overdose, and should prompt consideration of tapering or referral to a pain subspecialist.
- Level I treatment approaches should be implemented as first steps toward rehabilitation before Level II treatments are considered.
- Medications are not the sole focus of treatment in managing pain and should be used when needed to meet overall goals of therapy in conjunction with other treatment modalities.
- Careful patient selection and close monitoring of all non-malignant pain patients on chronic opioids is necessary to assess the effectiveness and watch for signs of misuse or aberrant behavior.
- Pain should be assessed regularly in all patients with terminal illness, including those with cognitive impairment.
- In patients with constant pain that responds to opioids, scheduling opioids with adequate breakthrough doses provides optimal analgesia.
- When patients develop opioid tolerance, rotating to an alternative opioid may improve analgesia.
- Tricyclic antidepressants, serotonin-norepinephrine reuptake inhibitors, and gabapentinoids are first-line therapies for neuropathic pain. Opioids are also effective.

- Adjunctive therapies, such as the combination of exercise and psychoeducational approaches can lead to a significant reduction in pain and improvement in functional status for a number of musculoskeletal conditions
- Although usually delivered as a structured course of one-on-one sessions with a therapist, cognitive behavioral therapy (CBT) can also be effectively administered in other formats, such as groups, via the computer, or tele-medicine.

Additionally, the CDC recently released guidelines for opioid prescribing, summarized as follows:[33-35]

- Chronic pain should be managed primarily with non-pharmacologic therapy or with medications other than opioids.
- Physicians should routinely discuss the risks and benefits of therapy and the mutual responsibility to mitigate risk with patients who are receiving opioids.
- When opioids are prescribed, they should be titrated to the lowest effective dosage.
- Treatment should be offered or arranged for patients with opioid use disorder.

Family physicians should also be aware of tools and resources that can help manage the risks associated with prescribing opioids, including systematic approaches to identify drug-seeking patients, using a streamlines approach to prescription management, prescription refill practices appropriate for highly diverted drug classes, strategies for managing *difficult* patients, and engaging in CME based specifically on the Food and Drug Administration (FDA) opioids REMS blueprint.[36-41] Additionally, Physicians should be aware of resources, such as those from the Alliance of States with Prescription Monitoring Programs, that provides tools and information to help physicians stay informed about prescription monitoring programs (PMPs) in their state.[42]

Physicians can improve patient satisfaction with the referral process by using readily available strategies and tools such as, improving internal office communication, engaging patients in scheduling, facilitating the appointment, tracking referral results, analyzing data for improvement opportunities, and gathering patient feedback.[43,44]

These recommendations are provided only as assistance for physicians making clinical decisions regarding the care of their patients. As such, they cannot substitute for the individual judgment brought to each clinical situation by the patient's family physician. As with all clinical reference resources, they reflect the best understanding of the science of medicine at the time of publication, but they should be used with the clear understanding that continued research may result in new knowledge and recommendations. These recommendations are only one element in the complex process of improving the health of America. To be effective, the recommendations must be implemented. As such, physicians require continuing medical education to assist them with making decisions about specific clinical considerations.

Resources: Evidence-Based Practice Recommendations/Guidelines/Performance Measures

- Rational use of opioids for management of chronic nonterminal pain[1]
- (ASIPP) guidelines for responsible opioid prescribing in chronic non-cancer pain[45]

- ICSI Guideline on Chronic Pain Assessment and Management[30]
- CDC Guideline for Prescribing Opioids for Chronic Pain[35]
- Pharmacologic management of pain at the end of life[22]
- Rethinking the difficult patient encounter[36]
- Adding health education specialists to your practice[46]
- Envisioning new roles for medical assistants: strategies from patient-centered medical homes[47]
- The benefits of using care coordinators in primary care: a case study[48]
- Engaging Patients in Collaborative Care Plans[49]
- The Use of Symptom Diaries in Outpatient Care[50]
- Health Coaching: Teaching Patients to Fish[51]
- Medication adherence: we didn't ask and they didn't tell[52]
- Encouraging patients to change unhealthy behaviors with motivational interviewing[53]
- Integrating a behavioral health specialist into your practice[54]
- Simple tools to increase patient satisfaction with the referral process[43]
- A systematic approach to identifying drug-seeking patients[37]
- A streamlined approach to prescription management[38]
- Rethinking your approach to prescription "refills"[39]
- "Refills" for schedule II controlled substances?[40]
- A tool for safely treating chronic pain[41]
- Alliance of States with Prescription Monitoring Programs[42]
- FDA Risk Evaluation and Mitigation Strategy (REMS) for Extended-Release and Long-Acting Opioids[55]
- FamilyDoctor.org. Chronic Pain | Overview (patient education)[56]
- FamilyDoctor.org. Opioid Addiction | Overview (patient resource)[57]

