

Effective Chronic Pain Management & Chronic Opiate Therapy Guideline

Is this Patient taking pain medication on a chronic basis or needing a refill?

NO

Prescribe appropriate medication for event

Follow up needed for continued pain medications?

NO

See patient as needed

YES

YES

Opiates should **never** be considered first line agents in the management of chronic pain and should be prescribed only after determining that alternative therapies do not deliver adequate pain relief. (CDC 2016)

Provider Panel Specialist or Appropriate Clinical Support Staff completes the following the day prior to the appointment:

If pain is in chief complaint or they have a narcotic medication on their current medication list:

1. Place the Behavioral Health Screen (BHS-6), A Three-Item Scale Assessing Pain Intensity and Interference (PEG) - at all appointments, and Opioid Risk Tool (ORT) (at initial visit only) on the Department Appointment Registry (DAR)
2. Pull Prescription Drug Monitoring Program (PDMP) report and attach to huddle sheets, if applicable.

Office Visit

Rooming staff reviews and enter screening tools into flowsheets:

1. Update HM Modifier for PDMP
2. Additional screeners as needed: Columbia Suicide Severity Rating Scale (CSSR-S), Patient Health Questionnaire (PHQ-9), Generalized Anxiety Disorder Scale (GAD-7), Drug Abuse Screening (DAST-10), Alcohol Use Disorders Identification Test (AUDIT)
3. Physician/APP reviews huddle sheets including PDMP and enters room

Conduct a complete history and physical exam (pertinent to conditions identified) along with appropriate diagnostic workup and consultation for condition being treated

The risk of substance abuse, misuse, or diversion must be taken into account **anytime** opiates are being prescribed.

Documentation needs to include: 1) Nature & intensity of pain; 2) Current & past treatments; 3) Underlying/coexisting conditions; 4) Substance abuse/social (DUI); 5) Sexual abuse; 6) PTSD; 7) Depression; 8) Prescription Drug Monitoring Program; & 9) Completed Opioid Risk Tool

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Are non-opioid treatment and/or non-pharmacologic treatments an option?

YES

NO

Develop & Document Treatment Plan:

- Include goals of therapy, i.e. pain relief, improved social & physical function, expectations, & alternatives
- Use Chronic Pain Menu (See Page 5)

Chronic Pain Patients (new patient establishing with APP/physician)

1. Pain Medication Agreement (updated/signed yearly) (EPIC – Resources – Pain Management Enterprise – Chronic Pain Medication Agreement)
 - Sign agreement and send to scanning
 - Add “pain medication agreement” to Problem List (create Smartphrase below to add to Details section)
Smartphrase (.painproblast):
Prescriber: @PCP@
Before prescribing any opioids for this patient, please contact the on call staff at @DEPTNAME@.
Pharmacy: @PHARM@
Collateral Treatment:
Short term goal:
Long term goal:
Acceptable level of pain:
Date Contract Signed: ***
2. Add Diagnosis for which pain meds are prescribed if not already on problem list
3. Compliance Drug Screen
 - Initial, then yearly/random, and PRN
4. Complete Chronic Pain Action Plan (.cpactionplan)
5. Offer Behavioral Health
6. Obtain outside records regarding prior pain management
7. Calculate MME
8. Document non-response to non-opioid treatment and non-pharmacological treatments (i.e., Physical Therapy)
9. Okay to give 1 week of prescription
 - Send patient to do a Urine Drug Screen (UDS) if indicated that day
 - No further refills if:
 1. Abnormal UDS
 2. UDS not completed
 3. Records not obtained/not consistent with patient report
 - 3 month refills if:
 - Normal UDS/as expected send postdated scripts for 3 months to pharmacy
10. 3 month rechecks for 1st year, then 3-6 months as indicated by physician/APP
11. Shared decision making on additional referrals (see Chronic Pain Menu – Page 4)

Note: A signed OTA is **not required** for providers using opiates for the short term (less than 3 months) for management of acute illnesses, injuries, or surgery.

For Established Patients see Page 3

Chronic Pain Patients (Established with department)

- 3 month rechecks for 1st year, then 3-6 months as indicated by physician/APP
- Pain Medication Agreement (updated/signed yearly)
 - Sign agreement and send to scanning
- 1. Add to Problem List (use Smartphrase .painproblast, see below)
 - Smartphrase:
 - Prescriber: @PCP@
 - Before prescribing any opioids for this patient, please contact the on call staff at @DEPTNAME@.
 - Pharmacy: @PHARM@
 - Collateral Treatment:
 - Short term goal:
 - Long term goal:
 - Acceptable level of pain:
 - Date Contract Signed: ***
- 2. Add diagnosis for which pain medications are prescribed if not already on problem list
- 3. Compliance Drug Screen
 - Initial, then yearly/random, and PRN
- 4. Complete Chronic Pain Action Plan (.cpactionplan)
- 5. Offer Behavioral Health
- 6. Calculate MME
- 7. Okay to give 3 months of medication
 - Send patient to do UDS if indicated that day
 - Rooming staff/Panel specialist will notify physician/APP of UDS status at the end of the day
 - Call to cancel remaining prescription (postdated scripts) at pharmacy if sample not given or abnormal findings on UDS
 - Have nursing contact patient to schedule clinic appointment to discuss
- 8. Shared decision making on additional referrals (See Chronic Pain Menu – Page 4)

