

TPT Toolkit®

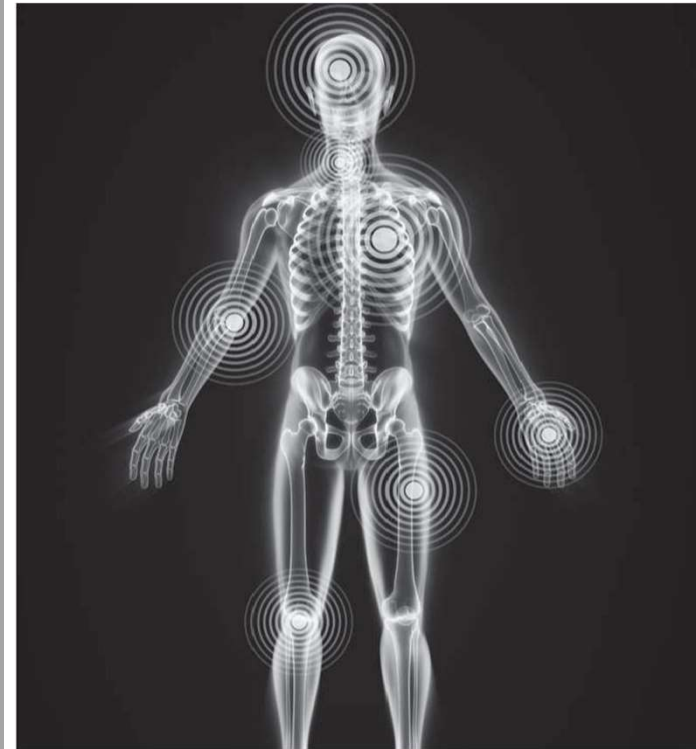
2025

Targeted Pain Treatment® Resources and References

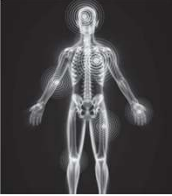
compiled by
Stephanie G. Vanterpool, MD, MBA, FASA
Director of Comprehensive Pain Services
Associate Professor of Anesthesiology
University of Tennessee Graduate School of Medicine

Targeted Pain Treatment

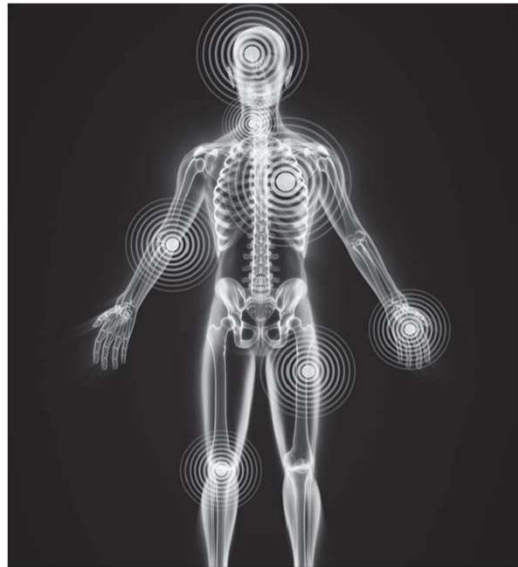
"accurate diagnosis and targeted treatment of pain"



TARGETED PAIN TREATMENT[®]

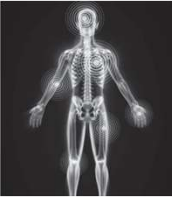


***Accurately
diagnose the
CAUSE(s)
of the pain***

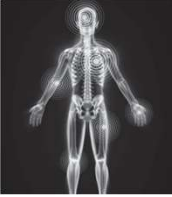


***Target the
treatment to the
CAUSE(S)
of the pain***

4 Components of Targeted Pain Treatment



- 1. **Accurate Diagnosis:** Identify ALL of the causes of pain that are present
- 2. **Targeted Treatment:** Target the causes of pain in a way that is specific, *strategic, and safe*
- 3. **Focus on Function:** work with patients to continue to optimize their function
- 4. **Engagement & Empowerment:** engage the patient in the treatment process. Empower them to decide and do what is best for their function and quality of life.



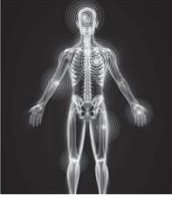
TPT Toolkit[®] - Overview

ACCURATE DIAGNOSIS

1. Causes of Pain
2. Pain States and Mechanisms
3. Common Anatomic Causes of Pain (by pain complaint)
4. S.C.R.I.P.T. History
5. Pain **RED** Flags

TARGETED TREATMENT

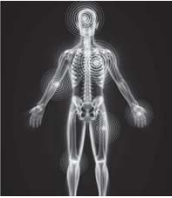
1. M.I.P.S. – Multimodal approach to treating pain
2. TPT Pain Assessment Template
3. Targeted Medications – “Specific, Strategic, Safe”
4. Targeted Medications – Examples
5. Targeted Interventions - “Specific, Strategic, Safe”