References

1. Berland D, Rodgers P. Rational use of opioids for management of chronic nonterminal pain. *American family physician.* 2012;86(3):252-258.
2. Johannes CB, Le TK, Zhou X, Johnston JA, Dworkin RH. The prevalence of chronic pain in United States adults: results of an Internet-based survey. *The journal of pain : official journal of the American Pain Society.* 2010;11(11):1230-1239.
3. American Academy of Pain Medicine. AAPM Facts and Figures on Pain. 2013;
4. Institute of Medicine (IOM) Committee on Advancing Pain Research C, and Education,. *Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education, and Research.* Washington DC: National Academy of Sciences.; 2011.
5. Manchikanti L, Helm S, 2nd, Fellows B, et al. Opioid epidemic in the United States. *Pain physician.* 2012;15(3 Suppl):ES9-38.
6. AAFP. 2012 CME Needs Assessment: Clinical Topics. American Academy of Family Physicians; 2012.
7. American Academy of Family Physicians (AAFP). AAFP FMX CME Outcomes Report. Leawood KS: AAFP; 2016.

8. American Academy of Family Physicians (AAFP). AAFP FMX CME Outcomes Report. Leawood KS: AAFP; 2015.
9. American Academy of Family Physicians (AAFP). 2012 AAFP Scientific Assembly: CME Outcomes Report. Leawood KS: AAFP; 2012.
10. American Academy of Family Physicians (AAFP). 2013 AAFP Scientific Assembly: CME Outcomes Report. Leawood KS: AAFP; 2013.
11. American Academy of Family Physicians (AAFP). AAFP Assembly CME Outcomes Report. Leawood KS: AAFP; 2014.
12. Rasu RS, Sohraby R, Cunningham L, Knell ME. Assessing chronic pain treatment practices and evaluating adherence to chronic pain clinical guidelines in outpatient practices in the United States. *The journal of pain : official journal of the American Pain Society.* 2013;14(6):568-578.
13. Morasco BJ, Duckart JP, Dobscha SK. Adherence to clinical guidelines for opioid therapy for chronic pain in patients with substance use disorder. *Journal of general internal medicine.* 2011;26(9):965-971.
14. Starrels JL, Wu B, Peyser D, et al. It made my life a little easier: primary care providers' beliefs and attitudes about using opioid treatment agreements. *Journal of opioid management.* 2014;10(2):95-102.
15. Okie S. A flood of opioids, a rising tide of deaths. *The New England journal of medicine.* 2010;363(21):1981-1985.
16. National Survey on Drug Use and Health. United States Department of Health and Human Services.; 2009. http://www.icpsr.umich.edu/icpsrweb/SAMHDA/studies/29621/version/2.
17. CDC. Policy Impact: Prescription Painkiller Overdoses. 2011;
18. Vital signs: overdoses of prescription opioid pain relievers---United States, 1999--2008. *MMWR Morbidity and mortality weekly report.* 2011;60:1487-1492.
19. Becker WC, Starrels JL, Heo M, Li X, Weiner MG, Turner BJ. Racial differences in primary care opioid risk reduction strategies. *Annals of family medicine.* 2011;9(3):219-225.
20. Gugelmann HM, Perrone J. Can prescription drug monitoring programs help limit opioid abuse? *JAMA : the journal of the American Medical Association.* 2011;306(20):2258-2259.
21. Rastogi R, Meek BD. Management of chronic pain in elderly, frail patients: finding a suitable, personalized method of control. *Clinical interventions in aging.* 2013;8:37-46.
22. Groninger H, Vijayan J. Pharmacologic management of pain at the end of life. *American family physician.* 2014;90(1):26-32.
23. Manchikanti L. National drug control policy and prescription drug abuse: facts and fallacies. *Pain physician.* 2007;10(3):399-424.
24. Bohnert AS, Valenstein M, Bair MJ, et al. Association between opioid prescribing patterns and opioid overdose-related deaths. *JAMA : the journal of the American Medical Association.* 2011;305(13):1315-1321.
25. Webster LR, Cochella S, Dasgupta N, et al. An analysis of the root causes for opioid-related overdose deaths in the United States. *Pain medicine (Malden, Mass).* 2011;12 Suppl 2:S26-35.