In order for Chronic Opiate Therapy (COT) to be deemed successful the following criteria must be met & documented in the patient's medical record.

Analgesia – decrease in pain

Activity – Increase in function

Adverse effects – absence of debilitating side effects

Aberrant Behavior – Patient requesting refills early? Current UDS/PDMP checks on chart?

When/if issues arise with the level of analgesia or use of prescription medication; primary care provider offices are encouraged to direct the patient to the make an expedited appointment for a re-visit with the Pain Clinic.

Indications for discontinuation of Chronic Opiate Therapy (COT)

- Violation of the Opiate Treatment Agreement (OTA)
- Failure to meet therapeutic goals
- Failure to comply with treatment recommendations (pharmacologic or not)
- Patient with intolerable or life threatening side effects
- Patient refuses UDS or pill count requests
- Unexpected UDS and/or PDMP results
- When in the clinical judgment of the medical provider, the risks of treatment with COT outweigh its potential benefits

Referral to Behavioral Health/Substance Use Evaluation if you suspect abuse or misuse/craving/seeking of medication

Chronic Pain Menu

- Physical Therapy
- Chiropractor
- Osteopathic Manipulative Therapy (OMT)
- Acupuncture
- Dry Needling
- TENS Unit
- Meditation
- Yoga
- Sleep Medicine/Hygiene
- Comprehensive Pain Clinic
- Massage
- Behavioral Health
- Chronic Pain Group
- Exercise Physiology
- Weight Loss Clinic
- Genetic Testing

Clinical Pearls

1. **Patients seen in the Pain Clinic within the last 12 months are considered “active” pain clinic patients & are therefore considered to be “co-managed.”**
2. Only the provider is managing the patient’s treatment plan or his designee (usually from the same office) will write prescriptions.
3. Integrate pain control into a comprehensive evaluation & management plan.
4. Assess & manage disability & physical, psychosocial & psychiatric co-morbidities.
5. Identify & treat the specific source of pain when possible.
6. Individualize pain control & use analgesic drugs based on a case-by-case analysis of risk & benefit.
7. Importance of Therapeutic Relationship
8. Select the simplest approaches recognizing the value of a multi-modality approach that uses pharmacologic and non-pharmacologic means.
9. Obtain the input of consultants when there is uncertainty.
10. Single provider. Single pharmacy.
11. Providers should recognize that tolerance & physical dependence are normal consequences of sustained use of opioid analgesics & not the same thing as addiction.
12. Patients receiving COT should be seen face-to-face & response to therapy documented at least every 3 months. More stringent visits may be advisable based on the individual needs and patient risk profile. Subsequent USD’s & PDMP checks will be obtained yearly (at minimum) or sooner if situation dictates.
13. When the prescribing physician is not in the office for a week or longer the practice group will assign another provider to manage the patient’s plan of care. Prescription authority can be transferred between the PCP and Pain Clinic for patients being co-managed.
14. Morphine milliequivalents information for narcotics can be found under Resources-Pain Management Enterprise-ADMG MME Calculator

References

1. Report of the Minnesota Board of Medical Practice Work Group on Appropriate Prescribing of Controlled Substances for the Management of Pain published November 10, 2007
2. ICSI Health Care Guideline - Assessment and Management of Acute Pain, March, 2008
3. ICSI Health Care Guideline - Assessment and Management of Chronic Pain, March, 2008
4. Opioid Treatment Guidelines, Journal of Pain, Vol. 10, No 2 (February), 2009: pp. 113-130.
5. U.S. Department of Justice, Drug Enforcement Administration, Office of Diversion Control, Practitioner’s Manual, Section V- Valid Prescription Requirements, August, 2006
6. Chronic Opioid Therapy (COT) Safety Guideline For Patients with Chronic Non-Cancer Pain, Group Health Cooperative, 2014
7. Fishman, Scott M. Responsible Opioid Prescribing: A Clinician’s Guide. Waterford Life Sciences, Washington, DC, 2014
8. Dowell D, Haegerich TM, Chou R. CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016. MMWR Recomm Rep 2016;65(No. RR-1):1–49.