TPT Toolkit[®] - Overview

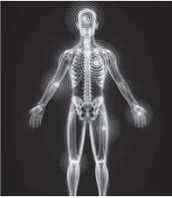
RESOURCES

1. TPT Patient Handout- FAQ
2. [Targeted Pain Treatment Documentary – Hope for Patients with Pain](#)
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4. 4E's of Patient Education
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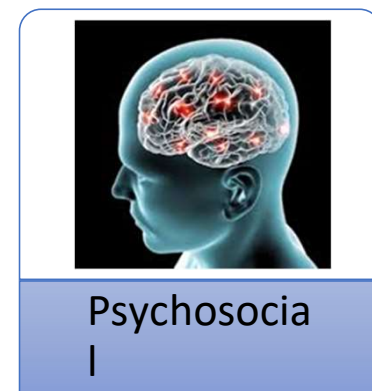
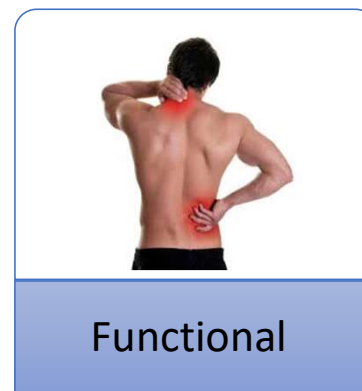
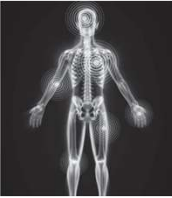
ACCURATE DIAGNOSIS

TPT Toolkit [®] - Accurate Diagnosis



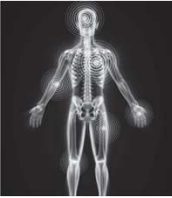
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Accurately Diagnose the CAUSE(s) of Pain



Can have multiple types and mechanisms of pain affecting the same location at the same time!!

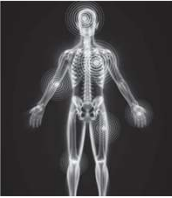
Pain States



PAIN STATE	PATHOLOGY	SYMPTOMS
Nociceptive 	Evidence of noxious (mechanical, thermal, chemical) insult	Pain localized to area of stimulus/joint damage
Inflammatory 	Evidence of inflammation (sterile or infectious)	Redness, warmth, swelling of affected area
Neuropathic 	Evidence of sensory nerve damage	Burning, tingling or shock-like, spontaneous pain; paresthesias, dysesthesias
Dysfunctional/centralized 	Pain in the absence of detectable pathology	No identifiable noxious stimulus, inflammation or neural damage; evidence of increased amplification or reduced inhibition

*Modified from Table 1. in Vardeh D, et.al. *J Pain*. 2016 Sep;17(9 Suppl):T50-69. doi: 10.1016/j.jpain.2016.03.001. Review. (used with permission)

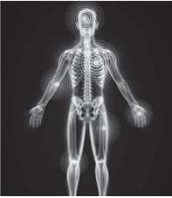
Pain Mechanisms



PAIN MECHANISM	CLINICAL DIAGNOSTIC CRITERIA	CLINICAL EXAMPLE	SPECIFIC TREATMENT EXAMPLE
Nociceptive Transduction	Proportionate pain in response to identifiable noxious stimulus	Mechanical nerve root compression	Remove mechanical stimulus
Peripheral Sensitization	Primary hyperalgesia due to decreased transduction threshold of nociceptor terminal	Rheumatoid arthritis, Cellulitis	Anti-inflammatory (e.g. NSAID, coxibs); immunosuppressant
Ectopic activity	Spontaneous pain in the absence of obvious trigger, relieved by local nerve block	Trigeminal neuralgia	Na Channel Blockers, Ca Channel Blockers
Central sensitization	Secondary hyperalgesia; temporal summation, allodynia	Complex Regional Pain Syndrome (CRPS)	NMDA Antagonists (e.g. Ketamine)
Central disinhibition	Secondary hyperalgesia, allodynia	Fibromyalgia	GABA-A subunit agonists Dual amine uptake inhibitors (e.g. SNRI)

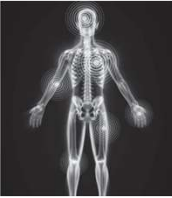
*Adapted from Table 2. in Vardeh D, et.al. *J Pain*. 2016 Sep;17(9 Suppl):T50-69. doi: 10.1016/j.jpain.2016.03.001. Review. (used with permission)

Common Anatomic Causes of Pain (1 of 3)



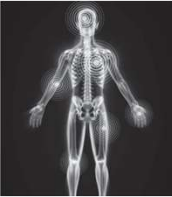
Area of pain	Possible Anatomic Cause
Head	occipital nerve (posterior), myofascial trigger points (trapezius, levator scapula, cervical paraspinous muscles, other neck muscles, cervical facet joints, cervical degenerative disc disease (DDD)
Neck	myofascial trigger points, cervical DDD, cervical facet joints
Shoulder	myofascial trigger points, cervical DDD, cervical facet joints
Upper Arm pain	myofascial trigger points, cervical DDD with radiculopathy, cervical facet joints
Lower arm pain/Hand/Finger pain	cervical DDD with radiculopathy, nerve entrapment, myofascial trigger points,
Thoracic back pain	myofascial trigger points, intercostal nerves, thoracic facet joints, thoracic DDD