26. Grattan A, Sullivan MD, Saunders KW, Campbell CI, Von Korff MR. Depression and Prescription Opioid Misuse Among Chronic Opioid Therapy Recipients With No History of Substance Abuse. *The Annals of Family Medicine.* 2012;10(4):304-311.
27. Lesko S, Hughes L, Fitch W, Pauwels J. Ten-year trends in family medicine residency productivity and staffing: impact of electronic health records, resident duty hours, and the medical home. *Family medicine.* 2012;44(2):83-89.
28. Webster LR. Ending unnecessary opioid-related deaths: a national priority. *Pain medicine (Malden, Mass).* 2011;12 Suppl 2:S13-15.
29. Ospina MB, Taenzer P, Rashiq S, et al. A systematic review of the effectiveness of knowledge translation interventions for chronic noncancer pain management. *Pain research & management : the journal of the Canadian Pain Society = journal de la societe canadienne pour le traitement de la douleur.* 2013;18(6):e129-141.
30. National Guideline Clearinghouse. Assessment and management of chronic pain. 2013;
31. Allegrante JP. The role of adjunctive therapy in the management of chronic nonmalignant pain. *The American journal of medicine.* 1996;101(1A):33S-39S.
32. McBeth J, Prescott G, Scotland G, et al. Cognitive behavior therapy, exercise, or both for treating chronic widespread pain. *Archives of internal medicine.* 2012;172(1):48-57.
33. CDC Releases Final Guideline for Prescribing Opioids for Chronic Pain: More Research Still Needed to Support the Guidance. *AAFP News.* 2016.
34. Bredemeyer M. CDC Develops Guideline for Opioid Prescribing. *American family physician.* 2016;93(12):1042-1043.
35. Centers for Disease Control and Prevention. CDC Guideline for Prescribing Opioids for Chronic Pain. 2016;
36. Edgoose J. Rethinking the difficult patient encounter. *Family practice management.* 2012;19(4):17-20.
37. Pretorius RW, Zurick GM. A systematic approach to identifying drug-seeking patients. *Family practice management.* 2008;15(4):A3-5.
38. Sinsky TA, Sinsky CA. A streamlined approach to prescription management. *Family practice management.* 2012;19(6):11-13.
39. Teichman PG, Teichman A. Rethinking your approach to prescription "refills". *Family practice management.* 2011;18(6):16-19.
40. Teichman P. "Refills" for schedule II controlled substances? *Family practice management.* 2011;18(1):4; author reply 4.
41. Teichman PG. A tool for safely treating chronic pain. *Family practice management.* 2001;8(10):47-49.
42. Alliance of States with Prescription Monitoring Programs. Alliance of States with Prescription Monitoring Programs. 2013;
43. Jarve RK, Dool DW. Simple tools to increase patient satisfaction with the referral process. *Family practice management.* 2011;18(6):9-14.
44. American Academy of Family Physicians (AAFP). FPM Toolbox: Referral Management. 2013;
45. Manchikanti L, Abdi S, Atluri S, et al. American Society of Interventional Pain Physicians (ASIPP) guidelines for responsible opioid prescribing in chronic non-cancer pain: Part 2--guidance. *Pain physician.* 2012;15(3 Suppl):S67-116.
46. Chambliss ML, Lineberry S, Evans WM, Bibeau DL. Adding health education specialists to your practice. *Family practice management.* 2014;21(2):10-15.

47. Naughton D, Adelman AM, Bricker P, Miller-Day M, Gabbay R. Envisioning new roles for medical assistants: strategies from patient-centered medical homes. *Family practice management.* 2013;20(2):7-12.
48. Mullins A, Mooney J, Fowler R. The benefits of using care coordinators in primary care: a case study. *Family practice management.* 2013;20(6):18-21.
49. Mauksch L, Safford B. Engaging Patients in Collaborative Care Plans. *Family practice management.* 2013;20(3):35-39.
50. Hodge B. The Use of Symptom Diaries in Outpatient Care. *Family practice management.* 2013;20(3):24-28.
51. Ghorob A. Health Coaching: Teaching Patients to Fish. *Family practice management.* 2013;20(3):40-42.
52. Brown M, Sinsky CA. Medication adherence: we didn't ask and they didn't tell. *Family practice management.* 2013;20(2):25-30.
53. Stewart EE, Fox CH. Encouraging patients to change unhealthy behaviors with motivational interviewing. *Family practice management.* 2011;18(3):21-25.
54. Reitz R, Fifield P, Whistler P. Integrating a behavioral health specialist into your practice. *Family practice management.* 2011;18(1):18-21.
55. U.S. Food and Drug Adminstration. Drug Safety and Availability: Risk Evaluation and Mitigation Strategy (REMS) for Extended-Release and Long-Acting Opioids. 2013;
56. FamilyDoctor.org. Chronic Pain | Overview. 2000;
57. FamilyDoctor.org. Opioid Addiction | Overview. 2006;