Common Anatomic Causes of Pain (2 of 3)

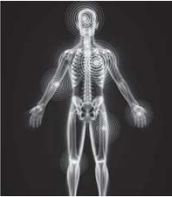


Area of pain	Possible Anatomic Cause
Low back pain (above lumbosacral junction)	myofascial pain without trigger points (spasm), lumbar facet joints, lumbar DDD with or without radiculopathy, myofascial trigger points
Low back/Buttock pain (below lumbosacral junction)	lumbar facet joints (L5/S1), lumbar DDD with or without radiculopathy, sacroiliac joint arthropathy, piriformis muscle syndrome, sacral pain (responding to caudal ESI),
Lower abdominal Wall	Ilioinguinal or iliohypogastric neuralgia (especially after hernia repair) Scar, nerve entrapment, abdominal wall trigger points
Groin Pain	Referred from SI joint, Referred from L1/2 nerves, Ilioinguinal neuralgia, genitofemoral neuralgia
Hip pain	greater trochanteric bursitis, sacroiliac joint arthropathy, hip joint (degeneration), lumbar ddd with radiculopathy (L2/3 or L3/4), myofascial trigger points in the lumbar region with peripheral radiation

Common Anatomic Causes of Pain (3 of 3)

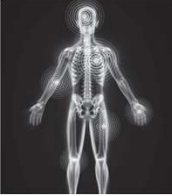


Area of pain	Possible Anatomic Cause
Thigh pain - Lateral	greater trochanteric bursitis, intra articular hip, ddd with radiculopathy, sacroiliac joint arthropathy
Thigh pain - posterior	sacroiliac joint arthropathy, DDD with radiculopathy (usually L5/S1), Lumbar spondylosis (L4/5, L5/S1), piriformis syndrome,
Thigh pain - anterior	DDD with radiculopathy (L2/3, L3/4), Lumbar facet joints (L3/4, L4/5) Sacroiliac joint arthropathy, intra articular hip
Knee pain	knee joint, DDD with radiculopathy (L3/4 and L4/5)
Lower leg pain	Knee joint, DDD with radiculopathy (L4/5, L5/S1)
Ankle/Foot pain	DDD with radiculopathy (L4/5 (medial, dorsal aspect), L5/S1 (lateral, plantar aspect)), Ankle joint, metatarsal joints, nerve entrapments, Neuromas



The S.C.R.I.P.T. History Template

S.C.R.I.P.T.	Information to Gather
<u>S</u>tory	- Circumstances of Onset (acute, trauma, insidious, etc) - Details, Details, Details
<u>C</u>urrent Symptoms	-Pain location -Pain description -ROM -Aggravating Factors -Alleviating factors
<u>Rx</u> (Relevant Meds)	-Anti-inflammatories, Muscle relaxers, Nerve pain medication
<u>I</u>nterventions	-Previous injections to the area (what was injected, what type of injection was done?)
<u>P</u>hysical Therapy	-Previous PT, Massage, chiropractic, other
<u>T</u>ests	-Imaging of the affected area, NCS/EMG, etc (if done)



Pain RED Flags (1 of 2)

- Pain RED Flags

- Findings on patient assessment that should trigger you to look for a more accurate cause of the pain



Outside the Expected Location

- E.g. Patient with LEFT leg pain, but RIGHT L4/5 disc bulge



Out of Proportion to Diagnosis

- E.g. Patient with cervical radiculopathy, but completely unable to abduct right shoulder due to pain

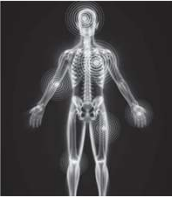


“Something’s not right”

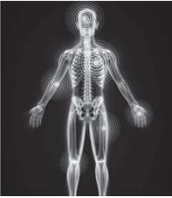
- E.g. patient with previous well-healed hip fracture, now with new pain in same area, negative imaging, no trauma

PAIN RED FLAG Prompt to identify the Accurate Dx and treat the CAUSE of the pain

Pain RED Flags (2 of 2)

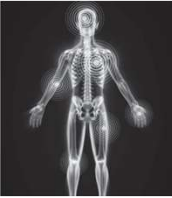


- Resolving Pain RED Flags
 - Step 1. Re-visit the Story – make sure you’re not missing anything.
 - Step 2. Clarify the current symptoms – location, radiation, sensation, etc
 - Step 3. Repeat the physical exam
 - Step 4. Evaluate existing tests
 - Step 5. Order new tests if needed.

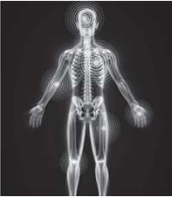


TARGETED TREATMENT

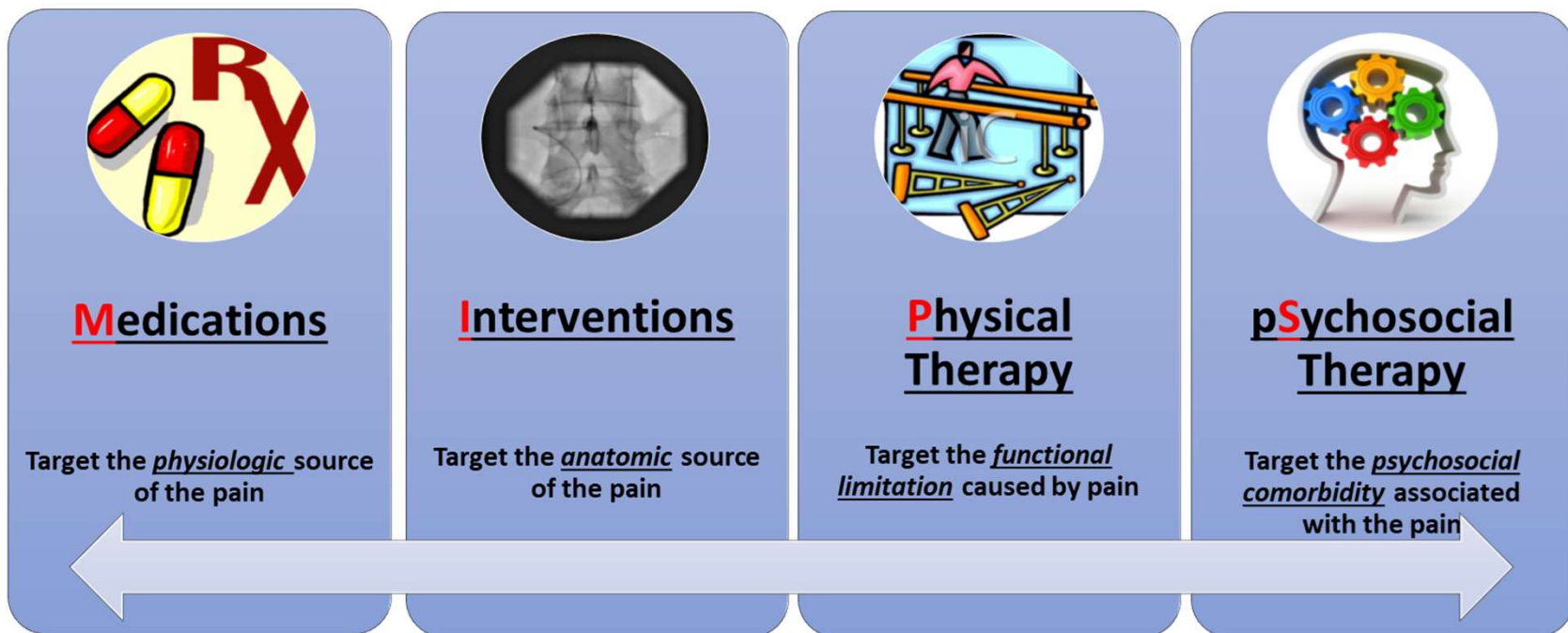
TPT Toolkit[®] - Targeted Treatment

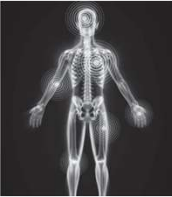


1. M.I.P.S. – Multimodal approach to treating the cause(s) of pain
2. TPT Plan - Pain Assessment Template*
3. Function Optimization Template *
4. Targeted Medications – “Specific, Strategic, Safe”
5. Targeted Medications – Examples
6. Targeted Interventions – “Specific, Strategic, Safe”



Target the Treatment to the Cause(s) “Multimodal” Approach – M.I.P.S.





TPT Plan – Pain Assessment Template

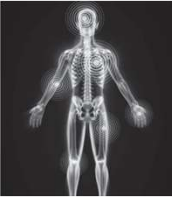
<u>Patient ID:</u>	Patient descriptor (name, age, relevant clinical background)
<u>Pain complaint:</u>	Location and chronicity
<u>Pain State(s) present:</u>	(Select all that apply): Nociceptive, Inflammatory, Neuropathic, Central/dysfunctional
<u>Pain Mechanism(s) present:</u>	(Select all that apply): nociceptive transduction, peripheral sensitization, ectopic activity, central sensitization, central disinhibition
<u>Cause(s) of pain:</u>	(select all that apply) Physiologic, Anatomic, Functional, Psychosocial (specify and elaborate as needed- e.g Anatomic, post-surgical pain after total hip arthroplasty, or Physiologic and anatomic pain due to disc herniation with radicular symptoms and ectopic activity of the nerve.
<u>Rationale for treatment plan:</u>	Address each cause, state and mechanism with the comprehensive, multimodal treatment plan (M.I.P.S): <ul style="list-style-type: none">– Medications (target the physiologic cause)– Interventions (target the anatomic cause)– Physical therapy (target the functional limitation)– psychosocial Treatment (target the psychosocial comorbidity)

Function Optimization Template



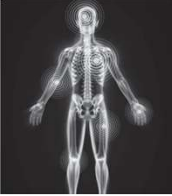
Component	Documentation	Notes
<u>Current Functional Status</u>	Functional Performance Functional Capacity Potential for future functional decline	May use the Tennessee Functional Status Questionnaire, or other validated function assessment tool.
<u>What is limiting function the most?</u>	List the principal pain/function-limiting diagnosis	May have more than one CAUSE of pain – physiologic, anatomic, functional, psychosocial
<u>Functional Micro-goal</u>	S.M.A.R.T. functional goal that is reasonably achievable in 1 month (micro-goal)	Specific, measurable, attainable, relevant, time-bound. Maintain motivation
<u>MIPS treatment plan</u>	(See TPT Plan - Pain assessment template)	Remember SSS (“specific, strategic, safe”) for medications and interventions
<u>Accountability plan</u>	Follow up timing. How progress will be measured	Get buy-in of patient and family members.

Specific-Strategic-Safe...for Medications!



Medication Selection

Specific	Strategic	Safe
Target identified pain mechanism(s)	What's limiting function the most?	Drug-drug interactions
Mode of delivery (oral, injectable, topical, etc)	Initiation and titration of multiple medications	Physiologic considerations
	Strategic consideration of side-effect profile	Warnings on sedation, driving, operating heavy equipment, etc.



Targeted Medications - Examples

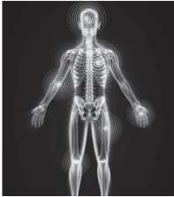
Goal: Target the physiologic cause of pain

Cause	Medication Class	Examples
Muscle Spasm	Muscle Relaxer	Cyclobenzaprine, Methocarbamol, Metaxalone, Orphenadrine, Tizanidine
Neuropathic (Nerve) Pain	Neuromodulator ("Nerve Pain Medication")	Gabapentin, Pregabalin
Inflammation	Anti-inflammatory ("NSAID")	Ibuprofen, celecoxib, Meloxicam, Etodolac, Diclofenac
Central Sensitivity	Certain antidepressants	Duloxetine, Minalcipram

- Remember – opioids do not target the cause of the pain.

Pain Medications (non-opioids)

Inflammatory Pain	<p>NSAIDs (non-steroidal anti-inflammatory drugs)</p> <ul style="list-style-type: none"> • ibuprofen (PO) • naproxen (PO) • ketorolac (PO, IM, IV) • diclofenac (PO, topical gel) • etodolac (PO) • meloxicam (PO) • methyl salicylate/menthol (topical) <p>Steroids (oral, intra-articular, peri-neural, epidural, IM, IV)</p>
Neuropathic Pain & Central Pathologic Pain** **(evidence for efficacy for pain treatment is mixed and limited for many of these medications)	<p>Anticonvulsants</p> <ul style="list-style-type: none"> • gabapentin, pregabalin <p>SNRIs (serotonin, norepinephrine reuptake inhibitors)</p> <ul style="list-style-type: none"> • duloxetine, milnacipran <p>Tricyclic anti-depressants</p> <ul style="list-style-type: none"> • amitriptyline, nortriptyline <p>Na⁺ channel blockers</p> <ul style="list-style-type: none"> • lidocaine (topical cream, topical patch, IM, IV), mexilitine, topiramate <p>TRPV1 ion channel blocker</p> <ul style="list-style-type: none"> • capsaicin (topical cream/ointment, topical patch) <p>NMDA receptor antagonists</p> <ul style="list-style-type: none"> • ketamine (IV), memantine (PO), dextromethorphan
Nociceptive Pain	<p>Antispasmodics (muscle spasm related pain)</p> <ul style="list-style-type: none"> • cyclobenzaprine, tizanidine, baclofen, diazepam/lorazepam <p>Acetaminophen and NSAIDs also effective, especially if inflammatory pain is also present</p>
Non-specific Pain	<p>Acetaminophen</p> <p>Alpha agonists</p> <ul style="list-style-type: none"> • clonidine (PO, patch), dexmedetomidine



Common Nonopioid Adjuvant Dosage for Adult Patients				
Group	Drug	Route	Dose	Side Effects
COX-1, 2 Inhibitors	Aspirin	PO	325–650 mg	Urticaria, angioedema, Reye's syndrome (avoid in children <12 y)
	Ibuprofen	PO, IV	PO: 200–800 mg tid IV: 400–800 mg tid	GI pain, dyspepsia, bone fracture
	Ketorolac	IV/IM	15–30 mg q6h (max 120 mg daily)	GI pain, dyspepsia Caution in elderly and with renal impairment
	Diclofenac	IV, IM, PO, topical	50–100 mg	GI pain, dyspepsia
	Meloxicam	PO	7.5–15 mg q24h	GI pain, dyspepsia
	Naproxen	PO	250–500 mg q6–8h (max 1,000 mg daily)	GI pain, dyspepsia
	Celecoxib	PO	100–200 mg daily	Reduced GI side effects (short-term)
	Acetaminophen (CNS COX-1,2)	PO, PR, IV	PO: 500–1,000 mg IV: 500–1,000 mg q4–6h; max 4 g/d	Hepatotoxicity, GI upset

Anticonvulsants	Gabapentin	PO	300 mg PO tid titrated to range of 600–1,200 mg tid	Sleepiness, confusion, bloating, leukopenia, thrombocytopenia
	Pregabalin	PO	25–150 mg PO daily, titrate to tid as tolerated	Sleepiness, confusion, bloating
Alpha2 agonists	Tizanidine	PO	2–4 mg qhs, titrate to 2–12 mg tid as tolerated	Hypotension, bradycardia, sleepiness, dizziness, nausea, dry mouth, anxiety, blurred vision, ↑ LFT
	Clonidine	PO, IV, epidural, topical	PO: 0.3–0.4 mg epidural: 30–40 mcg/h	Hypotension, bradycardia, sleepiness, dizziness, dry mouth, decreased bowel motility
TCA's	Amitriptyline	PO	10–25 mg qhs, titrate up to 25–150 mg qhs over several days	Sleepiness, dry mouth, ↑ HR, blurred vision, urinary retention, constipation
	Nortriptyline	PO	10–25 mg qhs, titrate up to 25–150 mg qhs over several days	Sleepiness, dry mouth, ↑ HR, blurred vision, urinary retention, constipation
SNRI	Duloxetine	PO	30–60 mg/d	Nausea, dry mouth, headache, sleepiness

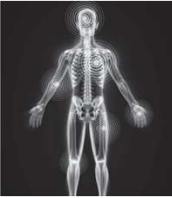
Edwards DA, Acute Pain Management. In Urman & Ehrenfeld editors. Pocket Anesthesia. 3rd Ed, Lippincott William & Wilkins, 2016. (used with permission)

Targeted Interventions – S.S.S.



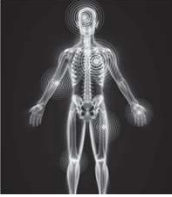
Specific, Strategic, Safe

<u>Specific</u>	<u>Strategic (choice)</u>	<u>Safe</u>
<ul style="list-style-type: none">• Where exactly is the pathology?<ul style="list-style-type: none">• E.g shoulder pain ☐ Shoulder joint versus subacromial bursa?• What technique will target it the best?<ul style="list-style-type: none">• The more specific the injection to the identified anatomic cause, the better (once all other factors are considered for safety, etc).	<ul style="list-style-type: none">• 1. Start with the “worst pain” first<ul style="list-style-type: none">• Get a quick win, move to the next cause• “don’t work on the roof if the kitchen is on fire”• 2. Start “from the inside out”<ul style="list-style-type: none">• If pain is all in the same general location (e.g. low back) address the deeper structures first• “don’t patch the drywall if the pipe is still leaking”	<ul style="list-style-type: none">• Cumulative Steroid Dose<ul style="list-style-type: none">• Risk/benefit of steroid• Imaging Guidance<ul style="list-style-type: none">• Fluoroscopy• Ultrasound• Anatomic considerations<ul style="list-style-type: none">• Abnormal anatomy• Severe pathology• Pharmacologic considerations<ul style="list-style-type: none">• Anticoagulants• Contrast dye allergies



RESOURCES

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TPT FAQ - Patient Handout (PDF attached)



Targeted Pain Treatment (TPT) Frequently Asked Questions Patient Handout

Prepared by: Angelina Poppe, D.Litt, RPAAC
Edited by: Stephanie G. Vanterpool, MD, MBA, FASA
Rev. 01/20/2019

TPT FAQ 2019

Overview

1. What is Targeted Pain Treatment (TPT)?
 - a. Targeted pain treatment (TPT) is the process of accurately diagnosing the cause(s) of a patient's pain and targeting the treatment to the cause(s).
2. What about TPT makes it so different from traditional pain management with pain scores?
 - a. Targeted Pain Treatment focuses first on accurately identifying all of the causes of the pain that the patient is experiencing, and then targets treatment to the identified causes. This is different from some approaches to pain management that have traditionally focused on lowering the pain score, without always treating the true cause of the pain.

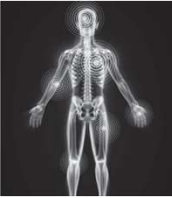
ACCURATE DIAGNOSIS

3. Why is an "accurate diagnosis" in TPT so important and what does it mean?
 - a. In TPT, "accurate diagnosis" means identifying the specific cause(s) of the pain that the patient is experiencing.
 - b. The cause(s) of pain may be:
 - i. Physiologic (related to how the body processes pain signals).
 - ii. Anatomic (related to structures in the body such as muscles, bones, joints and nerves).
 - iii. Functional (related to injury, posture, movement or other position related factors).
 - iv. Psychosocial (related to the way the mind deals with emotions, stresses and other environmental factors which can affect pain perception or experience).
4. Can I have more than one cause of pain in the same location (e.g. low back) at the same exact time?
 - a. Yes, it is possible to have different causes of pain affecting the same area of your body. For example, if you have low back pain and leg pain, it could be due to a combination of muscle spasms (physiologic), a pinched nerve in your back (anatomic), and possibly made worse by the way you walk or stand (functional). In order to get the best, lasting pain relief, we have to treat ALL of the identified causes of your back and leg pain.
5. How can you determine the cause of my pain?
 - a. In order to make an accurate diagnosis of the patient's pain the provider must obtain a detailed history, physical examination and complete the proper tests and studies (MRI, x-ray, CT, etc).
6. What do I need to tell you about my pain to help you figure it out?
 - a. You will want to tell your provider as many details as possible about your pain, how it started, what it feels like, and what you've done for it so far, so that he or she can figure out what is causing your pain.

TARGETED TREATMENT

7. Why is it important to treat all of the causes of my pain?
 - a. In order for the patient to feel the most relief, all the causes of pain should be correctly diagnosed and treated. For example, if a patient is suffering from muscle spasm and a herniated disc in their back, both must be treated otherwise the patient could feel minimal relief due to the other untreated cause.
8. What are medications supposed to target? How are they chosen?
 - a. Medications target the physiologic source of pain. In order to choose the correct medication, we have to understand the different working parts or pain states. For example, pain may be a result of inflammation, muscle spasms, nerve damage etc. By identifying the pain state, we can choose a medication that correctly targets that type of pain.
9. What are "interventions" and what kind of pain do they target?
 - a. Intervention are injections or procedures that target the anatomic (physical) structure(s) that are causing the pain. Once these structures are identified, your provider may either do an injection targeting the physical cause of your pain, or may refer you to a specialist for a more complex injection.
10. If I need more than one injection, how can you choose which injection to do first?
 - a. Your provider may choose or recommend one of two strategies. If you have one anatomic cause of pain that is much, much worse than the others, he or she may recommend targeting that structure first. If you have more than one anatomic structures at the same intensity of pain, your provider may choose to work from the "inside-out" (starting with the deepest physical structure and working their way out to the surface). When using injections, it is important to be specific (get as close as possible to the cause), and safe (consider all factors such as your medications, diseases or anatomy, and use image guidance as recommended).
11. What kind of pain can be targeted by physical therapy?
 - a. Physical therapy targets the functional causes of pain that results from the body's physical limitations, flexibility, and changes in posture. It also helps to strengthen muscles to prevent re-injuries.
12. What is psychosocial treatment and how does it help my pain?
 - a. Sometimes a person's emotions or conditions such as anxiety or depression can affect how a person copes with or experiences their pain. Psychosocial therapy may help with the person's ability to cope with their emotions and better manage their pain experience. Some examples of psychosocial therapy include counseling with a psychologist, cognitive behavioral therapy and meditation.

Targeted Pain Treatment Documentary (PBS)



<https://www.pbs.org/video/targeted-pain-treatment-hope-for-patients-with-pain-pdtmd6/>



Targeted Pain Treatment: Hope for Patients with Pain

Explore how Dr. Vanterpool and her expert team are revolutionizing the way chronic pain is treated. This documentary goes beyond traditional approaches to uncover innovative therapies that address the root causes of pain—not just the pain score. Through the personal journeys of real patients, you'll witness stories of hope, resilience, and life-changing relief.

[▶ Watch Now](#)

TFSQ

A: <3 METS

B: 3 to <4 METS

C: 4 to <5 METS

D: 5 to <6 METS

E: >= 6 METS

Tennessee Functional Status Questionnaire Index Scoring System Guideline

Question Number (1-5)	Score (1-13 total possible score)
TFSQ 1 (2-6 possible points)	A=2 points B=3 points C=4 points D=5 points E=6 points
TFSQ 2 (2-6 possible points)	A=2 points B=3 points C=4 points D=5 points E=6 points
TFSQ 3 (+1, -1 or 0 possible points)	a= +1 points b= -1 points c= 0 points
TFSQ 4 (-1 or 0 possible points)	a= -1 points b= 0 points
TFSQ 5 (-1 or 0 possible points)	a= -1 points b= 0 points

Minimum score 1

Maximum score 13

Higher score = higher functional status

Tennessee Functional Status Questionnaire (TFSQ) -Version 9 (9/19/2020)

Please use the table below to answer Questions 1 and 2: |

A	B	C	D	E
<ul style="list-style-type: none"> Self-Care – shower/wash, dress, use bathroom, Eat Shop at store, make food Walk around house Sit at computer Ride mower, water grass 	<ul style="list-style-type: none"> Activities in Column A, and at least one activity below: Child care – lift a child Sweep/Vacuum/Clean inside house Walk the Dog/ Walk on flat firm surface Trim shrubs or trees, use leaf blower 	<ul style="list-style-type: none"> Activities in Column B, and at least one activity below: Elder care, care for disabled adult Sweep outside house, sidewalk, or garage. Push a wheelchair/ Walk fast while holding less than 25 lbs. Push a power mower, Rake lawn, Play Golf (walk and pull clubs) 	<ul style="list-style-type: none"> Activities in column C and at least one activity below: Walk/run - play with children - vigorous only active periods Carry 1-15lb load upstairs; Walk fast on a flat surface (4mph) (walk a mile in 15 minutes) Softball or baseball; Tennis, doubles; Health club/gym work out 	<ul style="list-style-type: none"> Activities in column D and at least one activity below: Move Furniture, household items, carry boxes Walk 3.5mph (very fast) up hill Jog, singles tennis, basketball game, hard work out (high impact aerobics)

1. Choose the column that best matches what you **usually** do in a day (your usual activity level) (circle one)

Column: A B C D E

2. Choose the column that best matches what you **can** do on your **best** day (circle one)

Column: A B C D E

3. In the last 60 days, has your **usual** activity level **changed**? (circle one)

a. I am now **more** active than I was 60 days ago.

b. I am now **less** active than I was 60 days ago.

c. My activity level is the **same** as it was 60 days ago.

4. In the last 60 days, have you had **pain** that affects your activity level?

a. Yes

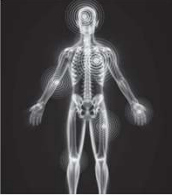
b. No

5. In the last 60 days, have you gone to the **emergency room** (ER)/**hospital** or had a **surgery**?

a. Yes

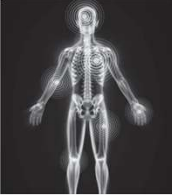
b. No

The 4 E's of Patient Education



- **#1. Engage**
 - Connect, Compassion, Comedy, Compliments
- **#2. Empathize**
 - 5 empathy skills
- **#3. Explain**
 - Start with Why
- **#4. Empower**
 - Power to choose

ABCDs of Pain Advocacy



A. Ask questions (*WHAT's causing my pain? WHAT can we do about it?*)



B. Be optimistic/open to treatment options



C. Clarify the plan (*WHY are we doing it?*)



D. Do your part (*Focus on function*)

HHS Pain Management Best Practices Report



- Link:
 - <https://www.hhs.gov/sites/default/files/pmtf-final-report-2019-05-23.pdf>
- Highlights
 - 2.1 Approaches to Pain Management
 - 2.2 Medications
 - 2.3 Restorative therapies
 - 2.4 Interventional procedures
 - 2.5 Behavioral health Approaches
 - 2.6 Complementary and Integrative Health
 - 2.7 Special Populations



Tennessee Chronic Pain Guidelines – 4th Ed.

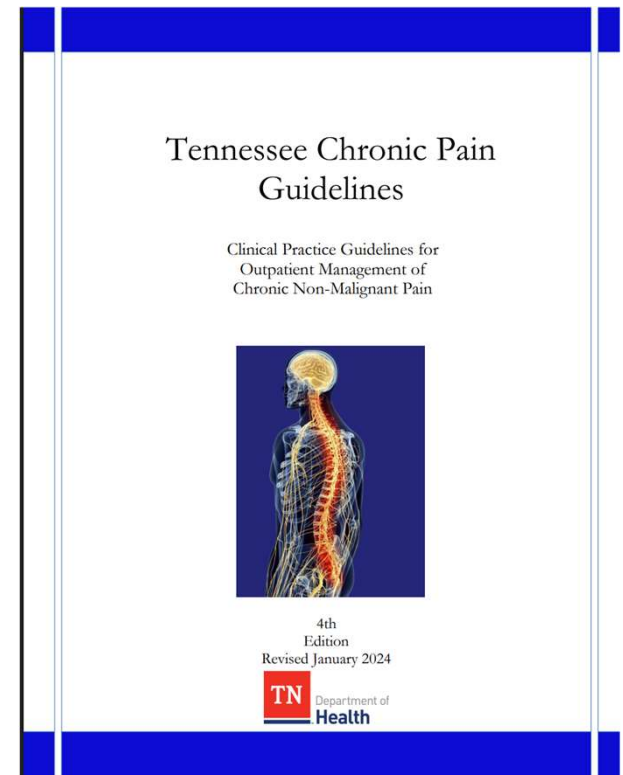


- Link:

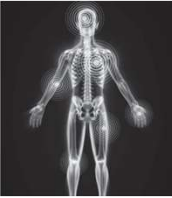
- <https://www.tn.gov/content/dam/tn/health/healthpr/ofboards/pain-management-clinic/ChronicPainGuidelines.pdf>

- Appendices

- CSMD: Controlled Substance Monitoring Database
- Urine Drug Testing
- ****OPIOID CONSENT****
- ****CONTROLLED SUBSTANCE AGREEMENT****
- Naloxone
- Perioperative management
- Useful links



Tennessee Medicine – Special Opioid Edition



- Link
 - <https://www.tnmed.org/assets/files/magazine/TennMedQtr4.pdf>
- Highlights
 - Physician supervision toolkit
 - Editorials
 - Targeted Pain Treatment
 - Neonatal Opioid Withdrawal
 - TN in Opioid Abuse Epidemic
 - CDC guidelines for chronic pain
 - TN Chronic Pain Guidelines
 - TMA Role in Fighting the Opioid Epidemic

